### Sample Care Plan

**Care Plan**

Client: Jerry X.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Coordinator: Ben C.\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_3/2/17\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immediate goals**  **Completed by**

* + Complete Housing Intake at the City of Dallas 3/15/17\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Complete Medical appointment\_\_\_\_\_\_\_\_\_\_\_ 3/8/17\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Long term goals**

Medical

* + Complete 3/15/17 medical appointment\_\_\_\_\_
	+ Complete follow up labs, if needed\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental

* + Schedule Dental appointment when most recent labs are available \_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adherence

* + Pick up medication refills when ready\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Basic Needs

* + Update paperwork to access food pantry\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Housing

* + Meeting with the City of Dallas on 3/15/17 for housing services\_\_\_\_\_\_\_\_\_\_
	+ Continue to stay at homeless shelter until housing in available\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Income

* + Continue to work with attorney on SSI denial
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health

* + Check in with therapist on a weekly basis\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Abuse

* + Maintain sobriety\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Continue to check out CMA and other 12 step groups\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Support

* + Consider attending Depression support group\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal

* + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Safety

* + Work with shelter staff if any safety issues arise\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Self-Sufficiency Goal

* + Long term goal is to go Community College\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next Care Plan Meeting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATH CLIENT INDIVIDUALIZED SERVICE PLAN**

|  |  |  |
| --- | --- | --- |
| Client Name: | Date Plan Begins: | Case Manager UF CARES: |
| Primary Case Manager: | Date Plan Ends: | Case Manager River Region: |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **#** | **Identified Service Need** | **Service Provider** | **Goals/Objectives & Desired****Outcomes (Action Steps)** | **Realistic Time Frames** | **Date Outcome Met** | **Barriers (If Applicable)** |
| **1** |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |
| **8** |  |  |  |  |  |  |
| **9** |  |  |  |  |  |  |
| **10** |  |  |  |  |  |  |

Client’s Statement and Agreement: I have participated in the creation of this plan for my care. I understand that I have to take responsibility for MY plan in order for the plan to succeed. The case manager has explained to me what portions of the plan I am solely responsible for and those that my case manager will assist me. I agree to follow all aspects of this plan and advise my case manager if there are any significant changes in my life that make it necessary to change my plan. I agree to stay in contact with my case manager as planned.

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UF CARES Case Manager’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

River Region Case Manager’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Case Management Care Plan

**Client ID** \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ **MR#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CM**\_\_\_\_\_\_\_\_\_\_

**Date Attainable Specific Goal Date Attained**

\_\_\_/\_\_\_/\_\_\_ 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_ 10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

Last HIV medical visit: Within the last 6 months 7-11 months ago 12 or more months ago Never

Did you miss your last HIV medical care appointment? Yes No If yes, Why?

Is your next HIV medical care appointment scheduled? Yes No If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Need mental health services? Yes No Currently receiving MH services? Yes No Referred MH? 

Need subst. abuse services? Yes No Currently receiving SA services? Yes No Referred SA? 

 Date Enroll SA Services\_\_\_\_/\_\_\_\_/\_\_\_\_ Date Completed SA Services\_\_\_\_/\_\_\_\_ /\_\_\_\_

**Notes (cite goal number if applicable):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Case Manager Signature  **Copy given to client**

**SPNS CLIENT SERVICES PLAN**

(Case Management, Home Health Aide, Respite, Housing, Mental Health, Substance Treatment)

*INSTRUCTIONS: This form must be completed every 4 to 6 months. Number those needs that apply and list below, then fill in below grid with corresponding numbers. Include all needs.*

|  |  |  |
| --- | --- | --- |
| **Client ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Name of Person Completing Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Services Site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Needs to be addressed:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| \_\_\_\_ | Financial Assistance | \_\_\_\_ | Medical Coverage | \_\_\_\_ | Home Care |
| \_\_\_\_ | Health Services | \_\_\_\_ | Legal Assistance | \_\_\_\_ | Basic Needs |
| \_\_\_\_ | Psychosocial Support | \_\_\_\_ | Housing Assistance | \_\_\_\_ | Transportation |
| \_\_\_\_ | Behavioral Health | \_\_\_\_ | Substance Abuse | \_\_\_\_ | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Need #** | **Client will do:** | **Staff person will do:** | **Date Due** | **Date Done (use code below)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Codes: C=Completed, P=Pending (paperwork filed, awaiting decision), DNF=Did not follow through (indicate who), CL=Closed

|  |  |  |
| --- | --- | --- |
| Client Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Staff Signature:  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Update Due (6 months) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_