Section

3

Using the MSDP Individualized Action Plan (IAP) Group Documentation Processes/Forms

This section provides a sample of each Action Plan Group form type, guidelines for the use of each form, and instructions for completion of the forms, including definitions for each data field.

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Note: Forms utilized in this section of the manual have been modified in both height and width to accommodate the format of the MSDP Training Manual. Please utilize electronic versions of actual forms for reproduction and use within the program.

Expanded -

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

Date of Admission:	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**

Goal #:	**Start Date:**	**Target Completion Date:**
Linked to Assessed Need # _____ from form checked below dated _____: ☐CA ☐CA Update ☐ Psych Eval. ☐ Other:		
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 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's Initials:		

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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)**
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)**
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)**
Person's Initials:			

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: ☐ **None Reported**			
Agency Name:	**Contact and Title**	**Services Currently Provided**	**Release Signed**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

This Section Mandatory For Outpatient Substance Use Counseling Only (Check Here if Not Applicable: ☐)			
Medications as Reported by the Person Served on Date of IAP Development - ☐ **None Reported**			
Medication Name	**Dose**	**Plans for Change - Including Rate of Detox**	**Prescribed by**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**

Criteria - *How will the provider/client/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:

Person's Signature:			**Date:**
Was the person served provided copy of the IAP? ☐ **Yes** ☐ **No, Reason:**			**Person's Initials to confirm:**
Parent/Guardian Signature (if applicable): ☐ N/A	**Date:**	**Supervisor Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Provider Signature/Credentials:	**Date:**	**Psychiatrist/MD/DO Signature/Credentials (if applicable):** ☐ N/A	**Date:**

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

Date of Admission:	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**

Goal #:

Linked to Assessed Need # _____ 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)**:**

Person's Strengths 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)

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)

Person's Initials:

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: ☐ **None Reported**			
Agency Name:	**Contact and Title**	**Services Currently Provided**	**Release Signed**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

This Section Mandatory For Outpatient Substance Use Counseling Only (Check Here if Not Applicable: ☐)			
Medications as Reported by the Person Served on Date of IAP Development - ☐ **None Reported**			
Medication Name	**Dose**	**Plans for Change - Including Rate of Detox**	**Prescribed by**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**

Criteria - *How will the provider/client/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:

Person's Signature:			**Date:**
Was the person served provided copy of the IAP? ☐ **Yes** ☐ **No, Reason:**			**Person's Initials to confirm:**
Parent/Guardian Signature (if applicable): ☐ N/A	**Date:**	**Supervisor Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Provider Signature/Credentials:	**Date:**	**Psychiatrist/MD/DO Signature/Credentials (if applicable):** ☐ N/A	**Date:**

Short with Multiple Goals –

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

Date of Admission:	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**

Goal #:

Linked to Assessed Need # _____ 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):		
Person's Strengths 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)

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)

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Person's Name (First / MI / Last):	Record#:	D.O.B.:

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)**

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)**

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)**

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Date of Admission:	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**

Goal #:

Linked to Assessed Need # _____ 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)**:**

Person's Strengths 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)

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)

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Person's Name (First / MI / Last):	Record#:	D.O.B.:

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)

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)

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)

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Date of Admission:	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**

Goal #: 3

Linked to Assessed Need # _____ 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)**:**

Person's Strengths 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)

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)

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Person's Name (First / MI / Last):	Record#:	D.O.B.:

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)**

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)**

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)**

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: ☐ **None Reported**			
Agency Name:	**Contact and Title**	**Services Currently Provided**	**Release Signed**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

This Section Mandatory For Outpatient Substance Use Counseling Only (Check Here if Not Applicable: ☐)			
Medications as Reported by the Person Served on Date of IAP Development - ☐ **None Reported**			
Medication Name	**Dose**	**Plans for Change - Including Rate of Detox**	**Prescribed by**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**
How will the provider/person served/parent/guardian know that level of care change is warranted and what plans are being discussed at this point in treatment to prepare?	

Person's Signature:			**Date:**
Was the person served provided copy of the IAP? ☐ **Yes** ☐ **No, Reason:**			**Person's Initials to confirm:**
Parent/Guardian Signature (if applicable): ☐ N/A	**Date:**	**Supervisor Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Provider Signature/Credentials:	**Date:**	**Psychiatrist/MD/DO Signature/Credentials (if applicable):** ☐ N/A	**Date:**

Individualized Action Plan

Treatment Planning is a collaborative process and per best practice guidelines, regulatory requirements, and accreditation standards must demonstrate active participation of the person served and/or his or her parent/guardian. The title "Individualized Action Plan" has been identified for use to capture all of the work or "actions", which may be utilized in the course of treatment for persons served by a variety of programs. The Individualized Action Plan (IAP) must be completed for every person served and be linked to the treatment recommendations/assessed needs from the Comprehensive Assessment or other approved document. This form has been designed to facilitate active participation and plan development with the person served and/or his or her parent/guardian and to document the goals and objectives identified collaboratively with the person served, as well as steps that will be taken by the person served, parent/guardian/community, and other providers to achieve the desired goal(s).

