**U.S Probation Office – Western District of North Carolina**

**Sex Offender Treatment Plan**

Client Name: Enter Client Name Treatment Plan Type: [ ]  Initial

Treatment Provider: Enter Program Name [ ]  90-day Revision

Admission Date: Enter Date Treatment Plan Date: Enter Date

DSM Diagnosis: List Diagnoses

Current Medication(s): List Medication(s)

Short Term Goals/Objectives – Target Date:

|  |  |
| --- | --- |
| Goal #1 | Enter Goal #1* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #2 | Enter Goal #2* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #3 | Enter Goal #3* Enter Objective
* Enter Objective
* Enter Objective
 |

Long Term Goals/Objectives – Target Date:

|  |  |
| --- | --- |
| Goal #1 | Enter Goal #1* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #2 | Enter Goal #2* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #3 | Enter Goal #3* Enter Objective
* Enter Objective
* Enter Objective
 |

Identified Client Strengths/Abilities:

|  |  |
| --- | --- |
| Strength #1 | Enter Strength #1  |
| Strength #2 | Enter Strength #2 |
| Strength #3 | Enter Strength #3 |

Information on Family/Significant Others: Enter Information

Continued Need for Treatment (Check One): [ ] Yes [ ] No

**Additionally, the vendor shall:**

A. Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender

 Enter Comments

B. Individualize treatment to meet the offender’s needs

Enter Comments

C. Identify the issues to be addressed (including multi-generational issues if indicated), the planned intervention strategies, and the goals of treatment

 Enter Comments

D. Define the offender’s expectation s of treatment, the expectations of his/her family (when possible) and support systems of the treatment process, and address the issue of ongoing victim input (if possible)

 Enter Comments

E. Note the type and frequency of services to be received

Enter Comments

F. Note the specific criteria for treatment completion and the anticipated time frame

 Enter Comments

G. Provide documentation of treatment plan review (including the offender’s input), documenting the need for treatment at least every 90 days [ ]  Yes [ ]  No

 Enter Comments

H. The treatment plan is included with the Monthly Treatment Report and provided to the USPO after every revision, but at least every 90 days [ ]  Yes [ ]  No

 Enter Comments

Additional Comments: Enter Comments

 Type Clinician Name for Signature Enter Date

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Clinician Signature Date