90-DAY MENTAL HEALTH TREATMENT PLAN

NAME (Offender): _____

AGENCY: _____

DATE: _____

1. DSM IV DIAGNOSIS: _____

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:

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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