



Colorado Health Partnerships, LLC
Pikes Peak ♦ SyCare ♦ West Slope Casa ♦ ValueOptions

TREATMENT/DISCHARGE PLANNING FORM

CLIENT NAME: _____ CLIENT MEIDCAID #: _____

PROBLEMS AND GOALS (what is being treated) Complete all that apply:

1. **PROBLEM** (treatment issue identified by the client/guardian):

1. **GOAL** (objective, measurable, achievable goal in emotional/behavioral terms to address the above identified problem):

2. **PROBLEM** (treatment issue identified by the client/guardian):

2. **GOAL** (objective, measurable, achievable goal in emotional/behavioral terms to address the above identified problem):

3. **PROBLEM** (treatment issue identified by the client/guardian):

3. **GOAL** (objective, measurable, achievable goal in emotional/behavioral terms to address the above identified problem):



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CLIENT NAME: _____ CLIENT MEIDCAID #: _____

DISCHARGE CRITERIA (how will you know when treatment is over?)

CRITERIA:

CRITERIA:

Comments/Notes:

Client/guardian Signature: _____

Provider Signature (include credentials): _____

Date of Plan: _____