**Desired Outcome – Long Term Goals:**

**Barriers to Reaching Goals:**

Presenting Problems/Symptoms: (Based on DSM or client’s presentation. Must be related to information from Initial Assessment or Annual Assessment).

Functional Impairment(s) Caused by Problem(s)/Symptoms(s) (Work, School, Home, community, Living Arrangements, etc). (Based on DSM or client’s presentation. Must be related to information from Initial Assessment or Annual Assessment).

Do Cultural/linguistic, co-occurring, and/or health factors impact on Presenting Problems? If yes, describe:

Describe Client Strengths (As related to problems and objectives in client plan)

**OBJECTIVES:** (Must be specific, measurable/quantifiable, attainable, realistic, time-bound. Must related to assessment, presenting problems/symptoms and functional impairment. Include cultural/linguistic, co-occurring factors, if appropriate. Include Med Support and Targeted Case Management, if appropriate)

**CLINICAL INTERVENTIONS:** (Must be related to objective. List clinical intervention for each group/individual service. Includes Med Support and Targeted Case Management, if appropriate)

**OUTCOMES/date/Initials:** To be completed at the end of the Care Plan Review timeframe, 30 days, 3, 6, 12 months or more frequently as appropriate

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**Family Involvement**

Does client consent to family involvement? Y____ N_____ N/A____

Does family agree to participate? Y____ N_____

**Planned Family Involvement**

- Input for initial Assessment/Annual update
- Development of Treatment Plan
- Support for Life Domain Issues
- Psychoeducational Support Group
- Collateral
- Family Therapy
- Case Management

**Outcome Family Involvement**

- Input for initial Assessment/Annual update
- Development of Treatment Plan
- Support for Life Domain Issues
- Psychoeducational Support Group
- Collateral
- Family Therapy
- Case Management

**Frequency of Care Plan Review**

- ☐ 30 Days
- ☐ 3 Months
- ☐ 6 Months
- ☐ 12 Months

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**SIGNATURES**

- **Client**
  - Name: ___________________________
  - Date: ________________
  - Client received a copy of the care plan.
  - Client’s Initials: ________________

- **Licensed Mental Health Professional**
  - Name: ___________________________
  - Date: ________________

- **Family Conservator/Significant Other**
  - Name: ___________________________
  - Date: ________________

- **MD Medication, Medicare/Private Insurance**
  - Name: ___________________________
  - Date: ________________

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**Example:** This is a 2007 treatment plan form required by the San Bernardino County of Behavioral Health for all child and family therapy.