Action Plan

Aging & Disability Resource Center

Customer Name: _____ **Options Counseling Date:** _____

Customer Phone Number: _____

ADRC/ADRS Staff Name: _____

ADRC/ADRS Staff Phone Number: _____

Goal #1	Support Option/Referral	Referral Agency	Specific Action	Timeline	By Whom
Goal #2	**Support Option/Referral**	**Referral Agency**	**Specific Action**	**Timeline**	**By Whom**
Goal #3	**Support Option/Referral**	**Referral Agency**	**Specific Action**	**Timeline**	**By Whom**

Customer Signature: _____ *(In lieu of signature, please check ✓)*

I would like follow-up from ADRC/ADRS staff: ☐ Yes ☐ No **Customer declined action plan:** ☐ *(document plan in notes)*