The form has been designed using components, which can be combined to capture the total number of goals and objectives identified. The components include a goal section with corresponding objectives, as well as a page that provides space for additional necessary information such as other agencies/community supports and resources supporting the IAP and a medication list (mandatory for outpatient substance use counseling only). In addition, a section is provided at the end of the plan to specify the Transition/Level of Care/Discharge Plan. While this may be new to some users, it is in fact a mandatory element of the treatment planning process.

Two versions of the IAP form are available: a condensed version and an expanded version. Both contain identical information but are formatted differently to suit the needs of various persons who may be completing the form. The condensed version is organized with one goal and two corresponding objective spaces all on one page. The user can use as many of this page as necessary to capture the total number of identified goals. The expanded version, which provides larger spaces, breaks the goals and objectives into two separate pages that are used in conjunction for each identified goal. Again, as many pages as necessary should be used to capture the total number of identified goals and objectives. (The "objective sheet", which provides space for three objectives can also be used as necessary with either version if more space is needed for additional objectives). The final page for both versions is the same. Once all goals and objectives are completed and the final page added, the total number of pages should be counted and page "x" of "y" should be indicated in the header of each page.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
***Person's Name:**	Record first name, middle initial, and last name of the person served. Order of name is at agency discretion.
***Record Number:**	Record agency's established identification number for the person.
***D.O.B:**	Document date of birth of the person served.
Organization Name	Record the organization for whom you are delivering the service.
Date of Admission:	Record date the person served was admitted.
Date Plan Initiated:	Record date that the IAP was initially developed, including month, date, and year. This is the date that the person served signs the plan.
Plan Completed by:	Record the name of the person completing the IAP, his or her title, and the program(s) for which the plan is being developed.

Data Field	Goals/Desired Results/Target Date Instructions
Goal #:	To identify goals, number sequentially. **Example: Goal # 1** (**Note:** individual programs may have differing requirements as to what components must be included in an Individualized Action Plan/Treatment Plan. Providers should follow contractual and regulatory standards as applicable, i.e. for the CBAT and ICBAT programs, the individual goal sheets can be used for medical, educational, family, etc. goals)
Linked to Assessed Need # ____ from form dated _____:	List the number of the treatment recommendation/assessed need from the date of an approved form. Check off or indicate the other form name that contains the treatment recommendation/assessed need identified. **Example:** **Treatment Recommendation # 1 from form dated 01/08/07: Comprehensive Assessment**
Start Date:	The date the person served and provider(s) will begin to work on this goal.
Target Completion Date:	Record the date by which the person served would like to accomplish the goal or the date by which the person served and provider(s) believe the goal can be completed.

Desired Outcomes for this Assessed Need in Person's Words:	Document in the words of the person served his or her desired outcomes for the assessed need. This statement will be utilized in formulating the goal statement described below and can be used as a benchmark by the person served and provider for determining success in achieving the goal as treatment progresses. **Examples:** • **I want to stop losing my cool all the time!** • **I want to go back to school** • **I want my mom and I to stop fighting** • **I want to stop drinking**
State Goal below in Collaboration with the Person Served:	Reframe the desired outcome stated above by describing the goal from a clinical perspective in collaboration with the person served. Goals should be stated in attainable, behavioral/measurable terms. For some programs or courses of treatment, specific goals may be required (i.e. Tobacco Cessation, Medication Management, mandated treatment, etc.). **Example:** **Reduce the number and intensity of anger episodes at home.**

Data Field	Person's Strengths/Skills/Supports Instructions
Person's strengths and skills and how they will be used to meet this goal:	Document the strengths and skills the person served has that can be used to work towards and accomplish this goal. **Examples:** • **Person served can read at the high school level.** • **Person's family is still very involved and will provide support for medication management, transportation, and opportunities for socialization.** • **Person has group of close friends from residence with which he can socialize.** • **Person served currently works in a fast food restaurant and can follow fairly complex instructions.** • **Person served is healthy and is not on any medications for medical conditions.**
Supports and Resources needed to meet this goal:	List supports and resources that will be needed to accomplish the goal. Include natural and community supports as well as cultural and linguistic needs of the person and any reasonable accommodations/modifications to policies or practices that will be made. Be sure to consider supports beyond the behavioral health system to facilitate recovery and resiliency. **Examples:** • **AA meetings, Church, community support meetings** • **An interpreter, written materials in another language** • **Meeting space in an area accessible by wheel chair** • **Peer support worker**
Potential Barriers to meeting this goal:	Record any potential barriers to meeting the goal, which the person served identifies or that were identified while developing the IAP. **Examples:** • **Person served does not have drivers license** • **Person served does not have a stable recovery environment**

Data Field	Client Review/Goal Agreement Instructions
Person's Initials:	Person served should initial each goal and objective sheet to document active participation in development of the plan.

