



## Treatment Plan

Client Name \_\_\_\_\_

Case Number \_\_\_\_\_

Desired Goal in consumer's words:

(Goal and objectives must be understandable, measurable, achievable, time specific)

Goal #1: \_\_\_\_\_

Objective #1: By: \_\_\_\_\_

Objective #2: By: \_\_\_\_\_

Objective #3: By: \_\_\_\_\_

Objective #4: By: \_\_\_\_\_

Goal #2: \_\_\_\_\_

Objective #1: By: \_\_\_\_\_

Objective #2: By: \_\_\_\_\_

Objective #3: By: \_\_\_\_\_

Objective #4: By: \_\_\_\_\_

Client Name \_\_\_\_\_

Case Number \_\_\_\_\_

Goal #3: \_\_\_\_\_

Objective #1: By: \_\_\_\_\_

Objective #2: By: \_\_\_\_\_

Objective #3: By: \_\_\_\_\_

Objective #4: By: \_\_\_\_\_

**Interventions:**

Service \_\_\_\_\_ Frequency of Service \_\_\_\_\_

Duration of service \_\_\_\_\_

Frequency at which this plan will be review:

Monthly

Every 3 months

**Additional Referrals/Identified Needs:**

None Indicated

Psychiatric

Psychological

Medical/PCP

Educational

Vocational

Visual

Auditory

Substance Abuse

Dental

Other: \_\_\_\_\_

If the consumer is a child under the age of 18 years old, complete the Child/Adolescent Assessment Attachment to the Assessment and Treatment Plan.