

90-DAY SUBSTANCE ABUSE TREATMENT PLAN

NAME (Offender): _____

AGENCY: _____

DATE: _____

1. STAGE OF CHANGE: _____

2. SHORT TERM GOALS/TIME FRAME:

3. LONG TERM GOALS/TIME FRAME:

4. MEASURABLE OBJECTIVES:

5. FREQUENCY OF SERVICES:

6. SPECIFIC CRITERIA FOR TREATMENT COMPLETION:

7. DOCUMENTATION FOR TREATMENT PLAN REVIEW (INCLUDING D/O INPUT):

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8. INFORMATION ON FAMILY/SIGNIFICANT OTHERS:

9. CONTINUED NEED FOR TREATMENT (CHECK ONE): YES NO

**FORM SHOULD BE ATTACHED TO THE MONTHLY TREATMENT REPORT
(FORM 46) EVERY 90-DAYS**

COMMENTS:

Signature of Counselor

Date