Data Field	Objectives Instructions
GOAL # ___	Identify the number of the goal to which the objective applies. **NOTE:** In the condensed version, two objective spaces are automatically attached to each identified goal and this space is not provided. This data field must be completed when the objective sheet is utilized to tie it to its corresponding goal.

OBJECTIVE # ___	Number each objective sequentially and link to the appropriate goal **Examples:** • **Goal #1/Objective #1** • **Goal #1/Objective #2**
(OBJECTIVE):	Describe in measurable terms an objective that will assist the person served in reaching the identified goal. NOTE: In the condensed version there are two spaces provided per goal page. If additional objectives are needed for a specific goal insert an additional objectives sheet. **Examples:** • **Average number of anger episodes will decrease from 10 to 5 per week.** • **Identify and attend an after-school recreational program.** • **Demonstrate competency in using public transportation to get to MD appointments.**
Start Date:	The date the work on this objective will start.
Target Completion Date:	Record the date by which the person served would like to accomplish the objective or the date by which the person served and provider(s) believe the objective can be completed.
Person Served Will:	Indicate the specific actions the person served will take to support achievement of the stated objective. **Examples:** • **Person will ask mother to assist in monitoring number of angry outbursts per week.** • **Person served will talk with guidance counselor about available after-school programs.** • **Person served will attend weekly group on using public transportation.** • **Person served will determine if he is eligible for VA benefits by calling local VA.** • **Person will ask guardian for permission to explore self-management of an allowance.** • **Person served will get a psychiatric assessment to determine if he has ADD.**
Parent/Guardian/ Community/Other Will	Indicate the actions/support the parent/guardian/community/ others will provide to assist the person served in accomplishing the objective. If family or other involvement is not clinically indicated, check box. **Examples:** • **Mother will record number of angry outbursts of the person served per week on calendar.** • **Father will contact local YMCA for a catalog of available programs.** • **Guardian will accompany person on trip to the store via public bus.** • **Daughter will work with father to find VA telephone numbers.** • **Clubhouse Director will provide guardian with educational materials about money management.** • **Father will sign necessary permission forms for stepmother to be able to bring person served to medication appointments.**

Data Field	Interventions and Service Description Instructions
Intervention(s)/Method(s):	Describe the actual therapeutic or rehabilitative interventions/methods the clinician/trained other staff will provide to support/facilitate the person served in achieving the stated objective. *This is not the type or modality of the service (i.e. do not write "CBT" or "Individual Therapy" alone. The statement should be descriptive of the actual methods).* **Examples**: • **Teach/build anger management skills.** • **Help person identify strengths and interests.** • **Use CBT to assist person served in identifying negative/automatic thought**

	patterns regarding use of public transportation. • **Connect person served to available community resources.** • **Work with person and guardian to identify how they will know person served is ready to manage his own money.** • **Complete referral for medication evaluation.**
Service Description/ Modality:	Indicate the types of services the person will receive. Because this is a comprehensive plan this may not necessarily be a behavioral health service. **Examples:** • **Family Therapy** • **Individual therapy** • **Couples therapy** • **Group therapy** • **Psychopharmacology** • **Case management**
Frequency:	Indicate how often this service/activity will occur. For some services, the total number of hours ordered may need to be included. Please refer to agency-specific guidelines. **Examples:** • **Daily** • **.5 hours Weekly** • **Bimonthly** • **4 hours per week**
Responsible: (Type of Provider)	Indicate the credential or title of the program staff, not the specific individuals, that are responsible for providing the services listed. If the types of providers listed are not eligible to provide the service according to regulation or payer rules, the service may not be billable. If services are provided in a team format, the primary provider type should be listed. **Examples:** • **Psychiatrist** • **Nurse** • **Therapist** • **Community Support Staff** • **Case Manager**

Data Field	Identifying Information/Agencies Instructions
Other Agencies/Community Supports and Resources Supporting IAP:	List the agency name, contact person/title, and services currently being provided by external agencies/community supports and resources that are collaborating on or supporting the person's IAP. Indicate whether or not the appropriate release has been signed to allow for communication with each. Check if "None Reported". **Examples:** • **Other Mental Health agencies** • **State Departments (i.e. DSS, DMR, DMH)** • **Doctor/Nurse** • **Court/Probation Officer**

Data Field	Medication Information
Medications as Reported by Person Served on Date of IAP:	**NOTE: <u>This section is mandatory for outpatient substance use counseling programs only.</u>** If not applicable, check the box provided. Complete the information in the table as reported by the person served on the date that the IAP was developed. Complete all fields for each medication including name of medication, dose, plans for change (including rate of detoxification), and the person prescribing each medication. Check if "None Reported".

