MSDP

Individualized Action Plan-Version 1

Person's Name (First / MI / Last): Ramirez, Joel	**Record #:** 1234	**Date of Admission: 1-24-13**
Organization/Program Name: Child and Family Services of Boston	**DOB:** 1-15-2007	**Gender:** X☐ Male ☐ Female ☐ Transgender

Date of Admission: 1-24-13	**X☐ Annual IAP-Date: 1-24-13**	**Revised IAP-Date:**

Linked to Assessed Need(s): **from form dated:** 1-24-13 X☐CA ☐CA Update ☐Psych Eval. ☐Other:	**Start Date:** 1-24-13	**Target Completion Date:** 7-24-13

Desired Outcomes for this Assessed Need in Person's Words: "I want to do better in school and play more with friends".

GOAL (State Goal Below in Collaboration with the Person Served/Reframe Desired Outcomes)

Joel will be able to communicate effectively.

Person's Strengths, Preferences, and Skills and How They Will be Used to Meet This Goal: Joel is a very curious and sweet child who shows engagement at times. He has strong family support and the support of his church community.

Supports and Resources Needed to Meet This Goal: Joel will need the support of his family and school to achieve this goal.

Potential Barriers to Meeting This Goal: It is imperative that Joel receive Speech and Language testing as soon as possible so he can begin therapy to reinforce this goal.

OBJECTIVE # 1**:**2

Person Served Will: Attend counseling on a weekly basis to work on communication skills with his clinician.	**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated) Practice skills at home with Joel.	**Target Completion Date:**

Intervention(s) / Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**
1. Joel will engage in reciprocal conversation with this clinician. He will choose a "talking" object and will practice reciprocity.	Individual therapy	1 x week	clinician
2. Joel will be able to talk about dinosaurs for 5 minutes during each session, learning by verbal cues when his time is up.	Individual Therapy	1 x week	clinician
3.			
4.			

OBJECTIVE # 2**:**2

Person Served Will: Engage in social skills training.	**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated) Practice skills at home.	**Target Completion Date:**

Intervention(s) / Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**
1. Joel, through directed play, will practice eye contact	Individual Therapy	1 x week	clinician
2. Through directed play, Joel will practice interpreting social skills and cues	Individual Therapy	1 x week	clinician
3. Joel will attend a formal social skills group with peers and a professional facilitator.	Group	1 x week	School adjustment counselor

Person's Name (First / MI / Last): Ramirez, Joel	**Record#:** 1234	**D.O.B.:**
GOAL #: 2 Joel will practice frustration tolerance and emotion regulation.		

OBJECTIVE # 1**:**2

Person Served Will: Joel will learn how to regulate his emotions in order for him to not get to the point of intolerable frustration**.**	**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated) Reinforce skills at home.	**Target Completion Date:**

Intervention(s) / Method(s)	Service Description/ Modality	Frequency	Responsible: (Type of Provider)
1. Through directed play therapy, Joel will be placed in situations in which he will lose at a game, a battle or other type of situation which would make him frustrated	Individual Therapy	1 x week	clinician
2. Joel will be able to identify feelings, placing names with them.	Individual Therapy	1 x week	clinician
3. Joel will be do body mapping and be able to identify where in his body he feels his feelings.	Individual Therapy	1 x week	clinician
4.			

OBJECTIVE # 2**:**2

Person Served Will: Joel will learn how to decrease his anxiety.	**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated) Reinforce skills at home.	**Target Completion Date:**

Intervention(s) / Method(s)	Service Description/ Modality	Frequency	Responsible: (Type of Provider)
1. Joel will learn deep, diaphragmatic breathing skills	Individual Therapy	1 x week	clinician
2. Joel will listen to calming music.	Individual Therapy	1 x week	clinician
3. Joel will practice CBT skills, relating thoughts feelings and behaviors utilizing the Cognitive Triangle.	Individual Therapy	1 x week	clinician
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.			

Person's Name (First / MI / Last): Ramirez, Joel	**Record#:** 1234	**D.O.B.:** 1-15-07

This Section Mandatory for Outpatient Substance Abuse Counseling Only (Check Here if Not Applicable: ☐)

Medication Name	Dose	Plans for Change-Including Rate of Detox	Prescribed By
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: X ☐ None Reported (☐ No Change)

Agency Name:	Contact and Title	Services Currently Provided	Release Signed
Bates School	Amanda Hoffman, LICSW	SAC, lunch bunch weekly social skills group	X☐ Yes ☐ No
Others TBD and will update IAP when identified			☐ 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)

X☐ Reduction in symptoms as evidenced by: an increase in appropriate communication skills and reciprocal conversations

X☐ Attainment of higher level of functioning as evidenced by: decrease in anxiety, maintaining eye contact, increased tolerance for frustration, ability to identify feelings

☐ Treatment is not longer medically necessary as evidenced by:

☐ Other:

Plan Completed by (Name, Title, Program): Jane Doe, LMHC

Was the person served provided copy of the IAP/ X☐s Yes ☐ No, Reason:

Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential: Jane Doe, LMHC	**Date: 1-24-13**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date: 1-24-13**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**	**Next Appointment:** **Date: 2/3/13 - Time: 2:30** ☐ **am** X☐ **pm**	