CLIENT TREATMENT PLAN

Short-term Goals / Objectives: Must be **SMART**: **S**pecific, **M**easurable/Quantifiable, **A**ttainable within this Treatment Plan review period, **R**ealistic, and **T**ime-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # ___ 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 ☐ Trans Res ☐ Long-Term Res ☐ TBS ☐ DTI ☐ DR

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:

Objective # ___ Assigning Date: _____

Clinical Interventions:

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*MHS includes therapy/rehab (individual, family, or group), collateral and, in some instances, plan development services.

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

CLIENT TREATMENT PLAN ADDENDUM