TREATMENT SERVICES CONTRACT PROGRAM PLAN

Client Identifying Information

Client :	PACTS#:
Address:	Pretrial/Post Conviction:
Officer:	Client Phone:
Officer Phone:	DOB:

Provider Information

Provider:
Provider Location:
Attn:
Location Address:

Phone:
Fax:

Procurement No:
Effective Date:
Termination Date:

Authorized Services

Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)
2010	Individual Substance Abuse Counseling		1.0	Weekly	$0.00
2020	Group Substance Counseling		2.0	Monthly	$0.00

Instructions to Provider Regarding Client Needs and Goals of Treatment

_____ Officer:

_____ Referral Agent:

_____ Client: