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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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|  **Page:       of** |
| **Person’s Name** (First / MI / Last):       | **Record#:** |
| **Goal #:**      |
| **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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| **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:** | [ ]  Gro | [ ]  Other:       | [ ]  Other:       | [ ]  Other:       |
| **Frequency:** |       |       |       |       |
| **Type of Provider** |       |       |       |       |

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| **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** |       |       |       |       |
|  | **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** |
| 1.
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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** |