**Fountain of Hope Family Services**

**Continuing Care/Transition Plan  
Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Admission Date:\_\_\_\_\_\_**

**Legal Guardian (other representative):**

**Current Address: Telephone:**

**Staff Name:**

**Presenting Problem (s):**

**Continuing Care Plan Development:**

**Was client referred for ongoing or additional Referral Resources (when applicable):**

\_ Inpatient Drug/Alcohol Child Welfare Shelter Day Treatment

Psychiatric Services Medical Hospital YWCA Outpatient Drug/Alcohol

Vocational Evaluation DRS AA Meetings \_\_NA Meeting

Food Bank Dental Services Salvation Army Goodwill

\_YMCA Boys & Girls Club Other

**Support System:** Family Friends, Mother \_Farther

Brother Sister Social Worker Counselor

Pastor Sponsor

\_Self-Help-Group-Members others:

**Treatment Summary:** Individual was able to Identify and Process Issues Yes No

**Insight:**

Good Fair Superficial Lacking

Poor Blaming Better Out Look on Life

Has better Insight of Issues Improvement in Behaviors Other (describe)

**If symptoms recur or additional services are needed; client may contact CSI: Yes No at 405-601-6710**

**Progress: Improved Limited Improvement Worse No Change**

**Client Signature Guardian Signature**

**Staff Signature & Credentials Discharge Date**

Client Received Copy of Continuing Care Plan Yes No

In Person Mailed to Last Known Address