

SHARED PLAN OF CARE

HCP A program for children & youth with special health care needs



www.hcpcolorado.org



COLORADO
Department of Public
Health & Environment

Last Name: _____ First Name: _____ Date of Birth: _____

Date Action Plan Completed: _____

Family Member: _____ Phone #: _____

HCP Goal: Family will be confident in coordinating and advocating for their child's health care needs.

GOAL #1 <i>What is it that the family/child wants or needs? Include goal statement and desired outcome.</i>			
Next Steps: <i>List action/ interventions that will help achieve this goal.</i>			
	Person(s) Responsible	Target Date	Complete Date
a.			
b.			
GOAL #2 <i>What is it that the family/child wants or needs? Include goal statement and desired outcome.</i>			
Next Steps: <i>List action/ interventions that will help achieve this goal.</i>			
	Person(s) Responsible	Target Date	Complete Date
a.			
b.			

Insert LPHA Logo Here

GOAL #3 *What is it that the family/child wants or needs? Include goal statement and desired outcome.*

Next Steps: <i>List action/ interventions that will help achieve this goal.</i>	Person(s) Responsible	Target Date	Complete Date
a.			
b.			

Other priority areas that the Family/[child/youth] would like to visit between now and the 6 month review:

1	
2	
3	

I participated in the development of and agree with the above Child/Family Action Plan. _____ Date: _____

Copy to: Family / Copy to: _____ Phone #: _____

HCP Care Coordinator: _____ Phone #: _____