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date:	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or provider assessment.
How will the provider/person served/parent/ guardian know that level of care change is warranted?	Transition planning should begin as early as possible in the treatment process and documentation of the planning is required. To facilitate the process, checkboxes have been provided. Check all that apply and document evidence, which supports or describes any criteria checked. Examples: • Reduction in symptoms as evidenced by: improvement in withdrawal symptoms • Services are no longer medically necessary as evidenced by: completion of methadone protocol • Other: placement in a longer-term treatment program • Reduction in symptoms as evidenced by: client self-report that withdrawal discomfort has decreased • Services are no longer medically necessary as evidenced by: scores on the CIWA or COWS assessment • Other: completion of program and appointment with outpatient substance abuse counselor • Attainment of higher level of functioning as evidenced by: ability to manage his or her own medications • Attainment of higher level of functioning as evidenced by: person is no longer at a risk to self or others and is able to agree upon and follow a contract for safety

Data Field	Signatures/Confirmation Instructions
Person's Signature:	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date:	Date of person's signature.
Was the person served provided with copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If "No", document reason.
Client's Initials to confirm:	Person should initial to document that he or she has been offered a copy of the IAP, and either accepted a copy or elected not to receive a copy of the Treatment Plan.
Parent/Guardian Signature:	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives. Check if "N/A".
Date:	Date of Parent/Guardian Signature.

Data Field	Staff Signatures Instructions
Provider Signature/Credentials:	**Legible** signature and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date:	Date of this signature.
Supervisor's Signature/Credentials	**Legible** signature and credentials of supervisor. Check if "N/A". **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
Physician Signature/Credentials:	**Legible** physician's signature and credentials if required by agency policy. Please note certain payers do require physician's signature. Check if "N/A".
Date:	Date of this signature.

MSDP

Individualized Action Plan Review/Revision
Revision Date: *3-7-09*

Page: **of**

Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

Review/Revision Date:	**Individualized Action Plan Date:**	**Reviewed by (Name, Title, Program):**

☐ **Review/ Revision:**	☐30 day ☐60 day ☐90 day ☐180 Days ☐Other: Dates Covered:	**Complete pages 1 and 2 of IAP Review/ Revision form and attach as many Goal/Objective sheets as necessary.**
☐ **Rewrite:**	☐ Annual ☐ Other (specify):	**Use page 1 of IAP Review/Revision and attach new IAP**

Goal & Objective Status *(Active / New / Discontinued / Completed / Revised)*	**Evidence of Progress, Barriers, and/or Rationale for Addition of New Goal/Discontinuation of Goal, Revision or Rewrite:**
☐ **Goal #:** **Keyword or Goal Statement:**	☐**Active: check to indicate progress** ☐Partially Met ☐Not Met ☐Met ☐**New** ☐**Discontinued – actual date of goal discontinuation:** ☐**Completed – actual date of goal completion:** ☐**Revised**
☐ Obj. 1 ☐A ☐N ☐D ☐C ☐R ☐ Obj. 2 ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R	**Evidence/Rationale:** **Refer to Progress Note(s) of (Date):** (☐ Not Applicable)
☐ **Goal #:** **Keyword or Goal Statement:**	☐**Active: check to indicate progress** ☐Partially Met ☐Not Met ☐Met ☐**New** ☐**Discontinued – actual date of goal discontinuation:** ☐**Completed – actual date of goal completion:** ☐**Revised**
☐ Obj. 1 ☐A ☐N ☐D ☐C ☐R ☐ Obj. 2 ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R	**Evidence/Rationale:** **Refer to Progress Note(s) of (Date):** (☐ Not Applicable)
☐ **Goal #:** **Keyword or Goal Statement:**	☐**Active: check to indicate progress** ☐Partially Met ☐Not Met ☐Met ☐**New** ☐**Discontinued – actual date of goal discontinuation:** ☐**Completed – actual date of goal completion:** ☐**Revised**
☐ Obj. 1 ☐A ☐N ☐D ☐C ☐R ☐ Obj. 2 ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R	**Evidence/Rationale:** **Refer to Progress Note(s) of (Date):** (☐ Not Applicable)
☐ **Goal #:** **Keyword or Goal Statement:**	☐**Active: check to indicate progress** ☐Partially Met ☐Not Met ☐Met ☐**New** ☐**Discontinued – actual date of goal discontinuation:** ☐**Completed – actual date of goal completion:** ☐**Revised**
☐ Obj. 1 ☐A ☐N ☐D ☐C ☐R ☐ Obj. 2 ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R ☐ Obj. __ ☐A ☐N ☐D ☐C ☐R	**Evidence/Rationale:** **Refer to Progress Note(s) of (Date):** (☐ Not Applicable)

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

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

This Section Mandatory For Outpatient Substance Use Counseling Only (Check Here if Not Applicable: ☐)			
Medications as Reported by the Person Served on Date of IAP Development - ☐ None Reported (☐ No Change)			
Medication Name	**Dose**	**Plans for Change - Including Rate of Detox**	**Prescribed by**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Transition/Level of Care Change/Discharge Plan (☐ No Change)	**Anticipated Date:**
Criteria - *How will the provider/client/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:	

Person's Signature:			**Date:**
Was the person served provided copy of the IAP? ☐ **Yes** ☐ **No, Reason:**			**Person's Initials to confirm:**
Parent/Guardian Signature (if applicable): ☐ N/A	**Date:**	**Supervisor Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Provider Signature/Credentials:	**Date:**	**Psychiatrist/MD/DO Signature/Credentials (if applicable):** ☐ N/A	**Date:**

Individualized Action Plan Review/Revision

The Individualized Action Plan Review/Revision form has been created to document information from ongoing review(s), revision(s) of treatment goals and objectives and/or periodic rewrites. This form has been designed to minimize duplication of effort in creating subsequent action plans and maximize the documentation of information, which demonstrates evidence and/or rationale for revision.

Use the IAP Review/Revision form to update or modify the IAP in any of the following ways: 1) Revisions – to add a new goal; change goals, objectives or interventions; or change the frequency or duration of services; 2). Reviews – to record the progress of the person served and 3) Rewrites - annually, after three interim revisions, or per agency protocol, a "rewrite" of the actual IAP is warranted. This will facilitate the identification and tracking of treatment goals/objectives and progress made.

Use both pages of the Individualized Action Plan Review/Revision form for either a Review or Revision; Additional goal and/or objective sheets should be added as necessary. If you are adding a new goal or objective, attach the goal and/or objective page(s) from the IAP form to the IAP Review/Revision form.
When a Rewrite is being completed, page 1 of the IAP Review/Revision should be used and the new IAP should be attached.

If a goal/objective is new and not currently supported by the most recent Comprehensive Assessment, it is important to also complete a Comprehensive Assessment Update form.

Please note that this form does not have a billing strip. If you are reviewing progress in a way that is billable, e.g. meeting face-to-face with the person served to discuss progress and update the IAP, you also must complete a progress note that describes the service and refers the reader to the IAP update. Use the billing strip on the bottom of progress note to bill for the service.
This form should be placed in date order (or according to internal policy and procedure) with the original IAP and any other updates. Together these documents will constitute the current IAP from which services are provided and billed. It is important to remember that as with the IAP, any IAP revisions should be completed in collaboration with the person served. This form requires evidence of collaboration in a number of ways. In all cases, if a person refuses to collaborate, does not agree to goals, or will not review goals, a separate progress note should be written to describe the person's participation and the plan for moving forward.

Data Field	Identifying Information Instructions (*Fields for Client Name, Number, and D.O.B. must be completed on each page)
***Person's Name:**	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
***Record Number:**	Record your agency's established identification number for the person.
***D.O.B:**	Document date of birth of the person served.
Organization Name	Record the organization for whom you are delivering the service.
Review/Revision Date:	Record date that the review/revision is occurring.
Individualized Action Plan Date:	Record date of the IAP you are reviewing, including month, date, and year.
Reviewed by:	Record the name of the person completing the review/revision his or her title, and the program(s) for which the plan has been developed.

Data Field	Purpose Instructions
Review/Revision:	Check the review/revision box when the IAP is being reviewed or revised and complete both pages 1 and 2. In the adjacent section, identify the reason for the review by placing a check in the most appropriate box or by checking and specifying the reason after the "Other" box. Also include "Dates Covered" in the review.
Rewrite:	For Rewrites, place a check in the box, complete page 1 only of the Review/Revision form and attach the rewritten IAP. All goals and objectives should renumbered to reflect the rewritten plan.

