A black and blue logo

AI-generated content may be incorrect.**Greater Malden Behavioral Health, Inc.**

**TREATMENT PLAN**

**Name:** Click or tap here to enter text. **D.O.B.** Click to enter a date. **GMBH MIS#:** Click to enter text. **Date of Admission:** Click to enter a date.

**Treatment Plan Date:**Click or tap to enter a date. **Treatment Plan Review Date:** Click or tap to enter a date. **DX (1):** Click or tap here to enter text.

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| --- | --- | --- |
| **GOAL # 1: CANS DOMAIN:** | | |
| Objective: Click or tap here to enter text. | Intervention: Click or tap here to enter text. | **Responsible**  **Consumer**  **Clinician** |
| ***Person’s Strength’s, Resources Needed and/or Potential Barriers:*** Click or tap here to enter text. | | |
| **GOAL # 2: CANS DOMAIN:** | | |
| Objective: Click or tap here to enter text. | Intervention: Click or tap here to enter text. | **Responsible**  **Consumer**  **TTS** |
| ***Person’s Strength’s, Resources Needed and/or Potential Barriers:*** Click or tap here to enter text. | | |
| **GOAL # 3: CANS DOMAIN:** | | |
| Objective: Click or tap here to enter text. | Intervention: Click or tap here to enter text. | **Responsible**  **Consumer**  **Family**  **Clinician** |
| ***Person’s Strength’s, Resources Needed and/or Potential Barriers:*** Click or tap here to enter text. | | |
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| --- | --- | --- | --- |
| **Other Agencies/Community Resources Supporting Treatment Plan:** | | | |
| **Agency** | **Contact & Title** | **Service Provided** | **Released Signed** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | **YES  NO** |
| **Medication as Reported By Person Served:** | | | |
| **Agency** | **Contact & Title** | **Service Provided** | **Released Signed** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | **YES  NO** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | **YES  NO** |
| **Transition/Level of Care Charge/Discharge Plan (Determination that level of care change is warranted)** | | | |
| **Reduction in symptoms as evidence by:** Click or tap here to enter text. | | | |
| **Attainment of higher level of functioning as evidence by:** Click or tap here to enter text. | | | |
| **Treatment is no longer medically necessary as evidenced by:** Click or tap here to enter text. | | | |
| **SIGNATURES** | | |  |
| **Consumer/Client: Received Copy of Plan** | | | **Date:** Click to enter a date. |
| **Parent/Guardian:** | | | **Date:** Click to enter a date. |
| **Provider Name/Credentials:** Click or tap here to enter text. | | | **Date:** Click to enter a date. |
| **Provider Signature:** | | | **Date:** Click to enter a date. |
| **Supervisor Name/Credentials:** Click or tap here to enter text. | | | **Date:** Click to enter a date. |
| **Supervisor Signature:** | | | **Date:** Click to enter a date. |