

SINGLE PLAN OF CARE

Strengths Assessment

(Page 1 of 2)

Youth/Family Name		Date	
Address/Telephone		ID #	
Care Coordinator/ Case Manager			
If this page is blank, please check, which of the following has been completed, and attach that form. ____ Family Assessment CSSB ____ Treatment/Rehab Plan			
Basic Needs			Attachment
<u>Strengths:</u>		<u>Needs/Risks:</u>	
Social Network			Attachment
<u>Strengths:</u>		<u>Needs/Risks:</u>	
Family			Attachment
<u>Strengths:</u>		<u>Need/Risks:</u>	
Vocational/School			Attachment
<u>Strengths:</u>		<u>Needs/Risks:</u>	
Community			Attachment
<u>Strengths:</u>		<u>Needs/Risks:</u>	
Financial/Economic			Attachment
<u>Strengths:</u>		<u>Needs/Risks:</u>	
Health			Attachment
<u>Strengths:</u>		<u>Needs/Risks:</u>	

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(Page 2 of 2)

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Legal			Attachment
<u>Strengths:</u>		<u>Needs/Risks:</u>	
Leisure/Recreation			Attachment

<u>Strengths:</u>	<u>Needs/Risks:</u>
Emotional/Behavioral	Attachment
<u>Strengths:</u>	<u>Needs/Risks:</u>
Spiritual	Attachment
<u>Strengths:</u>	<u>Needs/Risks:</u>
Independent Living	Attachment
<u>Strengths:</u>	<u>Needs/Risks:</u>
Other	Attachment
<u>Strengths:</u>	<u>Needs/Risks:</u>

Narrative (Cultural Issues & Additional Comments):

