North Country Community Mental Health

Goal/Support # ________

Goal: ____

Start Date: ____________________ **Target Date of Completion:** ____________________

List Objective/s: ____

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Natural Supports and Planned Strategies

SELF: ____

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Person Responsible: ____________________ Frequency: ____________________

FAMILY AND FRIENDS: ____

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Person Responsible: ____________________ Frequency: ____________________

COMMUNITY: ____

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Person Responsible: ____________________ Frequency: ____________________

PUBLIC AGENCIES: ____

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Person Responsible: ____________________ Frequency: ____________________

COMMUNITY MENTAL HEALTH:

Objective: __________ Provider: __________ Service: __________ Frequency: __________

Objective: __________ Provider: __________ Service: __________ Frequency: __________

Objective: __________ Provider: __________ Service: __________ Frequency: __________

Objective: __________ Provider: __________ Service: __________ Frequency: __________

Documentation Instructions: --

CRISIS PLAN

Consumer will: ____

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Clinic will: ____

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Natural Supports will: ____

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Name:	ID #	Date

Plan of Service
Goals and Supports