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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:** |