HENDERSON MENTAL HEALTH CENTER, INC.
CHILD AND FAMILY INDIVIDUALIZED WRAPAROUND PLAN

CHILD & FAMILY NAME:	FACILITATOR/CM NAME:	DATE:	MED REC #:

Long Term Vision *(in client's words):*

LIFE DOMAIN & (# from SNCD)	MEASURABLE GOALS: *(in family's words)*	REFERRALS, SERVICES, COMMUNITY & NATURAL SUPPORTS, MEASUREABLE ACTION STEPS /FREQUENCY	PERSONS RESPONSIBLE TARGET DATE *(include phone #)*	DATE OF REVIEW/ UPDATES	DATE ACHVD

Conditions for discharge: Target goals achieved or when adequate social support system is established as determined by family/person served.
I have participated in the formulation of this wraparound plan:

Client: ____ Date: ____________ Team Member: _____________________________________ Date: ____________

Guardian: ____ Date: ____________ Team Member: _____________________________________ Date: ____________

Guardian: ____ Date: ____________ Team Member: _____________________________________ Date: ____________

Facilitator: ____ Date: ____________ Team Member: _____________________________________ Date: ____________