**INDIVIDUALIZED COMPREHENSIVE QUARTERLY TREATMENT PLAN**

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| Treatment Provider: | Click here to enter text. | Click here to enter a date. |
|  | Name and Location of Services | Date Plan Prepared |

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| **Client Name & PACTS #:** Click here to enter text.Click here to enter text. |
| Supervising USPO: Click here to enter text. |
| Date Client Entered Into Treatment Services: Click here to enter a date. |
| **Date Triad Completed:****PCRA Level and Dynamic Risk Factors Identified by PCRA:** |
| Click here to enter text. |
| **Type & Frequency of Services Anticipated in Next 90 Days:** |
| Click here to enter text. |

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| **Current Needs, Risks, and Responsivity of the Client (including the risks to reoffend):** |
| Click here to enter text. |
| **List Offenses If Client Charged With New Crimes Since Last Quarterly Treatment Plan:**Click here to enter text. |
| **Planned Intervention Strategies To Address Criminogenic Risks Listed Above:** |
| Click here to enter text. |

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| **Treatment Goals:** |
| * Short-Term Behavior Change Goals:

 Click here to enter text. |
| * Long-Term Behavior Change Goals:

 Click here to enter text. |
| **Measureable Objectives:** |
| Click here to enter text. |

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| **Define Client’s Input Into The Treatment Plan & Client’s Expectations of Treatment Services**:  |
| Click here to enter text. |
| **Identify the involvement of family, supportive collateral contacts, and community support entities (including USPO):**  |
| Click here to enter text. |

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| **Specific Criteria For Treatment Completion Or Advancement To Next Treatment Phase And Specify Need For Continued Treatment At This Time:** |
| Click here to enter text. |
| **Anticipated Time Frame For Treatment Completion Or Advancement to Next Treatment Phase:** |
| Click here to enter text. |

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Treatment Provider Signature & Date Client Signature & Date