**Treatment Plan Face Sheet**

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| **Client:** | **Record #:****Medicaid #:** | **Date:** |
| **DIAGNOSIS(ES):** | **Type: Principal (P) Both Principal & Primary (B)**  **Primary (R) Additional (A)** |
| **Code** | **Type** | **Description** |
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| **Supports/Strengths** |
| **Date** |  | **Date** |  |
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| **Preferences** |
| **Date** |  | **Date** |  |
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| **Problem(s)/Need(s)** |
| **Date** |  | **Date** |  |
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**Treatment Plan**

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| **Client:** | **Record #:****Medicaid #:** |
| **Date this Goal was initiated:** |
| **Goal 1** | **Service(s)/Interventions(s)****(including frequency)** | **Responsible** **Person/ Position** |
| Client will cooperate with the assessment process to determine ongoing mental health treatment needs. | Individual Assessment;Utilize assessment tools, discussion, and review of psychosocial history with client and family. | TherapistClientFamily |
| **Target Date** | **Reviewed Date** | **Status Code** | **Justification for Continuation/Discontinuation of Goal:** |
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| **Status Codes: N=New R=Revised O=Ongoing A=Achieved D=Discontinued** |

**Treatment Plan**

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| **Client:** | **Record #:****Medicaid #:** |
| **Date this Goal was initiated:** |
| **Goal # \_\_\_** | **Service(s)/Interventions(s)****(including frequency)** | **Responsible** **Person/ Position** |
|  | **Interventions To Be Used:** |  |
| **Target Date** | **Reviewed Date** | **Status Code** | **Justification for Continuation/Discontinuation of Goal:** |
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| **Status Codes: N=New R=Revised O=Ongoing A=Achieved D=Discontinued** |

**Service Plan Signature Form**

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| **Client:** | **Record #:****Medicaid #:** |
| **Therapist and Client/Legally Responsible Person sign below whenever the plan is implemented, reviewed, or revised.** |
| **Date** | **Staff Signature** | **Date** | **I have had input into this plan and I agree with this plan. (Client/Legally Responsible Person Signature)** |
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