MH 651
Revised 05/12/09

SPECIAL PROGRAM CCCP

Annual Cycle Month: **(Due prior to the 1st day of the Month)**
☐ **Jan** ☐ **Feb** ☐ **Mar** ☐ **Apr** ☐ **May** ☐ **Jun** ☐ **Jul** ☐ **Aug** ☐ **Sep** ☐ **Oct** ☐ **Nov** ☐ **Dec**

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be **SMART**: **S**pecific, **M**easurable/Quantifiable, **A**ttainable within this year, **R**ealistic, and **T**ime-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1 Effective Date: _____

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup Other _____

Client Involvement - Client agrees to participate by:

Signature(s)

Print Name	Signature & Discipline	Date	Co-signature & Discipline	Date

Outcomes: To be completed either when the objective is obtained or prior to the beginning of the next cycle month.

Initials: Date:

Short-term Goals / Objectives:

Objective # 2 Effective Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup Other _____

Client Involvement - Client agrees to participate by:

Signature(s)

Print Name	Signature & Discipline	Date	Co-signature & Discipline	Date

Outcomes:

Initials: Date:

*__MHS includes individual, group, psychological testing, collateral and consultation services.__

Family Involvement: ☐ Biological ☐ Other

Name: _____ Telephone Number: _____ Date of contact: _____

Family agrees to participate? ☐ Yes ☐ No (If yes, please specify):

Additional Client Contacts / Relationships:	**Interpretation**	**Client's Signature to the Care Plan**
☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds ☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run ☐ Education/AB 3632 ☐ Other _____	Prefer a language other than English: ☐ Yes ☐ No This plan was interpreted: ☐ Yes ☐ No Language: _____	Client's Signature: _____ Date: _____ Client offered a copy: ☐ Yes ☐ No Staff Initials: _____ Date: _____

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Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

Special Program Client Care Coordination Plan