CLIENT TREATMENT PLAN

Date: _____ **Next Review Date:** _____

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be **SMART**: **S**pecific, **M**easurable/Quantifiable, **A**ttainable within the 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 # 1 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 # 2 Assigning Date: _____

Clinical Interventions:

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)

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

Interpretation

Prefer a language other than English: ☐ Yes ☐ No This plan was interpreted: ☐ Yes ☐ No Language: _____

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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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.

Objective Number(s) 1 & 2	(A) PhD/PsyD, LCSW, MFT, RN, CNS	Licensed or registered and waivered PhD/PsyD, licensed or registered/waivered Social Worker and MFT, RN, registered CNS. **Signature minimally signifies consultation/discussion w/service delivery staff.**
	(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.**
	(C) All Other Staff/Title	Used for any staff not holding one of the licenses or registrations above. Second signature required.
	(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 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 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 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 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 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.

Name: **IS#:**

Agency: **Provider #:**

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