PROBATE COURT OF PORTAGE COUNTY, OHIO

PATRICIA J. SMITH, JUDGE

IN RE_____, RESPONDENT

CASE NO. _____

TREATMENT PLAN

[R.C. 5122.01]

Last Treatment Plan filed _____ Expiration of Commitment: _____

Type: ☐ ICC ☐ AOT ☐ OCC

1. Does the respondent require community psychiatric supportive treatment?
   ☐ Yes ☐ No
   If yes, who will be providing the service and with what frequency?

2. Does the respondent require assertive community treatment? ☐ Yes ☐ No
   If yes, who will be providing the services and with what frequency?

3. Does the respondent require individual or group therapy? ☐ Yes ☐ No
   If yes, who will be providing the services and with what frequency?

4. Is respondent prescribed any medications? ☐Yes ☐No
   If yes: Who is the prescribing physician?_____
   With what frequency will the respondent see the prescribing physician?

   List all medications to be taken by the respondent including their dosage information (attach addition pages if necessary)

5. Does the respondent require nursing services to assist with medications?
   ☐Yes ☐No
   If yes, who will be providing the service and with what frequency?

6. Does the respondent require peer support services? ☐ Yes ☐ No
   If yes, who will be providing the services and with what frequency?

7. Does the respondent require financial services? ☐ Yes ☐ No
   If yes, who will be providing the services and with what frequency?

8. Does the respondent require housing or supervised residential services?
   ☐ Yes ☐ No
   If yes, who will be providing the service and what specific services will be provided?

9. Does the respondent require alcohol or substance abuse treatment?
   ☐ Yes ☐ No
   If yes, who will be providing the services, what specific services will be provided, and with what frequency will the services be provided?

10. Are any other services prescribed to treat the respondent's mental illness?
    ☐ Yes ☐ No
    If yes, describe.

11. Are any other services prescribed to assist the respondent in living and functioning in the community? ☐ Yes ☐ No
If yes, describe.

12. Are any other services prescribed to prevent a deterioration of the respondent's current condition? ☐Yes ☐ No
If yes, describe.

13. Is there any additional information that you wish to provide to the Court regarding the Respondent and/or her treatment plan that was not addressed in the questions above? ☐ Yes ☐ No
If yes, describe.

I certify that the information in this Treatment Plan is true, accurate and complete to the best of my knowledge and belief.

_____	_____
Date	Signature
_____	_____
Agency	Printed Name & Title