HOMELESS HEALTH CARE LOS ANGELES
DRUG ABUSE HOMELESS DAY CARE SERVICES
90-DAY TREATMENT PLAN

CLIENT NAME__________________________________ **CLIENT ID#** ______________________**DATE OF LAST I**

Use index number for each problem/goal/action step.
¿DRUG USE ‡PSYCHOSOCIAL ¬MEDICAL/DENTAL √ HOUSING/BENEFITS ƒLEGAL/ADVOCACY ≈ EMPLOYMENT/VOCATI

DATE IDENTIFIED	INDEX NUMBER	PROBLEM STATEMENT	GOAL STATEMENT	ACTION STEPS
	1	Drug Use	Reduction/Elimination of Drug Use	1.) Attend Treatment Sessions
	1	Drug Use	Attend Acupuncture Treatment	1.) ___ session(s) per week
	2	Psychosocial	HIV/STD Health Education	1.) Participate in HIV education group and/or individual counseling
	7	Mental Health	Self-esteem, Communication, Relaxation, Anger Management, Depression, Anxiety	
	3	Medical/Dental	Medical Screening TB Dental Assessment	1.) See Clinician 2.) See Nurse 3.) Follow-up as needed
	4	Housing	Housing Stability	
	6	Employment/ Education		

Primary Counselor: ________________________________ **Date:** ________________________ **QA Aud**

Client Signature: ________________________________ **Date:** ________________________ **QA Aud**

Clinical Director: ________________________________ **Date:** ________________________ **QA Aud**

HHCLA: 1989, revised 06/02