# Santa Clara County Mental Health Department – Treatment Plan (TCP)

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| **Desired Results**: | |
| **Desired Transition:** | |
| **Obstacles**: | |
| **1.a Short Term Goal:** | **2.a Short Term Goal:** |
| **1.b Individual / Family / Supporters Strengths:** | **2.b Individual / Family / Supporters Strengths:** |
| **1.c Action Steps By Individual / Family / Supporters:** | **2.c Action Steps By Individual / Family / Supporters:** |
| **1.d Action Steps By Staff (Intervention):** | **2.d Action Steps By Staff (Intervention):** |

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| **SIGNATURES (Indicates person's participation / agreement with Treatment Plan):**<br><br>Client*: _____ Date:_____<br>*If no signature, see progress note dated: _____<br><br>Family or Support Person: _____ Date:_____<br><br>Program (Cost Center) Staff: _____ Date:_____<br><br>LPHA (if different from Program Staff):_____ Date:_____ | **AUTHORIZED PERIOD**<br>**Start Date**: **End Date:**<br>_____ _____<br><br>**Was a Copy of the Treatment Plan offered to Client?** Yes / No<br><br>If Yes: Accepted / Declined<br><br>If No, see progress note dated ____<br>_____ |

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| **TYPE OF SERVICE** (check √ ): | □ Outpatient MH | □ DTI | □ DR | □ AR | □ CR |
| **Client Name:** | | **Unicare #** | | **Program / Cost Center** | |