HOMELESS HEALTH CARE LOS ANGELES
DRUG ABUSE HOMELESS DAY CARE SERVICES
TREATMENT PLAN UPDATE

CLIENT NAME_____ **CLIENT ID#** _____**DATE OF LAS**

Use index number for each problem/goal/action step.
¿ **DRUG USE** ¡ **PSYCHOSOCIAL** ¬**MEDICAL/DENTAL** √ **HOUSING/BENEFITS** ƒ **LEGAL/ADVOCACY** ≈ **EMPLOYMENT/VOCA**

DATE IDENTIFIED	INDEX NUMBER	PROBLEM STATEMENT	GOAL STATEMENT	ACTION STEPS

Primary Counselor: _____ **Date:** _____ **QA Aud**

Client Signature: _____ **Date:** _____ **QA Aud**

Clinical Director: _____ **Date:** _____ **QA Aud**

HHCLA: 1989, revised 06/02