**Page:** **of**



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

|  |  |  |  |
| --- | --- | --- | --- |
| **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:** | | | |

|  |
| --- |
| **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:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. |  |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. |  |  | |  |

**Page:       of**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. |  |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. |  |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. |  |  | |  |

**Page:       of**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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** |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |
|  | |  |  | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |

|  |  |
| --- | --- |
| **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: | |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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** | |