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| *Current Recommended level of care for client:* |  |
| *Educational needs**Is there an* ***IEP*** *in place:* [ ] yes [ ] no, if no is an **IEP** recommended:[ ] yes [ ] no | School Name and Contact information:*Contact person:**Needs:**Status:**Goals:* |
| Supports for the following needs are recommended:[ ] Family/Primary Support [ ] Social Environment[ ] Economic[ ] Housing[ ] Education[ ] Access to Health Care [ ] Occupational[ ] Legal/Criminal[ ] Transportation needs[ ] Faith | Provide support names, contact information, appointments, plans to meet the needs, services coordinated, referrals to be made: |
| Follow up appointments for aftercare therapy services:[ ] appointment recommended [ ]  N/A, Client discharged to independence | Provider name:Contact information (phone, address, etc.):Type of therapy :Appointment scheduled: |
| Medication Therapy:[ ]  not recommended[ ]  client may benefit from Medication [ ]  recommended | Current Medications and dosages:Provider Name:Contact Information:Appointments scheduled: |

Provider signature, credentials and date of plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_