Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

Date of Admission:	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**

Goal #:	**Start Date:**	**Target Completion Date:**

Linked to Assessed Need # _____ from form checked below dated _____:
☐**CA** ☐**CA Update** ☐ **Psych Eval.** ☐ **Other:**

Desired Outcomes for this Assessed Need in Person's Words:

Goal (State Goal Below in Collaboration with the Person Served/Reframe Desired Outcomes)**:**

Person's Strengths and Skills and How They Will be Used to Meet This Goal:

Supports and Resources Needed to Meet This Goal:

Potential Barriers to Meeting This Goal:

Person's Initials:

MSDP

Individualized Action Plan
Revision Date: *3-7-09*

GOAL #: ____ OBJECTIVE # ____:			
Person Served Will:			**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)			**Target Completion Date:**
Intervention(s)/ Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**

GOAL #: ____ OBJECTIVE # ____:			
Person Served Will:			**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)			**Target Completion Date:**
Intervention(s)/ Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**

GOAL #: ____ OBJECTIVE # ____:			
Person Served Will:			**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)			**Target Completion Date:**
Intervention(s)/ Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**

Person's Initials:

MSDP

Individualized Action Plan
Revision Date: *3-7-09*

Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: ☐ **None Reported**			
Agency Name:	**Contact and Title**	**Services Currently Provided**	**Release Signed**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

This Section Mandatory For Outpatient Substance Use Counseling Only (Check Here if Not Applicable: ☐)			
Medications as Reported by the Person Served on Date of IAP Development - ☐ **None Reported**			
Medication Name	**Dose**	**Plans for Change - Including Rate of Detox**	**Prescribed by**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**

Criteria - *How will the provider/client/parent guardian know that level of care change is warranted?*
(Check All that Apply):

☐ Reduction in symptoms as evidenced by:

☐ Attainment of higher level of functioning as evidenced by:

☐ Treatment is no longer medically necessary as evidenced by:

☐ Other:

Person's Signature:			**Date:**
Was the person served provided copy of the IAP? ☐ **Yes** ☐ **No, Reason:**			**Person's Initials to confirm:**
Parent/Guardian Signature (if applicable): ☐ N/A	**Date:**	**Supervisor Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Provider Signature/Credentials:	**Date:**	**Psychiatrist/MD/DO Signature/Credentials (if applicable):** ☐ N/A	**Date:**