

State of Maine
Department of Health and Human Services, Office of Child & Family Services
Section 24: 90-Day Individual Treatment Plan Review

Date of Review: / /
<input type="checkbox"/> 90 Days
<input type="checkbox"/> 180 Days
<input type="checkbox"/> 270 days

Child/Youth Name: **DOB:**

MaineCare #: **Annual Treatment Plan Date:**

Date of Most Recent Treatment Authorization:

Agency:

Submitted by:
Name / Title

Dates of service being reviewed: to

Treatment Plan hours of service per week: **Total hours per plan for 90 days:**

Actual hours provided during review period:

Primary DSM-IV-TR Diagnosis & Code:

Axis I: **Axis II:**

Axis III: **Axis IV:**

Axis V: **C-GAS-Entry into Service:** **C-GAS-Current:**

Please complete the following as appropriate:

Natural Supports available to support child, as identified by parent/guardian(s):

Describe the nature of the parent/guardian involvement with specific treatment goals and the typical hours per week of involvement:

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Treatment planning must be individualized and appropriate to the child/adolescent's changing condition with realistic and specific goals, objectives and measurable outcomes, as identified in the assessment.

SHORT TERM GOALS

Met:

1.

2.

Unmet / Continuing (Include rationale):

1.

2.

Unmet / Discontinuing (Include rationale):

1.

2.

Unmet / Modified (Attach ITP page for the modification):

1.

2.

LONG TERM GOALS

Note any changes and rationale:

