

IEP – AB2726 Outpatient Mental Health Services Plan

Student's Name: _____ DOB: _____
District of Residence: _____ 7-digit CDS code: _____
Current Social/Emotional Student Behaviors Justifying Outpatient Care: _____

Goals of Client/Parent/Guardian: _____

Goals of AB2726 Outpatient Services (*Note: Global goal is always to improve educational functioning. This section should address specifics needed to accomplish this goal*): _____

Mental Health Services to be Provided

Duration time includes not only face-to-face time, but also any required additional activities.

Individual Therapy Loc: _____ Initial Date: _____ Freq: _____ Duration: _____ End Date: _____
Goal for Individual Therapy: _____

Group Therapy Loc: _____ Initial Date: _____ Freq: _____ Duration: _____ End Date: _____
Goal for Group Therapy: _____

Medication Monitoring Loc: _____ Initial Date: _____ Freq: _____ Duration: _____ End Date: _____
Goal for Medication Monitoring: _____

Collateral Loc: _____ Initial Date: _____ Freq: _____ Duration: _____ End Date: _____
Goal for Collateral Services: _____

Other (e.g., CM) Loc: _____ Initial Date: _____ Freq: _____ Duration: _____ End Date: _____
Goal for this service: _____

PERIODIC REPORT: (*A periodic report of pupil's progress will be provided concurrently to the report card.*)

Date of Scheduled Report Cards: (1) _____ (2) _____ (3) _____ (4) _____

IEP TEAM SIGNATURES: (*Signature verifies that the AB 2726 Outpatient Services are approved and incorporated as referenced, as part of this IEP, including conclusions, milestones/goals and service recommendations.*)

_____ Administrator/Designee Signature	_____ Printed Name	_____ Title	_____ Date
_____ DBH Representative Signature	_____ Printed Name	_____ Title	_____ Date

PARENT/GUARDIAN APPROVAL:

(Parent Initials) *I have been advised of my rights, including voluntary nature of AB 2726 services.*

(Parent Initials) *I have received a copy of the Mental Health Assessment*

(Parent Initials) *SBCDBH (AB2726) is not responsible for costs of medications or other medical services.*

_____ Parent/Guardian Signature	_____ Printed Name	_____ Title	_____ Date
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