

TREATMENT PLAN CHECKLIST

(Use to determine appropriateness of the treatment plan)

Issue(s) Identified in the D&N Petition...	Issue Presented by...	Does the Treatment Plan Address the Identified Issue?
<input type="checkbox"/> Abandonment	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Abuse: <input type="checkbox"/> physical <input type="checkbox"/> mental <input type="checkbox"/> sexual	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Beyond the control of a parent	<input type="checkbox"/> (Minor) mother _____ <input type="checkbox"/> (Minor) father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Case history: <input type="checkbox"/> delinquency <input type="checkbox"/> D&N <input type="checkbox"/> termination <input type="checkbox"/> truancy <input type="checkbox"/> other _____	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Domestic violence: <input type="checkbox"/> victim <input type="checkbox"/> perp.	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Failure to protect	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Homelessness	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Incarceration	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Lack of bonding/relationship	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no

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<input type="checkbox"/> Medical issues	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Mental health issues	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Neglect: <input type="checkbox"/> educational <input type="checkbox"/> emotional <input type="checkbox"/> medical <input type="checkbox"/> physical	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Runaway	<input type="checkbox"/> (Minor) mother _____ <input type="checkbox"/> (Minor) father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Sex offense <input type="checkbox"/> offender <input type="checkbox"/> victim	<input type="checkbox"/> (Minor) mother _____ <input type="checkbox"/> (Minor) father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Other issue(s): _____	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Other issue(s): _____	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Other issue(s): _____	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Other issue(s): _____	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no