



### Care Coordination Plan

Date: \_\_\_\_\_ Case Number: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Telephone - (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

The care coordination plan is designed to be a working document to develop goals together with your care coordinator that will assist you in your recovery process. Important things to remember when setting goals for your-self:

- Goals should be “**SMART**”: **S**pecific, **M**easurable, **A**ttainable, **R**ealistic and **T**imely
- Your care coordination plan should be related to your over-all long term goals
- Leave yourself enough time to develop long-term goals, it is not expected that long-term goals will be completed by a set time frame

The following are suggested questions that can help guide goal development:

- Who are the individuals in your life that can help you meet your goals?
- Who are the individuals in your life that may cause a barrier to you meeting your goals?
- How would your life look if you could meet your goals?
- How would your life look if you could not meet your goals?
- What barriers do you have now and how do they affect your life?

<b>Long Term Goal 1</b>	
Indicate your goal:	<b>Or:</b> <input type="checkbox"/> Long Term goal was not developed during this session
Indicate your barriers to achieving this goal:	
Notes:	

<b>Long Term Goal 2</b>	
Indicate your goal:	<b>Or:</b> <input type="checkbox"/> Long Term goal was not developed during this session
Indicate your barriers to achieving this goal:	
Notes:	

<b>Please indicate Goal Area(s) from the list below:</b>			
<input type="checkbox"/> Immediate Need	<input type="checkbox"/> Housing Status	<input type="checkbox"/> Medication Adherence	<input type="checkbox"/> Substance Use Disorder
<input type="checkbox"/> Language Needs	<input type="checkbox"/> Support System	<input type="checkbox"/> Dental Health	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Navigating Services	<input type="checkbox"/> Medical Insurance/Medi-Cal	<input type="checkbox"/> Finances	<input type="checkbox"/> Incarceration/Legal Issues

<input type="checkbox"/> Immigration Status	<input type="checkbox"/> Medical Care	<input type="checkbox"/> Safety Issues	<input type="checkbox"/> Healthy Habits/ Nutrition/Fitness
<input type="checkbox"/> Supportive Service Needs	<input type="checkbox"/> Transportation	<input type="checkbox"/> Children and Family Services	<input type="checkbox"/> Education/Job Training
<input type="checkbox"/> Employment	Other (please specify):		

**Step 1 Area:**

Indicate goal for this area:

Action	Person(s) Responsible for Helping to Achieve This Goal	Target Date	Date Achieved or Modified
1.			
2.			
3.			

Notes:

Referral Made **OR** N/A :

**Step 2 Area:**

Indicate goal for this area:

Action	Person(s) Responsible for Helping to Achieve This Goal	Target Date	Date Achieved or Modified
1.			
2.			
3.			

Notes:

Referral Made **OR** N/A :

Print Client Name:

Client Signature:

Date:

Care Coordinator Signature:

Date:

Licensed Practioner of the Healing Arts Signature:

Date: