Desired Outcome – Long Term Goals:				
Barriers to Reaching Goals:				
Presenting Problems/Symptoms: (Based on DSM or client's presentation. Must be related to information from Initial Assessment or Annual Assessment). Do Cultural/linguistic, co-occurring, and/or health factors impact on Presenting Problems? If yes, describe:			Functional Impairment(s) Caused by Problem(s)/Symptoms(s) (Work, School, Home, community, Living Arrangements, etc). (Based on DSM or client's presentation. Must be related to information from Initial Assessment or Annual Assessment	
Describe Client Strengths (As related to problems and objectives in client plan)				
OBJECTIVES: (Must be specific, measurable/quantifiable, attainable, realistic, time-bound. Must related to assessment, presenting problems/symptoms and functional impairment. Include cultural/linguistic, co-occurring factors, if appropriate. Include Med Support and Targeted Case Management, if appropriate)	**CLINICAL INTERVENTIONS:** (Must be related to objective. List clinical intervention for each group/individual service. Includes Med Support and Targeted Case Management, if appropriate.	**OUTCOMES**/date/Initials: To be completed at the end of the Care Plan Review timeframe, 30 days, 3, 6, 12 months or more frequently as appropriate		
Client agrees to participate by:		Staff Signature/Title:		
Family Involvement Does client consent to family involvement? Y_____ N_____ N/A_____ Does family agree to participate? Y_____ N_____	Planned Family Involvement ☐ Input for initial Assessment/Annual update ☐ Development of Treatment Plan ☐ Support for Life Domain Issues ☐ Psychoeducational Support Group ☐ Collateral ☐ Family Therapy ☐ Case Management	Outcome Family Involvement ☐ Input for initial Assessment/Annual update ☐ Development of Treatment Plan ☐ Support for Life Domain Issues ☐ Psychoeducational Support Group ☐ Collateral ☐ Family Therapy ☐ Case Management		
Frequency of Care Plan Review	☐ 30 Days	☐ 3 Months	☐ 6 Months	☐ 12 Months
SIGNATURES				
Client		Date	Client received a copy of the care plan. Client's Initials: Date:	
Licensed Mental Health Professional		Date		
Family Conservator/Significant Other		Date		
MD Medication, Medicare/Private Insurance		Date		
	Name: _____ MIS#_____ Agency:_____ Prov#: _____ San Bernardino County – Department of Behavioral Health			

Example: This is a 2007 treatment plan form required by the San Bernardino County of Behavioral Health for all child and family therapy.