|  |  |
| --- | --- |
| *Current Recommended level of care for client:* |  |
| *Educational needs*  N/A *:*  *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 | Provider name:  Contact information (phone, address, etc.):  Type of therapy :  Appointment scheduled: |
| Medication Therapy:  N/A | Current Medications and dosages:  Provider Name:  Contact Information:  Appointments scheduled: |

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