**State of Maine**
**Department of Health and Human Services, Office of Child & Family Services**
**Section 24: Treatment Plan Meeting Form**

**Child / Youth Name:** _____

*To be used at initial treatment planning meeting and at 90 day reviews. Please indicate below meeting attendance and obtain signatures of child/youth, parent/guardian and Section 24 provider.*

*"Did Not Attend, But Had Input" refers to psychological or other evaluations or reports, information from a teacher, etc.*

**Meeting Type: Initial ☐ 90-day review ☐**

| Team Members: | Please check one: | Invited | Attended | Did Not Attend | Did Not Attend, But Had Input |
|---|---|---|---|---|---|
| Child/Youth receiving services | | ☐ | ☐ | ☐ | ☐ |
| Parent/Guardian | | ☐ | ☐ | ☐ | ☐ |
| Section 24 Provider | | ☐ | ☐ | ☐ | ☐ |
| Other: | | ☐ | ☐ | ☐ | ☐ |
| Other: | | ☐ | ☐ | ☐ | ☐ |
| Other: | | ☐ | ☐ | ☐ | ☐ |
| Other: | | ☐ | ☐ | ☐ | ☐ |
| Other: | | ☐ | ☐ | ☐ | ☐ |

**SIGNATURES:**

_____ _____
**Child/Youth** **Date**

_____ _____
**Parent/Guardian** **Date**

_____ _____
**Section 24 Provider** **Date**