REPORTING AGENCY:______________________________ Rev. 1/2007

Treatment Plan for In-Home Family Treatment (H2011)

DSM IV Diagnosis **Reviewed Diagnosis:** ☐ New ☐ No Change ☐ Change (Attach Diagnosis Change Form)			**Plan Date:**
Axis	**Diagnosis Code**	**Diagnosis**	**Plan Update Due:**
I			
II			
III			

Axis IV: Problems With (Check all that apply)

☐ Primary Sup. Group:	☐ Housing:
☐ Social Environment:	☐ Economic:
☐ Education:	☐ Access/Health Care:
☐ Job/Occupation:	☐ Legal/Crime:
☐ Other:	

Axis V:	**Current GAF:**	**Highest GAF Last yr.:**	**Expected GAF at Discharge:**

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Recommended Treatment Regimen: (Services Authorized)

Treatment Modality	**Frequency**	**Duration**	**Responsible Person/Title**
In-Home Family Treatment – H2011			

Treatment Goal/Objective 1:

Treatment Goal/Objective 2:

Treatment Goal/Objective 3:

Treatment Goal/Objective 4:

I have had an opportunity to provide input to this plan and I agree with it. **Consumer Signature:**	**Date:** ____	**Guardian Signature (if applicable):**	**Date:** ____
LMHP:		**Title:**	**Date:** ____

In-Home Family Treatment Plan (sc 1_27_2007).doc

I have reviewed this case and concur that the diagnostic classification(s), goal)s), objectives(s), therapeutic interventions, services, frequency, responsible persons(s) and duration are accurate and services(ordered within all pages of this Plan is (are) clinically/medically appropriate and necessary: I hereby order the consumer noted to receive the services documented in this treatment Plan.

Physician:______________________________ **Dr. William Klontz** **Date:** ______________