**Aftercare Plan**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client want formal aftercare services? Yes \_\_\_No \_\_\_Undecided \_\_\_\_

Briefly describe aftercare services the client will receive and the purpose of these services:

Describe the client’s plan for maintaining or continuing to develop self-sufficiency abilities:

List referrals and resources needed (name, address, phone number…)

Describe the client’s support network in the community (name, relationship, contact information, type of support…)

Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_