**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 Dates1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Progress Toward Goal1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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:  |
| Present Level:  |
| Measurable Long-Term Goal:  |
| Parents will be informed of progress* Quarterly □ Trimester
* Semester □ Other:\_\_\_\_\_\_\_\_\_\_\_

How?* Annotated Goals/Objectives

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Periodic Review Dates1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Progress Toward Goal1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Student Signature Date Signature of Parent Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Mental Health Services Representative Date |

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