WASHINGTON COUNTY
OREGON

Residential Treatment Preliminary Discharge Plan

CLIENT INFORMATION

Client Name:	Client DOB:	Current Location:
County of Responsibility:	ENCC Name:	Phone Number:
Email:		

QUESTIONNAIRE

Program(s) Referred to:

Expected Outcome of Residential Treatment:

Treatment Team Discharge Plan:

Barriers to Discharge:

Special Needs Requests:

Amount of COR/Choice funding to be provided to meet these needs:

Additional Comments: