

SAMPLE INDIVIDUAL TREATMENT PLAN (ITP)

Client Name: _____

Date of ITP: _____

Date of Corresponding DA: _____ Date of Corresponding FA: _____

A Written Review of Progress on Previous Objectives for Individual Treatment Plan _____
Date

| Rehab Treatment Goal | Objective(s) | Progress Narrative for Objectives |
|----------------------|--------------|-----------------------------------|
| 1. | 1. 2. | |
| 2. | 1. 2. | |
| 3. | 1. 2. | |
| 4. | 1. 2. | |
| 5. | 1. 2. | |

Interpretive Summary

About the Person

Recovery Vision

Strengths and Resources that can lead to achieving this Recovery Vision

Functional Barriers which influence the achievement this Recovery Vision

Cultural Considerations in the design or delivery of ARMHS:

Other Factors to Consider

Preferences

Priorities for the next Individual Treatment Plan

Service Coordination

| Service | Provider | Contact Interval | Form of Contact |
|---------|----------|------------------|-----------------|
| | | | |
| | | | |
| | | | |

Referrals

| Service Needed | Potential Provider | Staff Member responsible for making referral | Timeline to Submit Referral |
|----------------|--------------------|--|-----------------------------|
| | | | |

SAMPLE INDIVIDUAL TREATMENT PLAN (ITP)

| | | |
|---|--|----------------------------|
| Recovery Vision | Functional Barriers | Strengths/Resources |
| Rehabilitation Treatment Goal: | | |
| Objective(s): | | |
| <p align="center">Rehabilitative Interventions</p> <p>ARMHS Services: <input type="radio"/> Basic Living Social Skills <input type="radio"/> Medication Education <input type="radio"/> Comm. Intervention <input type="radio"/> Peer Support Services <input type="radio"/> Transition to Community Living</p> <p>Other Service: _____</p> | | |
| <input type="checkbox"/> Targeted Skill to be learned or generalized: | How _____ will learn or generalize this skill | |
| _____ | Needed Materials, Tools... | |
| Staff Interventions | | |
| <input type="checkbox"/> Develop/Use Community Resources: | How _____ will develop or learn how to use this community resource | |
| _____ | Needed Materials, Tools... | |
| Staff Interventions | | |
| <input type="checkbox"/> Develop /Use Natural Support Network: | How _____ will develop or learn how to use this natural support: | |
| _____ | Needed Materials, Tools... | |
| Staff Interventions | | |
| Current Baseline Measurement: | Targeted Measurement: | |
| Modality | Intervention Time Frame | |
| 1:1 <input type="checkbox"/> Group <input type="checkbox"/> | Start Date: | |
| Frequency of Session: | End Date: | |
| Length of Session | | |
| Staff Member(s) Responsible (Name/Title) | | |
| _____ | | |

Signature Lines:

Client: _____ date _____

If client is not able to sign, please state reason: _____

MH Practitioner date Other date

MH Clinical Supervisor date Other date