Individualized Treatment Plan (ITP)

Agency Name:

Client Name / ID :

Level of Care at Admission:

- ◯ Level I-A: Non-Intensive OP Tx
- ◯ Level I-B: IOP Tx
- ◯ Level II-A: Non-Medical Community Residential
- ◯ Level II-B: Medical Community Residential
- ◯ Level III-A: Ambulatory Detox
- ◯ Level III-B: 23 Hour Observation Bed
- ◯ Level III-C: Sub-Acute Care
- ◯ Level IV: Acute Hospital Detox

Problem(s) to be Addressed (including diagnosis)**:**

1.
2.
3.
4.
5.
6.

Problem(s) to be Deferred:

1.
2.

Problem(s) to be Referred:

1.
2.

Problem Number 1:

Measurable Goal that Addresses Client's Need:

Measurable Objective 1-A — Time frame for achievement

Measurable Objective 1-B — Time frame for achievement

Measurable Objective 1-C — Time frame for achievement

Problem Number 2:

Measurable Goal that Addresses Client's Need:

Measurable Objective 2-A — Time frame for achievement

Measurable Objective 2-B — Time frame for achievement

Measurable Objective 2-C — Time frame for achievement

Problem Number 3:

Measurable Goal that Addresses Client's Need:

Measurable Objective 3-A — Time frame for achievement

Measurable Objective 3-B — Time frame for achievement

Measurable Objective 3-C — Time frame for achievement

Problem Number 4:

Measurable Goal that Addresses Client's Need:

Measurable Objective 4-A — Time frame for achievement

Measurable Objective 4-B — Time frame for achievement

Measurable Objective 4-C — Time frame for achievement

Problem Number 5:

Measurable Goal that Addresses Client's Need:

Measurable Objective 5-A — Time frame for achievement

Measurable Objective 5-B — Time frame for achievement

Measurable Objective 5-C — Time frame for achievement

Problem Number 6:

Measurable Goal that Addresses Client's Need:

Measurable Objective 6-A — Time frame for achievement

Measurable Objective 6-B — Time frame for achievement

Measurable Objective 6-C — Time frame for achievement

Individualized Treatment Plan (TIP)

Client Name / ID :

Services to be rendered:

Assessment | Case Management | Crisis Intervention | Family Counseling | Group Counseling

Individual Counseling | Intensive Outpatient | Medical / Somatic | Urinalysis

Type of Treatment Service	Frequency of Treatment Service	Duration of Treatment Service

Name of Client

Signature of Client

Date

Name of Qualified Staff and Credential(s)

Signature of Staff and Credentials

Date