90-DAY TREATMENT PLAN

NAME (Offender): _____

AGENCY: _____

DATE: _____

SUBSTANCE ABUSE – STAGE OF CHANGE:

DSM DIAGNOSIS: _____

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

_____

MEASURABLE GOALS

SHORT TERM GOALS:

LONG TERM GOALS:

MEASURABLE OBJECTIVES:

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

ANTICIPATED DURATION OF TREATMENT: _____

CRITERIA FOR COMPLETION OF TREATMENT:

DOCUMENTATION OF TREATMENT PLAN REVIEW (including client input):

INFORMATION ON FAMILY/SIGNIFICANT OTHERS/ COMMUNITY SUPPORT:

SEX OFFENDER TREATMENT SPECIFIC ITEMS

Identify the issues to be addressed:

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

Dynamic risk assessment used/dynamic risk factors identified:

THIS FORM SHOULD BE ATTACHED TO THE MONTHLY TREATMENT REPORT EVERY 90-DAYS.

COMMENTS:

Signature of Counselor

Date