90-DAY SEX OFFENDER TREATMENT PLAN

NAME (Offender): ______________________________

AGENCY: ______________________________

DATE: ______________________________

1. DSM IV DIAGNOSIS: ______________________________

2. SHORT TERM GOALS/TIME FRAME:

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3. LONG TERM GOALS/TIME FRAME:

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4. MEASURABLE OBJECTIVES:

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5. FREQUENCY OF SERVICES:

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6. SPECIFIC CRITERIA FOR TREATMENT COMPLETION:

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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

Additionally, the vendor shall:

A. Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender. ☐ YES ☐ NO

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B. Be individualized to meet the offender's needs.

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C. Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of treatment.

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D. Define the offender's expectations of treatment, the expectations of his/her family (when possible) and support systems of the treatment process, and address the issue of ongoing victim input (if possible).

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E. Note the type and frequency of services to be received.

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F. Note the specific criteria for treatment completion and the anticipated time-frame.

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G. Provide documentation of treatment plan review (including offender's input), documenting continued need for treatment at least every 90 days. ☐ YES ☐ NO

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H. The treatment Plan is attached to the monthly treatment report provided to the USPO after every revision, but at least every 90 days. ☐ YES ☐ NO

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COMMENTS:

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Signature of Counselor Date