Southern NH Services, Inc.-Child Development Program

MSW Intern Treatment Plan

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child Name |  | | Date of Birth |  |
| Caregiver(s) Name(s) | |  | | |
| Staff Names |  | | | |
|  | | | | |

Observation Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Needs Assessment Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Child/Family Interests and Strengths: | Identifying Concern(s): |

|  |  |
| --- | --- |
| Treatment Goals | Strategies |
|  |  |
|  |  |
|  |  |
| **Schedule of services:** | |
| **Additional Support Recommendations:** | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MSW Intern Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Supervisor Signature Date

I have read and understand the treatment plan as described here. I authorize these services for my child and/or family.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature Date