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| **Person Served Name:**  | **Avatar ID Number:**  |
| **Admission Date:** Enter Admission Date | **Primary Counselor:** Enter Primary Counselor Name |
| **DSM-5 Diagnosis:** Enter DSM Diagnosis | **Type of Treatment Plan:** Choose type of plan |
| **Treatment Plan Duration: From** Enter Start Date **to** Enter End Date |
| **Preferred Language:** Enter Preferred Language | **Interpreter Utilized:** Choose answer |

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| **Description of Services & Frequency** |
| **Service Type: Choose type of service Frequency of Service-**  |

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| **Evidence Based Practices Utilized:** | **[ ]  Motivational Interviewing [ ]  Cognitive-Behavioral Therapy [ ]  Relapse Prevention [ ]  Trauma-Informed Treatment [ ]  Psycho-Education** |

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| **Summary of Treatment Plan Progress** |
| **For Updated Treatment Plans Only:**Provide a summary of the person-served progress or lack of progress towards each goal identified on the previous treatment plan.Enter Summary of progress or lack of progress |

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| **STRENGTHS (May include assets, resources, and natural positives):**  Enter Strengths**NEEDS (May include liabilities, weaknesses and what the person-served needs to recover):**  Enter Needs**ABILITIES (May include skills, aptitudes, capabilities, talent, and competencies):** Enter Abilities**PREFERENCES (May include things the person-served feels will enhance their treatment experience):** Enter Preferences |

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| **Treatment Needs**(Use the + sign to the bottom right of this box for additional sections to document the history of multiple substances) |
| **Choose Dimension Choose Severity Rating****Statement of Need (Problem):** Enter Statement**Goal:** Enter Goal**Person Served Action Step:** Enter Action Step**Provider Action Step:** Enter Action Step**Target Date:** Enter Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **NATURAL SUPPORTS (May include family, friends, support groups, or other cultural and religious/spiritual supports):** Enter Natural Supports |
| **REFERRALS (Needs for person served beyond scope of program, or additional community-based services):** Enter Referrals |
| **Treatment Plan discussed in person served preferred language?** Yes or No |
| **Copy of Treatment Plan:** Chose Accepted or Declined |

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| **Person Served Name Printed:**      | **Person Served Signature:** | **Date:** |
| **Counselor/LPHA Name Printed, Title:**      | **Counselor/LPHA Signature:** | **Date:** |
| **Clinical Supervisor Name Printed, Title (Optional):**      | **Clinical Supervisor Signature (Optional):** | **Date:** |
| **LPHA/Medical Director Name Printed, Title:**      | **LPHA/Medical Director Signature:** | **Date:** |