

Action Plan

\*Client: (Required) \*DOB: (Required) \*Date: (Required)

**\*Goals:** (Required)

1. Goal 1
2. Goal 2
3. Goal 3

**Steps Taken:** (Optional)

Describe steps taken to complete Assessment/Action Plan

**Summary of Findings:**  (Optional)

Summarize describing what you learned

**\*Next Steps:** (Required)

Describe next steps, what to expect next

**Available Advocacy Services:**  (Optional)

Provide optional additional services offered

**\*Time estimate:** (Required)

Amount of time estimated to reach goals

I acknowledge that these are goals shared by Client and Company set forth on this day.

I acknowledge that time estimates are truly estimates and realize that goals may take more or less time to achieve; I also understand that I will be billed accordingly.

I acknowledge that Company will do everything in their power to achieve these goals, understanding that specific health, financial, or other outcomes cannot be guaranteed.

I agree to provide all necessary information to Company in order to increase the likelihood of desired outcomes.

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(Signature of Client or Authorized Representative) (Date)

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(Printed Name of Client or Authorized Representative) (Relationship to Client)

Your Advocacy Business, LLC

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