**90-DAY TREATMENT PLAN**

NAME (Offender): Last Name, First Name M.I.

PACTS No. PACTS

AGENCY: Enter Agency Name

DATE: Click to Enter Date

SUBSTANCE ABUSE – STAGE OF CHANGE: Choose an Item

DSM DIAGNOSIS: Enter Diagnosis

TYPE & FREQUENCY OF SERVICES (e.g., individual or group treatment, intensive outpatient, residential, etc.)

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MEASURABLE GOALS

 SHORT TERM GOALS:

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 LONG TERM GOALS:

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MEASURABLE OBJECTIVES:

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CONTINUED NEED FOR TREATMENT (Check one): € YES € NO

ANTICIPATED DURATION OF TREATMENT:

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CRITERIA FOR COMPLETION OF TREATMENT:

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DOCUMENTATION OF TREATMENT PLAN REVIEW (including client input):

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INFORMATION ON FAMILY/SIGNIFICANT OTHERS/COMMUNITY SUPPORT:

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SEX OFFENDER TREATMENT SPECIFIC ITEMS

Identify the issues to be addressed:

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Define offender’s expectations of treatment (and expectation of family/support systems/victim input if possible):

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Dynamic risk assessment used/dynamic risk factors identified:

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COMMENTS:

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Signature of Counselor Date

Revised: 11/13/2018