US PROBATION OFFICE – SOUTHERN DISTRICT OF GEORGIA
90-DAY MENTAL HEALTH TREATMENT PLAN

Offender Name: _____

Treatment Program: _____

Date: _____

DSM IV Diagnosis: _____

Short Term Goals/
Time Frame: _____

Long Term Goals/
Time Frame: _____

Measurable Objectives: _____

Frequency of Services: _____

Specific Criteria for
Treatment Completion: _____

Documentation for
Treatment Plan Review
(Including D/O Input): _____

Information on Family/
Significant Others: _____

Continued Need for
Treatment (Check One): ☐Yes ☐No

This Plan must be submitted at the commencement of treatment and with the Monthly Treatment Report (Form 46) at least every 90 days.

Comments: _____

_____ _____

Counselor Signature Date

Revised 06/27/16