CLIENT CENTERED PLAN

Please complete the items noted by the asterisks (**).

**Patient/Child's Name: _____

**Parents Name: _____
(if applicable)

**Primary
Problem: _____

_____

Intervention
Strategies: _____

_____

Goals/Outcome: _____

_____

Review
Plan: _____

_____

**Patient/Parent
Signature: _____

Therapist
Signature: _____

Date: _____

11-18-2011 per Medicaid workshop