Data Field	Status and Evidence/Rationale Instructions
Goal Status:	Check off and number each goal from the IAP being reviewed/revised. Use the space provided to either write out the goal statement or identify with a key word. Indicate whether the goal is Active, New, Discontinued, Completed, or Revised by checking the appropriate box. • If "Active" check to indicate progress towards meeting the goal. • If "Discontinued" log actual date of goal discontinuation. • If "Completed" log actual date of goal completion.
Objective Status	Under each identified goal, check off and number the current objectives being reviewed/revised. Indicate whether the objective is Active, New, Discontinued, Completed, or Revised by checking the appropriate box.

Data Field	Status and Evidence/Rationale Instructions
Evidence of Progress, Barriers, and/or Rationale for Addition of New Goal/Discontinuation of Goal, Revision or Rewrite	Use this space to document information regarding the person served and his or her treatment, which provides evidence and/or rationale for revisions and/or addition/discontinuation of goals or rewrite of the IAP. This section should summarize the progress towards meeting each goal and its respective objectives in the current plan, as well as describe any barriers, which have contributed to the person's difficulty or not meeting goals. Link progress/lack thereof to outcomes data when possible. **Example:** • **Depression has decreased as evidenced by TOP score shifting from 8 on the initial TOP to 3 on the Follow-up.** To link to relevant Progress Notes, check the box at the bottom of the section and list dates of Progress Notes. If not applicable, check the Not Applicable box.

Data Field	Identifying Information/Agencies Instructions
Other Agencies/Community Supports and Resources Supporting IAP:	List the agency name, contact person/title, and services currently being provided by external agencies/community supports and resources that are collaborating on or supporting the person's IAP. Indicate whether or not the appropriate release has been signed to allow for communication with each. Check if "None Reported" or "No Change" **Examples:** • **Other Mental Health agencies** • **State Departments (i.e. DSS, DMR, DMH)** • **Doctor/Nurse** • **Court/Probation Officer**

Data Field	Medication Information
Medications as Reported by Person Served on Date of IAP:	**NOTE: <u>This section is mandatory for outpatient substance use counseling programs only.</u>** If not applicable, check the box provided. Complete the information in the table as reported by the person served on the date that the IAP was developed. Complete all fields for each medication including name of medication, dose, plans for change (including rate of detoxification), and the person prescribing each medication. Check if "None Reported" or "No Change"

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date:	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or provider assessment.

How will the provider/person served/parent/ guardian know that level of care change is warranted?	Transition planning should begin as early as possible in the treatment process and documentation of the planning is required. To facilitate the process, checkboxes have been provided. If there has been no change since development of the initial or most recently rewritten plan, check "No Change". Otherwise, check all that apply and document evidence, which supports or describes any criteria checked. Examples: • Reduction in symptoms as evidenced by: improvement in withdrawal symptoms • Services are no longer medically necessary as evidenced by: completion of methadone protocol • Other: placement in a longer-term treatment program • Reduction in symptoms as evidenced by: client self-report that withdrawal discomfort has decreased • Services are no longer medically necessary as evidenced by: scores on the CIWA or COWS assessment • Other: completion of program and appointment with outpatient substance abuse counselor • Attainment of higher level of functioning as evidenced by: ability to manage his or her own medications • Attainment of higher level of functioning as evidenced by: person is no longer at a risk to self or others and is able to agree upon and follow a contract for safety

Data Field	Signatures/Confirmation Instructions
Person's Signature:	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date:	Date of person's signature.
Was the person served provided with copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If "No", document reason.
Client's Initials to confirm:	Person should initial to document that he or she has been offered a copy of the IAP, and either accepted a copy or elected not to receive a copy of the Treatment Plan.
Parent/Guardian Signature:	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives. Check if "N/A".
Date:	Date of Parent/Guardian Signature.

Data Field	Staff Signatures Instructions
Provider Signature/Credentials:	**Legible** signature and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date:	Date of this signature.
Supervisor's Signature/Credentials	**Legible** signature and credentials of supervisor. Check if "N/A". **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
Physician Signature/Credentials:	**Legible** physician's signature and credentials if required by agency policy. Please note certain payers do require physician's signature. Check if "N/A".
Date:	Date of this signature.

Individualized Action Plan: Psychopharmacology
Revision Date: *3-7-09*

Person's Name (First MI Last):			**Record #:**
D.O.B:	**Age:**	**Plan Completed by (Name, Title, Program):**	
Organization Name:			
Start Date:	**Target Completion Date:**	**Adjusted Target Date:** **Reason for adjustment:**	

Desired Outcomes in Person's Served Words:

State Goal below in Collaboration with the Person Served as identified in the: ☐ Psychiatric Evaluation and/or ☐ Comp. Assessment

☐ 1. Person Served will remain psychiatrically stable by reducing his/her signs and symptoms of mental illness and maximizing his/her level of independence.
☐ 2. Person Served will be able to recognize, accept, and manage his/her mental illness, including working with the medical staff to manage his/her medications.
☐ 3. Person Served will establish chemical dependence recovery that leads to improved physical and mental health.
☐ 4. Other:

Objectives:

☐ 1. Person's served current signs and symptoms will be reduced through the use of appropriate psychiatric medications.

☐ 2. Person served and medical staff will develop a medication regimen that is effective in reducing signs and symptoms while limiting side effects, including impact of co-morbid medical conditions.

☐ 3. Person's served mental status will improve or remain stable.

☐ 4. Person served will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.

☐ 5. Person served will be able to list medications, uses, and benefits.

☐ 6. Person served will take medications as prescribed.

☐ 7. Person served will take medications as prescribed with the assistance of medical staff for administration of medications or monitoring self-administration.

☐ 8. Person served will understand and manage other lifestyle activities that may increase symptoms or medication side effects, e.g., substance use, caffeine, weight control, other diet, etc.

☐ 9. Other:

Person's Strengths and Skills and How They Will be Used to Meet Goals:

Therapeutic Intervention Methods	**Provider**	**Frequency**	**Duration**
☐ Medication Management	☐ MD/DO ☐RNCS ☐NP	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Medication Education / Symptom / Illness Management	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Injections	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Physical Assessment (Vital signs, AIMS, weight, etc).	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Coordination	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Other	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):		☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:

Referrals/Additional Evaluations ☐ None required
☐ Physical Assessment ☐ Substance Abuse Assessment ☐Neurological Consult ☐ Psych Testing ☐ Neuropsych Testing
☐Nutritional/Dietician ☐Other (list):

Explained rationale, benefits, risks, and treatment alternatives to/for the Person Served? ☐Yes ☐No

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**
Criteria - *How will the provider/person served/parent/guardian know that level of care change is warranted?* (check all that apply): ☐ Psychopharmacology Services are no longer medically necessary. ☐ Other:	
Person Served / Guardian Response	☐ Person Served: ☐Understands Information ☐Does not Understand ☐Agrees with Medication ☐Refuses Medication ☐ Guardian: ☐Understands Information ☐Does not Understand ☐Agrees with Medication ☐Refuses Medication Comments:
If the Person Served refuses plan, describe plan for continuation of services:	
The Person Served received a copy of the IAP? ☐Yes ☐No (explain):	
Person's Served Signature:	**Date:**
Parent/Guardian Signature: ☐ Not applicable	**Date:**
RN/RNCS/NP/APRN Signature/Credentials: ☐ Not applicable	**Date:**
Psychiatrist/MD/DO Signature/Credentials: ☐ Not applicable	**Date:**

Individualized Action Plan: Psychopharmacology

This form is designed to be used for persons who are receiving psychopharmacology services only (i.e. medication management and no therapy). If the person served is receiving other services in addition to medication management, the medication management goals should be included in the IAP. This form is to be completed by the primary provider of psychopharmacology services.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

Data Field	Identifying Information Instructions **(*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)**
***Person's Name:**	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
***Record Number:**	Record your agency's established identification number for the person.
***D.O.B:**	Document date of birth of the person served.
Organization Name	Record the organization for whom you are delivering the service.
Age:	Document the age of the person served.
Plan Completed by:	Record the name of the person completing the Individualized Action Plan, his or her title, and the program(s) for which the plan is being developed.
Start Date:	The date the person served and provider(s) will begin to work on this goal.
Target Completion Date:	Record the date by which the person served would like to accomplish the goal or the date by which the person served and provider(s) believe the goal can be completed. This indicates the anticipated duration of treatment.
Adjusted Target Date:	If the target date needs to be changed later, the new date is entered here.
Reason for Adjustment:	If an adjustment is made to the target date, document the reason for the adjustment here.

