Client ID# _____

Client Service Plan

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

(***INSTRUCTIONS: This form must be completed every*** *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 Service Plan_____Service Site:___

Needs to be addressed:

____Financial Assistance
____Health Services
____Psychosocial Support
____Transportation
____Medical Coverage
____Legal Assistance
____Housing Assistance
____Substance Abuse
____Home Care
____Basic Needs
____Other_____
____Other_____

	Client Will Do:	**Staff Person will Do:**	**Date Due**	**Date Done/ code (below)**

Codes: C=completed, P=pending (paperwork filed, awaiting decision), DNF=did not follow through (indicate who), CL=closed

Client Signature: _____Date: _____ Worker Signature: _ _____Date:_____

Next Service Plan DUE (6 months): _____