Individual Treatment Plan

Level of Care: Outpatient/Professional Behavioral Healthcare

Client Information

Client Full Name

Date of Intake

Medicaid ID

Date of Next Review

Plan Type

☑ Initial Treatment Plan

Therapist Information

Therapist Name and Credentials

Email:

Therapist is charged with supporting client's mental health needs under Four Points Counseling Center including all areas of focus described in this treatment plan and the corresponding goals and objectives unless otherwise indicated.

Overview

Risk Status ◯ Minimal ◯ Low ◯ Moderate* ◯ High*

**Complete section below for status of moderate or high, otherwise proceed to Client Resources & Treatment Needs*

Plan For Support

Protective factors

Risk factors

Plan to mitigate risk factors and leverage protective factors

Client Resources & Treatment Needs

Notable client needs: Culture, language, mobility, cognition, other

Client supports, strengths and resources

Client statement of treatment needs

Therapist assessment of treatment needs

Phone calls: Included in treatment plan for service provision, support, and crisis intervention as needed and appropriate.

#1 Focus of Treatment:

Is the clinician above responsible for the treatment focus?

- ◯ Yes
- ◯ No, a collaborating therapist is the responsible clinician

Collaborating Therapist, if applicable

Symptom Severity ◯ Minimal ◯ Low ◯ Moderate ◯ High

Strengths-Based Goal

Objective 1

Objective 2

Intervention Methods and Service Frequency

Timeframe for Goal Attainment or Reassessment

#2 Focus of Treatment:

Is the clinician above responsible for the treatment focus?

- ◯ Yes
- ◯ No, a collaborating therapist is the responsible clinician

Collaborating Therapist, if applicable

Symptom Severity ◯ Minimal ◯ Low ◯ Moderate ◯ High

Strengths-Based Goal

Objective 1

Objective 2

Intervention Methods and Service Frequency

Timeframe for Goal Attainment or Reassessment

Medication Management

Medication prescriber, if applicable

All matters pertaining to medications including goals and objectives related to medication and symptom management through medication are deferred to the prescriber.

Coordination of Care

Care is coordinated with the client's primary care provider if consent was given upon admission. Care is coordinated with other providers as needed or requested by client. Please see chart for documentation.

Discharge Criteria

Therapist Acknowledgment

The treatment plan as outlined here was collaboratively developed and reviewed in the context of the client's history, diagnosis and risk status with consideration for progress toward previous established goals and objectives, as applicable. I have assessed the level of care and treatment to be appropriate and medically necessary. A copy of the document is available to the client immediately after signing and upon request at any time.

Therapist Signature

Date completed

**A discrepancy may exist between the date of treatment plan completion and the date of client signature due to administrative delay or technology issues. Please note the date above represents the date the treatment plan or plan update was finalized.*

☐ Client signature unable to be obtained

Client email

State the reason signature cannot be obtained and efforts made to develop the plan with the client and/or communicate the plan to the client.

Client Acknowledgment

☐ I participated in the development of this treatment plan. I agree with the goals and objectives reflected here.

Client Signature

Date

For a copy of the treatment plan:
If you are signing remotely, you will see a prompt to download after you click submit.
To request a copy at another time, please email info@fourpointscc.com or call 970-682-1337.