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| **Diagnosis** |
|  |
| **Strengths** |
| **Client Strengths** |
| **Additional Strengths:** |
| **Problems, Goals, Objectives and Interventions** |

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| **Signatures/Date Approved** |
| **Responsible Staff/Supervisor/Team Member(s)/Psychiatrist Electronic Signatures and Credentials**  &STFCONSENTX&  **Authorized Staff (HSPP, Psychiatrist or Physician) Signature indicates the above plan and diagnosis meets medical necessity criteria and continued services are appropriate.** |
| **Client/Family/Guardian Signatures** |

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| **Barriers to Client Signing:** |  |
| **Client Signature (Sign Below)** I participated in the development of this treatment plan and have intentions of working with my treatment providers in achieving my goals. I have been offered a copy of this plan. | |



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| --- | --- | --- |
| **Family/Guardian Signature (Sign Below)** | | **Relationship:** |
| **Barriers to Family/Guardian Signing:** |  | |
| I have reviewed this treatment plan and understand the contents of it. I have been offered a copy of this plan. | | |

