

Appendix 22 ■ Care Plan

Client Name:		MSSP #:		Care Plan Conference Date:		Duration of Care Plan	
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Date	Problem #	Problem Statement	Client Goal/ Outcome	Service Provider & Type (I, R, P, C)	Plan/Intervention	Date Resolved/ Comments

MSSP Staff Signatures:			
CM:	Date:	SCM:	Date:
I acknowledge receipt and acceptance of this Care Plan, and receipt of the notice regarding my rights to a fair hearing if I am dissatisfied with the action(s) affecting MSSP-funded services.		X	
		Client's Signature & Date	