**Treatment Plan – Group Home**

**Use of form:** Use of this form is voluntary; however, completion of this form meets the rule requirements for DCF 57.23(2). Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)m), Wisconsin Statutes.

**Instructions:** Complete each section of this form in detail regarding the resident.

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| **RESIDENT INFORMATION**  |
| Name – Last      | Name – First      |
| Alias (Nickname)      | Date of Birth (mm/dd/yyyy)      | Date of Placement (mm/dd/yyyy)      |
| **TREATMENT PLAN –** Must be completed by the program director once the assessment has been finished, with the participation of the resident, parent or guardian and the legal custodian if available. |
| Strengths**:**       |
| Needs**:**       |
| Preferences**:**       |
| **TREATMENT GOALS – Add additional treatment goals as appropriate.** |
| 1.
 | Treatment Goal (Description of goal):       |
|  | Timeframe for achieving goal:      |
|  | Behavior interventions to be used:       |
|  | Specific services to be provided to achieve treatment goals:       |
|  | Group home staff or agency responsible for implementation of the treatment plan:       |
|  | Specific Indicators that treatment goal has been achieved:       |
|  | Progress (include any barriers):       |
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|  | Group home staff or agency responsible for implementation of the treatment plan:       |
|  | Specific Indicators that treatment goal has been achieved:       |
|  | Progress (include any barriers):       |

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| **REASONABLE AND PRUDENT PARENTING** |
| Specific decisions or considerations:       |
| **ADDITIONAL INFORMATION** |
| Permanency planning goals:       |
| Independent living goals if resident is 15 years of age or older:       |
| Court ordered conditions:       |
| Projected length of stay and conditions for discharge:       |
| Participation in family contacts – resident and family members:       |
| Participation in public school:       |
| **DISCHARGE PLANNING** |
| Documentation of efforts to prepare the resident for discharge:       |
| Post discharge plan (to be completed within 30 days prior to a planned discharge):       |

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| Signature – Person Completing Treatment Plan      | Date – Completion of Treatment Plan      |
| Signature – Resident      | Date      |
| Signature – Parent/Guardian      | Date      |
| Signature – Legal Custodian      | Date      |
| Signature – Service Provider      | Date      |
| Signature – Service Provider      | Date      |