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|  |
| Person’s Name (First MI Last):       | Record #:       |
| Organization/Program Name:       | DOB:       | **Gender:** [ ]  Male [ ]  Female[ ]  Transgender |

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| **Date of Admission:**  | **[ ]  Annual IAP-Date:** **[ ] Revised IAP-Date:**  |
|  **Linked to Assessed Need(s):**  f**rom form dated:**      [ ] CA [ ] CA Update [ ] Psych Eval. [ ] Other:      | **Start Date:**      | **Target Completion Date:**      |
| **Desired Outcomes for this Assessed Need in Person’s Words:**        |

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|  **GOAL #:**      (State Goal Below in Collaboration with the Person Served/Reframe Desired Outcomes) |
|       |
| **Person’s Strengths, Preferences, 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:**       |

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| **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)** |
| 1.       |       |       |       |
| 2.       |       |       |       |
| 3.       |       |       |       |
| 4.       |       |       |       |

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| **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)** |
| 1.       |       |       |       |
| 2.       |       |       |       |
| 3.       |       |       |       |
| 4.       |       |       |       |

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|  **Person’s Name** (First / MI / Last):       | **Record#:**       |
| **GOAL #:**      (State Goal Below in Collaboration with the Person Served/Reframe Desired Outcomes) |
|        |

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| **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)** |
| 1.       |       |       |       |
| 2.       |       |       |       |
| 3.       |       |       |       |
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| **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)** |
| 1.       |       |       |       |
| 2.       |       |       |       |
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| **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)** |
| 1.       |       |       |       |
| 2.       |       |       |       |
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| **Person’s Name** (First / MI / Last):       | **Record#:**       |
| **This Section Mandatory for Outpatient Substance Abuse Counseling Only (Check Here if Not Applicable:** **[ ] )** |
| **Medications as Reported by Person Served on Date of IAP Development (None Reported:** **[ ] )** |
| **Medication Name** | **Dose** | **Plans for Change-Including Rate of Detox** | **Prescribed By** |
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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 |

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| **Transition/Level of Care Change/Aftercare/Discharge Plan** ([ ]  No Change) | **Anticipated Date:**  |
| **Criteria-***How will the provider/individual/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 not longer medically necessary as evidenced by:      [ ]  Other:       |

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| **Plan Completed by (Name, Title, Program):**       |
| **Was the person served provided copy of the IAP?** **[ ]  Yes** **[ ]  No, Reason:**       |

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| **Person’s Signature** (Optional, if clinically appropriate) | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** | **Next Appointment:****Date:** **Time:** [ ]  **am** [ ]  **pm** |