Print Form

Medical Case Management Service Plan

Case Manager:_____ **Date Completed:** _____

Identified Issue/Need to be Addressed	Action Needed	Individual Responsible for Action Needed	Activity (New/Updated)	Anticipated Time Frame (Completion Date)	*Further Action Required? (Yes/No)
Example: Unprotected sex – Need Harm Reduction	*Consistently carry condoms*	*Patient*	*New*	*10/25/10*	*No*

COMPLETE NEW SERVICE PLAN FORM UPON REASSESSMENT

*If "Yes", additional information on new or updated follow-up activities should be included in the subsequent Service Plan.

Medical Case Management Service Plan

Referral	Problem	Action Needed	Individual Responsible for Action Needed	Activity (New/ Updated)	Anticipated Time Frame (Completion Date)	*Further Action Required (Yes/No)
Agency/Subspecialty: *Example:* *COBRA*	*Need Housing Assistance*	*Require assistance identifying new housing that accepts DSS direct payment, eviction pending 11/1/10*	*Case manager*	*New*	*11/1/10*	*No*
Agency/Subspecialty:						
Agency/Subspecialty:						
Agency/Subspecialty:						
Agency/Subspecialty:						

Supervisor Signature **Case Manager Signature** **Patient Signature**

COMPLETE NEW SERVICE PLAN FORM UPON REASSESSMENT

*If "Yes", additional information on new or updated follow-up activities should be included in the subsequent Service Plan.