

**State of Hawaii, Department of Health
Child and Adolescent Mental Health Division
Mental Health Treatment Plan**

DOH Contract Provider Agency: _____ Start Date: _____
 Client: _____ FGC: _____ CR#: _____ End Date: _____
 DOB: _____ School/Program Currently Attending: _____ IDEA/504 Status: _____

Youth/Family Strengths and Resources:	Current Situation:
--	---------------------------

Domain	Goals: Relevant to Educational Benefit	Measurable Objectives (what needs to happen to reach the goal)	Strategies/Interventions	Provider, Resource/Service, Target Date to Reach Objective	Start Date	Date Ended
Family (1)						
School (2)						

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Domain	Goals: Relevant to Educational Benefit	Measurable Objectives (what needs to happen to reach the goal)	Strategies/Interventions	Provider, Resource/Service, Target Date to Reach Objective	Start Date	Date Ended
Community Environment (3)						
Individual (4)						
Social/Peer (5)						
Legal (6)						

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CRISIS PLAN (What to do in case of a mental health emergency)	TRANSITION/DISCHARGE PLAN (A)
	<p><i>Contingency Plan B (in the event the above plan becomes no longer viable):</i></p>

Diagnoses: _____ **Date:** _____

Axis I: Code #: _____ Description: _____

Code #: _____ Description: _____

Code #: _____ Description: _____

Axis II: Code #: _____ Description: _____

Code #: _____ Description: _____

Axis III: _____

Axis IV: _____

GAF Score - Current:	GAF Score – Past Year:	CAFAS Score:	
		Date:	

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(Can attach the Diagnostic Assessment Form. Be sure to record updated CAFAS scores.)

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Provider	Frequency of Services	Start/End Date of Services
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.

AGENCIES INVOLVED:

MHTP Participants

Name	Signature	Date	Position/Agency	Phone #	Fax #

Date of Next Review: _____