MSDP

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

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

Review/Revision Date:	**Individualized Action Plan Date:**	**Reviewed by (Name, Title, Program):**

☐ **Review/ Revision:**	☐30 day ☐60 day ☐90 day ☐180 Days ☐Other: Dates Covered:	**Complete pages 1 and 2 of IAP Review/ Revision form and attach as many Goal/Objective sheets as necessary.**
☐ **Rewrite:**	☐ Annual ☐ Other (specify):	**Use page 1 of IAP Review/Revision and attach new IAP**

Goal & Objective Status *(Active / New / Discontinued / Completed / Revised)*	**Evidence of Progress, Barriers, and/or Rationale for Addition of New Goal/Discontinuation of Goal, Revision or Rewrite:**
☐ **Goal #:** **Keyword or Goal Statement:**	☐**Active: check to indicate progress** ☐Partially Met ☐Not Met ☐Met ☐**New** ☐**Discontinued – actual date of goal discontinuation:** ☐**Completed – actual date of goal completion:** ☐**Revised**
☐ Obj. 1 ☐**A** ☐**N** ☐**D** ☐**C** ☐**R** ☐ Obj. 2 ☐**A** ☐**N** ☐**D** ☐**C** ☐**R** ☐ Obj. __ ☐**A** ☐**N** ☐**D** ☐**C** ☐**R** ☐ Obj. __ ☐**A** ☐**N** ☐**D** ☐**C** ☐**R** ☐ Obj. __ ☐**A** ☐**N** ☐**D** ☐**C** ☐**R** ☐ Obj. __ ☐**A** ☐**N** ☐**D** ☐**C** ☐**R** ☐ Obj. __ ☐**A** ☐**N** ☐**D** ☐**C** ☐**R**	**Evidence/Rationale:** **Refer to Progress Note(s) of (Date):** **(**☐ Not Applicable)
☐ **Goal #:** **Keyword or Goal Statement:**	☐**Active: check to indicate progress** ☐Partially Met ☐Not Met ☐Met ☐**New** ☐**Discontinued – actual date of goal discontinuation:** ☐**Completed – actual date of goal completion:** ☐**Revised**
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Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: ☐ **None Reported (**☐ **No Change)**			
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 (☐ No Change)			
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 (☐ No Change)	**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:**