LIFE TREATMENT PLAN

Villager Name:	DOB: 06/14/2006	SSN#
DCF Involved Y/N:	Insurance Y/N If yes # _____	Date Developed:

ILP Needs Statement & Objective:

Intake Key Observations:	Coaching Recommendation
○ **Gang Related** ○ **Pre-Substance Abuse** ○ **Pre-Mental Health** ○ **Violent Behavior** ○ **DJJ Referral** ○ **DCF Youth / Family** ○ **SOA Referral** ○ **Tier 3** ○ **Tier 2** ○ **Tier1** ○ **Probation / Diversion**	○ HRBII Hi-Fi Coaching Program ○ Programming/Mentoring ○ Community Based Programming Clinical Referral Recommendation ○ Mental Health Pre-Screen ○ Mental Health – Full Mental Health Assessment ○ Substance Abuse Support ○ Family Therapy & Counseling ○ Individual Therapy & Counseling ○ Parent Support Programming
Human Deficiency Measure: (1-4) __ **Financial** __ **Social** __ **Human** __ **Cultural / Environment**	Coaching Action Plan ○ Work-Readiness ○ Community Engagement ○ SE & Life Skills Development ○ Housing & Residential Needs

Stage of Change:	Pre-Cont.	Contemplation	Preparation	Action	Maintenance	Relapse

Goal

_____

_____

(What is the end result you are trying to achieve)

Barriers to Objective:

_____

_____

Measurable

_____

_____

Client Initial _____

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LIFE Coaching Responsibilities:

- Implement Anger Management curriculum with the consumer
- Assess factors causing increased anger through the creation of a list
- Assess current coping strategies
- Educate/demonstrate new coping skills and tools w/ client
- Check in with client weekly regarding the client's attendance in virtual school
- Provide continual encouragement and motivation to client to complete assignments
- Provide assistance with any challenges the client may experience with homework
- Assess progress after interventions have been implemented
- Other: _____

Consumer Responsibilities:

- Identify each social support role
- Practice effective communication when addressing needs
- Other: _____

Client Responsibilities:

- Explore possible factors causing anger through individual therapy
- Report current coping strategies
- Learn and implement new coping skills and tools
- Report progress of new interventions
- Individual counseling
- Engage and participate in individual therapy
- Identify strengths to build self-esteem and self-efficacy
- Take medication as prescribed, daily
- Individual counseling
- Enroll into virtual school everyday
- Complete all homework assignments and projects
- Inform caregivers, case manager & life coach of any difficulties or challenges the client may endure when completing assignments
- Other: _____

Mentor & Village Provider Responsibilities:

- Encourage the client's development by being nurturing, responsive and caring
- Encourage caregivers to continue providing a stable attachment for the client
- Provide a positive, stimulating and interactive environment for the client
- Address the child's medical, safety and housing needs, as appropriate
- Other: _____

Clinical Responsibilities:

- Provide All Clinical Services
- Therapist will work with client to review identified needs through assessment & refer consumer to local agencies & organizations that can be of assistance
- Identify family supports
- Other: _____

Client Initial _____

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Village Signature & Update Page

Villager Name _____ Ongoing SE Tier (1-3) _____ Date _____

Ongoing RECOMMENDATIONS:

☐ **CONTINUE TO FOLLOW INITIAL TREATMENT PLAN**

☐ **THE INITIAL TREATMENT PLAN was reviewed and amended to meet the Consumer's current needs**

☐ **CONSUMERS WILL BE DISCHARGED**

Discharge Plan: (Where will the consumer be residing when services are completed, and what possible social or other services might they need and be linked with at that time?)

Treatment Team Certification: *By signing below, I agree to participation and understanding of the goals and objectives listed in this plan and agree to play my required role in achieving the goals/objectives. I also understand that this is an initial treatment plan based on the information gathered at the time of intake. A review of this plan will occur within 45 days after the initial writing of this plan and changes will be made if determined necessary at the time.*

Documentation of 45-day review: ○ Addendum deemed necessary; see attached	**Coaching Signature _____**
○ Addendum deemed necessary @ this	Date _____

Coaching Tier: _____ Change Readiness (0-10) _____ Motivation to Change (0-10) _____

Recommended Individual LIFE Plan Framework:

Coaching Tier	Client Description	Tier Service Rate Private /Billable (Hourly)	Recommended Monthly Service (RMSH) Hours
LCT0	CBP Community Based Program, No Known MH Diagnosis	$40 / $75	4
LCT1	Mentor - Referred, Moderate – Intensive Behaviors No MH Diagnosis	$50 / $100	8
LCT2	HRBII- Referred Behavioral Intensive w/ Mental Health Diagnoses	$75 / $150	2
LCT3	HRBII - Mandated Coaching - WRAP	$125 / $250	2
			0

Estimated Monthly Cost **$_____** ***Not Including Enrichment Hours***

By signing, Client accepts the above treatment plan and cost of treatment services. Target service start date is _____ and payment is agreed on a _____ basis.

Client signature _____ Date _____

Client Initial _____