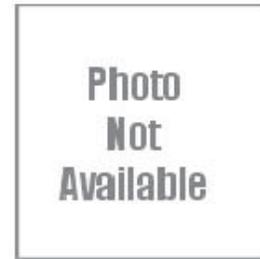


TREATMENT SERVICES CONTRACT PROGRAM PLAN

**Client Identifying Information**

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



**Provider Information**

Provider:	Procurement No:
Provider Location:	Effective Date:
Attn:	Termination Date:
Location Address:	
Phone:	
Fax:	

**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: