

# CLIENT TREATMENT PLAN

Date: \_\_\_\_\_ Next Review Date: \_\_\_\_\_

**Client Long Term Goals:** (use client direct quote)

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**Short-term Goals / Objectives:** Must be SMART: Specific, Measurable/Quantifiable, Attainable within the Treatment Plan review period, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

**Objective # 1** Assigning Date: \_\_\_\_\_

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**Clinical Interventions:** Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

**Type of Service:**  MHS\*  TCM  Med Sup  Crisis Res  Trans Res  Long-Term Res  TBS  DTI  DR

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<p><b>Client Involvement</b></p> <p>Client agrees to participate by:</p>	<p><b>Family Involvement:</b> <input type="checkbox"/> Biological <input type="checkbox"/> Other (If other, please specify below)</p> <p>Family is available <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Client consents to family participation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Family agrees to participate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify)</p>
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**Short-term Goals / Objectives:**

**Objective # 2** Assigning Date: \_\_\_\_\_

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**Clinical Interventions:**

**Type of Service:**  MHS\*  TCM  Med Sup  Crisis Res  Trans Res  Long-Term Res  TBS  DTI  DR

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<p><b>Client Involvement</b></p> <p>Client agrees to participate by:</p>	<p><b>Family Involvement:</b> <input type="checkbox"/> Biological <input type="checkbox"/> Other (If other, please specify below)</p> <p>Family is available <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Client consents to family participation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Family agrees to participate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify)</p>
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\*MHS includes therapy/rehab (individual, family, or group), collateral and, in some instances, plan development services.

**Interpretation**

Prefer a language other than English:  Yes  No This plan was interpreted:  Yes  No Language: \_\_\_\_\_

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

**Name:** \_\_\_\_\_ **IS#:** \_\_\_\_\_  
**Agency:** Los Angeles County – Department of Mental Health **Provider #:** \_\_\_\_\_

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