## CLIENT TREATMENT PLAN

**Problems/Needs Goals Interventions**

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A. Anticipated length of treatment/service:

B. Services provided (please highlight):

Case Management Medication Referral Therapy Referral Food Resources

Medical Referral Housing Resources Employment Resources

C. Signatures:

Client: Date:

Parent/Guardian/Responsible Adult: Date:

Client unwilling/ unable to sign because\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TREATMENT PLAN TO BE UPDATED ANNUALLY**