Jefferson Franklin
COMMUNITY ACTION CORPORATION

Termination of Services/Aftercare Plan

Client name:	Clinician:
DOB:	Date:
Client insurance #:	ICD-10 diagnosis:
Treatment start date:	Treatment discharge date:

Frequency of visits: _____ Duration of visits: _____

Treatment goals obtained: ☐ Yes ☐ No ☐ Partially

Reason for discharge

☐ No further care needed
☐ Admission to hospital
☐ Death
☐ Refused services
☐ Transfer to other agency
☐ Lack of funds
☐ Lack of progress
☐ Moved out of area
☐ Other _____

Primary concerns at intake:

_____
_____
_____
_____
_____

Status of concerns at discharge:

_____
_____
_____
_____
_____

Summary of treatment provided: _____
_____
_____
_____

Discharge recommendations: _____
_____
_____
_____

Referral source (if applicable): _____
_____

Clinician signature:	Date:

Updated 8/29/18

community Action PARTNERSHIP
Helping People. Changing Lives.

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