Jefferson Franklin
COMMUNITY ACTION CORPORATION

Treatment Plan

Client name:	Clinician:
DOB:	Date:
Client insurance #:	ICD-10 diagnosis:

Other agencies involved: ______________________________

Plan to coordinate services: ______________________________

Presenting problem: ______________________________

Long-term goal: ______________________________

Short-term goals/objectives: ______________________________

Reassessment date: ______________________________

Therapeutic interventions: ______________________________

Referral sources: ______________________________

Review dates:
Completion date:

Clinician signature:	Date:

Updated 8/29/18

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