1014–Client Plan

Plan date: Renewal Date:

Plan end date:

Plan name:

Plan type: ☐Annual ☐Initial ☐Plan update ☐Service added

Staff ID:

ROI for PCP obtained: ☐Yes ☐No

Client signature: _____ Date:

Family/Support Person/Counselor Signature: _____ Date:

Staff/Supervising Counselor Signature: _____ Date:

Co-Signature (LPHA): _____ Date:

Physician Signature: _____ Date:

Client Copy of the Plan

I have been informed of my right to receive a copy of the client plan and I would like to receive a copy
☐Yes ☐No

Client refuses a copy of the plan
☐Yes ☐No

Client signature (treatment copy): _____ Date:

Explanation if Client Signature is not obtained:

Humboldt County Department of Health & Human Services	DHHS-Behavioral Health 720 Wood Street Eureka, CA 95501 **CONFIDENTIAL PATIENT INFORMATION** (SEE CA W&I CODE 5328, 42 CFR PART 2)	**Client Treatment Plan**	Client Name	
			Client ID	
			Client DOB	

Problem 1:

goal 1:

Interventions:

goal 2:

Interventions:

goal 3:

Interventions:

Problem 2:

goal 1:

Interventions:

goal 2:

Interventions:

goal 3:

Interventions:

Problem 3:

goal 1:

Interventions:

goal 2:

Interventions:

goal 3:

Interventions:

Participant:

Role:

Notification required
☐Yes ☐No