

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

<b>Child/Youth Name:</b>	<b>DOB:</b>
	<b>Age:</b>
<b>Section 24 Provider Agency:</b>	
<b>Date of Individual Treatment Plan:</b>	

**TREATMENT PLAN DOMAINS:** *For each goal, please complete each of the following domains:*

<b>Objective:</b>	Describe what the child will do in <u>observable</u> and <u>measurable</u> terms.
<b>Measurement:</b>	What is the method of measurement?
<b>Standard:</b>	How will you know when the child has met this objective?

Method	Parent Role	Role of Others	Resources/ Equipment	Barriers	Frequency/ Duration/ Intensity
What will be done to help child meet the objective?	What will the parent do to help the child meet this objective?  When?  How often?	Who else may be helping the child?  What will they do?  How often?	What will the child need to help him/her meet this objective?	Note any barriers or other factors in meeting the goal.	<u>Frequency:</u> How often will the child work on this during one shift?  <u>Duration:</u> For how long a period of time during this shift?  <u>Intensity:</u> How many times per week?

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**Child/Youth Name:**

**Presenting Problem:**  
*Describe a problem behavior that can be changed with treatment from this service.*

**Current Level of Performance:**  
*How often does this problem behavior occur?*

**Long Term Goal:**  
*What do you want to happen to this problem behavior in 1 year?*

**Short Term Goal:** *What do you want to happen to this problem behavior in 90 days? NOTE: Short-term goal can be broken down into several objectives.*

**Objective:**

**Measurement:**

**Standard:**

Method	Parent Role	Role of Others	Resources/ Equipment	Barriers	Frequency/ Intensity/ Duration	Target Date:
						<u>90-Day Review:</u> Met <input type="checkbox"/> Unmet <input type="checkbox"/>

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**Child/Youth Name:**

<b>Objective:</b>						
<b>Measurement:</b>						
<b>Standard:</b>						
Method	Parent Role	Role of Others	Resources/ Equipment	Barriers	Frequency/ Intensity/ Duration	Target Date:
						<u>90-Day Review:</u> Met <input type="checkbox"/> Unmet <input type="checkbox"/>

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**Child/Youth Name:**

<b>Discharge Criteria:</b> <i>How will we (provider &amp; parent) know that the need(s) are met and our work is done?</i>
<b>Projected Discharge Date:</b>

**(1.) Date of 90-Day Review:**

**(2.) Date of 90-Day Review:**

**(3.) Date of 90-Day Review:**

<p><b>Potential Risks:</b></p> <ul style="list-style-type: none"> <li>More intensive services may be needed.</li> <li>Parent/guardian may have to rearrange schedule to participate in the treatment program.</li> <li>Problem behaviors may become more challenging.</li> </ul>	<p><b>Potential Benefits:</b></p> <ul style="list-style-type: none"> <li>Appropriate treatment services will be available to my child.</li> <li>My child may be more successful in life.</li> <li>Problem behaviors may decrease.</li> </ul>
<p><b>Consent to Services:</b></p> <ul style="list-style-type: none"> <li>I understand the Risks and Benefits that may occur by participating in this service.</li> <li>I have contributed to the development of this treatment plan.</li> <li>I agree with the goals and objectives of this treatment plan.</li> </ul>	<p><b>Individual Treatment Plan Copies:</b></p> <ul style="list-style-type: none"> <li>I will receive a copy of this plan from the Section 24 provider within 30 days of my signing this plan.</li> <li>My child's case manager (if my child has one) will receive a copy of this treatment plan from the Section 24 provider within 30 days of signing this plan.</li> </ul>

*(Signatures on following page)*

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**Child/Youth Name:**

**Signature(s):**

\_\_\_\_\_

\_\_\_\_\_

**Child/Youth Receiving Services**

**Date**

\_\_\_\_\_

\_\_\_\_\_

**Parent/Guardian**

**Date**

\_\_\_\_\_

\_\_\_\_\_

**Parent/Guardian**

**Date**

\_\_\_\_\_

**Title**

\_\_\_\_\_

**Section 24 Agency Provider**

**Date**

<b>Comments (Parent and/or other):</b>

*For Section 24 Agency:*

Authorized copy of plan sent to parent/guardian  
Date: \_\_\_\_\_

Authorized copy of plan sent to Case Manager  
Date: \_\_\_\_\_