## NON-MEDICAL CASE MANAGEMENT CARE PLAN

Name: \_\_\_\_\_\_\_Client #: \_\_\_Dates: \_\_\_\_\_\_\_\_\_\_

Current Needs to be Addressed: (*Pick top 4 from acuity scale, or ask client what their priorities are*)

|  |  |
| --- | --- |
| 1. | 2. |
| 3. | 4. |

Frequency of Contact: Method(s) of Contact: 🞏 Home Visits 🞏 Community Visits

🞏 Telephone 🞏 Written Correspondence

Client’s Signature:

Case Manager’s Name and Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Date** | **Priority Number** | **Goal** | **Action Steps** | **Responsible Person(s)** | **Target Date** | **Date Achieved** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Client  Case Manager  Community Resources |  |  |
|  |  |  |  | Client  Case Manager  Community Resources |  |  |
|  |  |  |  | Client  Case Manager  Community Resources |  |  |
|  |  |  |  | Client  Case Manager  Community Resources |  |  |
|  |  |  |  | Client  Case Manager  Community Resources |  |  |
|  |  |  |  | Client  Case Manager  Community Resources |  |  |