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| Person’s Name (First MI Last): | | Record #: | Date of Admission: |
| Organization/Program Name: | | DOB: | **Gender:**  Male  Female  Transgender |
| **Annual IAP-Date:** | **Revised IAP-Date:** | | |
| **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:** | | | |
| **Person Served Will:** | | | |
| **Parent/Guardian/Community/Other Will: (**Not Clinically Indicated) | | | |

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| **Goal #:** | | | | | | | | |
| **Linked to Assessed Need(s):** **from 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)**:** | | | | | | | | |
| **Objective #**      **:** | | | | | | | | |
| **Intervention(s) / Method(s)** | | | **Start Date:** | | | **Target Completion Date:** | | |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| **Service Modality:** | Individual Therapy | Couple/ Family Therapy | | Medication Services | | | Case Management | |
| **Frequency:** |  |  | |  | | |  | |
| **Type of Provider** |  |  | |  | | |  | |
| **Service Modality:** | Group | Other: | | Other: | | | Other: | |
| **Frequency:** |  |  | |  | | |  | |
| **Type of Provider** |  |  | |  | | |  | |

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| **Person’s Name** (First / MI / Last): | | | | | | | **Record#:** |
| **Goal #:** | | | | | | | |
| **Objective #**      **:** | | | | | | | |
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| **Frequency:** |  |  | |  | |  | |
| **Type of Provider** |  |  | |  | |  | |
| **Service Modality:** | Group | Other: | | Other: | | Other: | |
| **Frequency:** |  |  | |  | |  | |
| **Type of Provider** |  |  | |  | |  | |

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| **Type of Provider** |  |  | |  | |  |
| **Service Modality:** | Gro | Other: | | Other: | | Other: |
| **Frequency:** |  |  | |  | |  |
| **Type of Provider** |  |  | |  | |  |

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| **Frequency:** |  |  | | | |  | | |  | | |
| **Type of Provider** |  |  | | | |  | | |  | | |
| **Service Modality:** | Group | Other: | | | | Other: | | | Other: | | |
| **Frequency:** |  |  | | | |  | | |  | | |
| **Type of Provider** |  |  | | | |  | | |  | | |
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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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| **Does the person served have a disability that requires modification of policies, practices, or procedures?**  Yes  No  **If yes, document any modifications made:** | | | |
| **Describe the plan for initiation, coordination, and management of concurrent additional substance use disorder treatment, treatment of co-occurring disorders, and/or primary medical care:** | | | |
| **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 no 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** | |