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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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_