

**ORANGE COUNTY SOCIAL SERVICES AGENCY**  
**ASSESSMENT AND TREATMENT PLAN**

DATE OF INTAKE \_\_\_\_\_ PRE-TEST SCORE \_\_\_\_\_  
ORIGINAL [ ] REVISED [ ] EXTENSION REQUEST [ ]

\_\_\_\_\_  
CASE NAME                      CASE#                      SOCIAL WORKER                      PROGRAM                      BLDG#  
\_\_\_\_\_  
CONTRACTOR'S NAME                      PHONE#                      PREPARED BY: SIGNATURE/TITLE                      DATE  
\_\_\_\_\_  
CLIENT NAME AND DOB                      CLIENT NAME AND DOB                      CLIENT NAME AND DOB

BASED ON ASSESSMENT, SPECIFY TYPE OF INTERVENTION PLANNED:                      Individual, Conjoint, Family, Group

**SECTION A Goals**

GOAL #1 (be concise) \_\_\_\_\_

Changes in problem behavior affecting abuse/risk required to reach this goal:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

GOAL #2 (be concise) \_\_\_\_\_

Changes in problem behavior affecting abuse/risk required to reach this goal:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

GOAL #3 (be concise) \_\_\_\_\_

Changes in problem behavior affecting abuse/risk required to reach this goal:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

ESTIMATED TIME NEEDED TO REACH THESE GOALS: \_\_\_\_\_

**SECTION B**

Narrative summary (include observations regarding client motivation, insight, commitment to change and progress):

**SECTION C** Intervention provided in current month:

Service Codes (more than one may apply):

- O     Orientation                             GC     Group Counseling                     L/C     Letter Contact
- I     Intake/Assessment                     HS     In-Home services                     T/C     Telephone Contact
- IC    Individual Counseling                 PA     Parent Aide                             C     Cancellation
- CC    Conjoint Counseling                 SAC    Sexual Abuse Counseling             N/S    No Show (give reason if known)
- COL   Collateral Contact                     PE     Parent Education                     N/C    No contact this Month
- FC    Family Counseling

DATE & LENGTH	SERVICE CODE	NAME OF CLIENT(S) SEEN OR COLLATERAL CONTACT	CONTACT MADE BY: NAME OF PERSON/TITLE	LOCATION IF APPLICABLE	FOCUS/PURPOSE