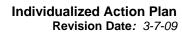


Individualized Action Plan Revision Date: 3-7-09

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Person's Name (First / MI / L	_ast):			Record#	:	D.O.B.:			
Organization Name:									
Date of Admission:	Date Plan Initiated:		Plan Completed by (Name, Title, Progra			am):			
Goal #:		Start Date:			Farget Completion	n 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 Collabo	ration with the	e Person Served/Reframe	e Desired Outco	mes):					
Person's Strengths and Skills and How They Will be Used to Meet This Goal:									
Supports and Resources Need	ed to Meet	This Goal:					_		
Potential Barriers to Meeting Ti	his Goal:								
Person's Initials:									





GOAL #: OBJECTIVE #:					
Person Served Will:	,	Start Date:			
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)			Target Co	ompletion Date:	
Intervention(s)/ Method(s)	Service Description/ Modality	Frequ	ency	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	escription/ 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/ F Modality			Responsible: (Type of Provider)	
Person's Initials:					



Provider Signature/Credentials:

Individualized Action Plan Revision Date: 3-7-09

of Page: 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:

| Outpatient | Description 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: Supervisor Signature/Credentials (if applicable): N/A Parent/Guardian Signature (if applicable): N/A Date: Date:

Date:

Psychiatrist/MD/DO Signature/Credentials (if applicable): N/A

Date: