CLIENT TREATMENT PLAN

Date: Next Review Date:			
Client Long Term Goals: (use client direct quote)			
Short-term Goals / Objectives: Must be SMART: Specific, Measurable/Q	uantifiable, Attainable within the Treatment Plan review period, Realistic, and Time-		
bound. Must be linked to the client's functional impairment and diagnosis / symptom Objective # 1	natology as documented in the Assessment. Assigning Date:		
Clinical Interventions: Must be related to the objective and achievable within	the time frame of this Plan. Describe proposed intervention and duration (specify if time		
frame is less than 1 yr). Type of Service : MHS* TCM Med Sup Crisis Res Tran			
Client Involvement	Family Involvement: Biological Other (If other, please specify below)		
Client agrees to participate by:	Family is available Yes No Client consents to family participation? Yes No N/A Family agrees to participate? Yes No (If yes, please specify)		
Short-term Goals / Objectives:			
	Assigning Date:		
Objective # 2	Assigning Date:		
Objective # 2 Clinical Interventions: Type of Service: MHS* TCM Med Sup Crisis Res Trans	Res Long-Term Res TBS DTI DR		
Objective # 2 Clinical Interventions: Type of Service: MHS* TCM Med Sup Client Involvement	Res Long-Term Res TBS DTI DR		
Objective # 2 Clinical Interventions: Type of Service: MHS* TCM Med Sup Crisis Res Trans Client Involvement Client agrees to participate by:	Bis Res Long-Term Res TBS DTI DR Family Involvement: Biological Other (If other, please specify below) Family is available Yes No Client consents to family participation? Yes No Family agrees to participate? Yes No (If yes, please specify)		
Objective # 2 Clinical Interventions: Type of Service: MHS* TCM Med Sup Crisis Res Trans Client Involvement Client agrees to participate by: *MHS includes therapy/rehab (individual, family, or group), collateral and, in so	Res Long-Term Res TBS DTI DR Family Involvement: Biological Other (If other, please specify below) Family is available Yes No Client consents to family participation? Yes No Family agrees to participate? Yes No (If yes, please specify) me instances, plan development services.		
Objective # 2 Clinical Interventions: Type of Service: MHS* TCM Med Sup Crisis Res Trans Client Involvement Client agrees to participate by: *MHS includes therapy/rehab (individual, family, or group), collateral and, in so	Bis Res Long-Term Res TBS DTI DR Family Involvement: Biological Other (If other, please specify below) Family is available Yes No Client consents to family participation? Yes No Family agrees to participate? Yes No (If yes, please specify)		
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Objective # 2 Clinical Interventions: Type of Service: MHS* TCM Med Sup Crisis Res Trans Client Involvement Client agrees to participate by: *MHS includes therapy/rehab (individual, family, or group), collateral and, in so Prefer a language other than English: Yes No This confidential information is provided to you in accord with State and Federal laws	Bres Long-Term Res TBS DTI DR Family Involvement: Biological Other (If other, please specify below) Family is available Yes No Client consents to family participation? Yes No Client consents to family participation? Yes No Mame: Yes No (If yes, please specify) Is#: Name: IS#: Ited Name: IS#: Agency: Provider #: Provider #:		

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- Except for Medicare, a signature on line (A) OR (B) is REQUIRED for ALL objectives.
- Signer or Co-Signer must meet Scope of Practice and Procedure Codes Manual requirements.
- Signatures must be obtained when objectives are created (both initial and additional) and at each review period.
- One signature block can be used for multiple objectives created on the same day if the objectives are within the scope of the signator.

	(A) PhD/PsyD, LCSW, MFT, RN, CNS	Licensed or registered <u>and</u> waivered PhD/PsyD, licensed or registered/waivered Social Worker and MFT, RN, registered CNS. Signature minimally signifies consultation/discussion w/service delivery staff.
Objective Number(s)	(B) MD/DO, NP	MD/DO or NP required for objectives associated with Medication Support Services. MD/DO required for any service claiming to Medicare for Directly-Operated; signature minimally signifies consultation/discussion w/service delivery staff.
1 8 2	(C) All Other Staff/Title	Used for any staff not holding one of the licenses or registrations above. Second signature required.
<u>1 & 2</u>	(D) Client*	Document reason for lack of signature below. Signature should be obtained as soon as possible with regular updates in Progress Notes until obtained.
	(E) Client Collateral*	Preferred: Parent, Authorized Caregiver, Guardian, Conservator, or Personal Representative for treatment.

*The signature of the individual signing the Consent for Services is preferred. If unavailable, the signature of one of the client collaterals is permissible.

Objective Number(s)	PhD/PsyD, LCSW, MFT, RN, CNS		Date:		
	MD/DO, NP		Date:		
	All Other Staff/Title		Date:		
	Client*		Date:		
	Client Collateral*		Date:		
Client was off	Client was offered a copy of this objective: Accepted Declined Staff Initials: Date:				
If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.					

Objective	PhD/PsyD, LCSW, MFT, RN, CNS			Date:
	MD/DO, NP			Date:
Number(s)	All Other Staff/Title			Date:
	Client*			Date:
	Client Collateral*			Date:
Client was off	Fered a copy of this objective: 🗌 Acc	epted Declined	Staff Initials:	Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective M Number(s) A C	PhD/PsyD, LCSW, MFT, RN, CNS			Date:
	MD/DO, NP			Date:
	All Other Staff/Title			Date:
	Client*			Date:
	Client Collateral*			Date:
Client was offered a copy of this objective: Accepted Declined Staff Initials: Date:				
If the required Client/Other's signature is not above please justify/explain the refusal or unavailability of the Client/Other and the plan for				

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

Agency:

IS#:

Provider #:

Los Angeles County – Department of Mental Health

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