**Mental Health Treatment Plan**

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| --- | --- | --- | --- | --- |
| Area of Need: | | | | |
| Present Level: | | | | |
| Measurable Long-Term Goal: | | | | |
| Parents will be informed of progress   * Quarterly □ Trimester * Semester □ Other:\_\_\_\_\_\_\_\_\_  How?  * Annotated Goals/Objectives   □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Periodic Review Dates 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Progress Toward Goal 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sufficient Progress to Meet Goal □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Benchmark/Short-Term Objective: | | | | Date:  □ Achieved  □ Reviewed |
| Person(s) Responsible: \_ | | | |
| Benchmark/Short-Term Objective: | | | | Date:  □ Achieved  □ Reviewed |
| Person(s) Responsible: \_ | | | |
| Area of Need: | | | | |
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| Parents will be informed of progress  * Quarterly □ Trimester * Semester □ Other:\_\_\_\_\_\_\_\_\_\_\_  How?  * Annotated Goals/Objectives   □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Periodic Review Dates 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Progress Toward Goal 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sufficient Progress to Meet Goal  □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Benchmark/Short-Term Objective: | | | | Date:  □ Achieved  □ Reviewed |
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| Person(s) Responsible: \_ | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Student Signature Date Signature of Parent Date | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Mental Health Services Representative Date | | | | |

Date: Student: Type of Service: Start Date: Duration: