Your Company Name

Your Company Address

Master Treatment Plan

CLIENT NAME:Client Name goes here MR# Case number goes here

Date of admission: **Treatment plan developed date:**

Level of Care: ▢ Outpatient therapy ▢ Medication Management ▢ PSR ▢ Clubhouse ▢ Individual Therapy

INITIAL DISCHARGE CRITERIA:
content goes here content goes here

CODE	DIAGNOSIS

WHO WILL DO THAT	MODALITY	FREQUENCY

Treatment Plan Problem Area - Goal #1

GOAL#1			
Objective	**Measurable Objective (Short Term Goal) to be met in 6 Months**	**Date Opened**	**Date Resolved**
1.1			
Intervention			
1.2			
Intervention			
1.3			
Intervention			

Treatment Plan Problem Area - Goal #2

GOAL#2			
Objective	**Measurable Objective (Short Term Goal) to be met in 6 Months**	**Date Opened**	**Date Resolved**
2.1			
Intervention			
2.2			
Intervention			
2.3			
Intervention			

Treatment Plan Problem Area - Goal #3

GOAL#3			
Objective	**Measurable Objective (Short Term Goal) to be met in 6 Months**	**Date Opened**	**Date Resolved**
3.1			
Intervention			
3.2			
Intervention			
3.3			
Intervention			

ANTICIPATED LENGTH OF TREATMENT: ▢ 1 Month ▢ 3 Month ▢ 6 Month

DATE OF NEXT SCHEDULED TREATMENT PLAN REVIEW:

Treatment Plan Problem Area - Goal #4

GOAL#4			
Objective	**Measurable Objective (Short Term Goal) to be met in 6 Months**	**Date Opened**	**Date Resolved**
4.1			
Intervention			
4.2			
Intervention			
4.3			
Intervention			

ANTICIPATED LENGTH OF TREATMENT: ▢ 1 Month ▢ 3 Month ▢ 6 Month

DATE OF NEXT SCHEDULED TREATMENT PLAN REVIEW:

Master Treatment Plan

CLIENT NAME: MR#

Certification of need for outpatient treatment: As a clinical and/or Licensed Practitioner to provide Mental Health Services in the State of Florida and trained in the diagnosis and treatment of psychiatric illness, I certify that services are medically necessary and appropriate to the patient's diagnosis and needs.

Client has reviewed and agreed to comply with goals as established in the Master Treatment Plan. This Service plan has been explained to client in terms that client can understand, and copy has been provided to client.

I agree to the Treatment plans, goals, objectives and services recommended.

Client Signature	Print Name	Date

The signatures of the treating clinician, client and the other members of client's Treatment Team formally accept the services, goals, and objectives, as outlined within, for a period of six (), unless agreed upon to extend such treatment.

Clinical Treatment Team Members:

Clinician's Signature & Credentials	Print Name	Date

I have Reviewed and I concur with the diagnosis and recommendations:

Clinical Director's Signature & Credentials	Print Name	Date