CLIENT CARE COORDINATION PLAN

Short-term Goals / Objectives:

Objective # ____ Effective Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other _____

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: _____ Date: _____

Short-term Goals / Objectives:

Objective # ____ Effective Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other _____

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: _____ Date: _____

Short-term Goals / Objectives:

Objective # ____ Effective Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other _____

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: _____ Date: _____

*MHS includes therapy/rehab (individual, family, or group), psychological testing, collateral and team conference/consultation services.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health