Data Field	Goals, Objectives and Interventions Instruction
Desired Outcomes in Person's Served Words:	Document the goal in the words of the person served. This should reflect his or her desired outcome and can be used as a benchmark by the person and provider for determining success in achieving the goal as treatment progresses. **Examples:** • **I want to stop losing my cool all the time!** • **I want to go back to school.** • **I want my mom and I to stop fighting.** • **I want to stop drinking.**
State Goal Below in Collaboration with the Person Served as Identified in the:	Check off the source(s) (Psychiatric Evaluation and/or Comprehensive Assessment) of the identified need of the person served. Check the appropriate goal(s) in the list provided to indicate the desired outcomes of the person served (family/guardian as appropriate), or check *Other* and specify the goal.
Objectives:	Check the appropriate objective(s) which will help person served reach his/her identified goal(s), or check *Other* and specify the objective.
Person's Strengths and Skills and How They Will be Used to Meet Goals	Document the strengths and skills that can be used to work towards accomplishing the person's goals. **Examples:**

	• **Person's family is still very involved and will provide support for medication management.** • **Person is able to self administer medications** • **Person is medication compliant.**
Therapeutic Intervention Methods, Provider, Frequency, and Duration:	Check the appropriate Therapeutic Intervention Methods and corresponding Provider(s), Frequency, and Duration of services for each intervention. If a therapeutic intervention is not listed, check *Other* and list. If a noted service has a frequency, which may fluctuate check *Other* in the Frequency section and write "See the Follow Up Plan on the Psychiatric Progress Note" or "Refer to _____ (insert name of other documentation source in record, which specifies frequency and rationale).
Data Field	**Transition/Level of Care Change/Discharge Plan**
Anticipated Date:	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or the provider's assessment.
How Will the Provider/Person Served/Parent/ Guardian Know That Level of Care Change is Warranted?	If "Other" document evidence, which supports or describes criteria. When discharge is indicated, provider should complete Transition Discharge Summary and Plan.
Data Field	**Referrals, Rationale, and Response Instruction**
Referrals/Additional Evaluations:	Check box(es) that best identifies additional assessment needs of the person served or check *Other* and list the additional assessment needed. Check none required as applicable.
Explained rationale, benefits, risks and treatment alternatives to/for the person served?	Check *Yes* or *No* if the rationale, benefits, risks and treatment alternatives contained in the Individualized Action Plan: Psychopharmacology were explained to the person served (parent/guardian as appropriate).
Person Served/Guardian Response:	Check appropriate response from person served (or parent/guardian as appropriate).
If Person Served refuses plan, describe plan for continuation of services	Document recommendations for follow up services if the person served has not agreed to the IAP: Psychopharmacology.
Person Served received a copy of the IAP?	Check *Yes* or *No* to indicate whether or not the person served received a copy of the IAP: Psychopharmacology. If *No*, provide explanation.

Data Field	**Signatures Instruction**
Person Served Signature/Date:	The person served should be given the option to sign the IAP: Psychopharmacology. If the person does not sign, list the reason(s)/explanation, or document the reason(s)/explanation in a progress note and list the date here (i.e. "See Progress Note dated 01/01/08).
Parent/Guardian Signature/Date:	The parent/guardian signature is necessary if person served is a minor or an adult who has a legal guardian. This space can also be used for any family/significant other as defined by the person served if he/she wishes them involved in process. Check if *Not applicable*.
RN/RNCS/NP/ APRN Signature/ Credentials and Date:	If a nurse is the author of the plan, **legibly** record signature and credentials, according to agency policy and date. Check if *Not applicable*.
Psychiatrist/MD/ DO's/Credentials/ Date:	**Legibly** record **Psychiatrist/MD/DO**'s signature and credentials, according to agency policy, and date. Check if *Not applicable*.

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Individualized Action Plan: Detoxification
Revision Date: *3-7-09*

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

Date of Admission:	**Anticipated Discharge Date:**	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**
Linked to Assessed Need(s) #: ☐CA ☐CA Update ☐ Psych Eval. ☐ Other:		**from form dated:**	

Desired Outcomes in Person's Words:

Treatment Area: Acute Withdrawal ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated	**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Medical detox component will be completed with minimal physiological and psychological complications. ☐ Other:	
Objectives:	☐Person will complete medication protocol per physician orders. ☐Withdrawal symptoms will be monitored and treated. ☐If person is pregnant, the pregnancy protocol will be followed. ☐Other:	

Therapeutic Intervention(s)/ Method(s)	**Frequency**	**Responsible: (Type of Provider)**
☐ Person will receive medication as prescribed by the M.D.	☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Vital signs will be monitored per physician's orders.	☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:	☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Medical Issues ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated	**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Medical issues will not interfere with the completion of the detoxification program. ☐ Other:	
Objectives:	☐ Person's medical issues will be assessed and monitored ☐ Person will follow physician's orders regarding the treatment of medical issues. ☐ Person will be educated on the medical issue and proper care. ☐Other:	

Therapeutic Intervention(s)/ Method(s)	**Frequency**	**Responsible: (Type of Provider)**
☐ A physical exam will be conducted within 24 hours of admission.	☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ All identified medical issues will be noted in the record and monitored by the program.	☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Prescription medications and treatments prescribed by a physician to manage the medical issue will be provided to person.	☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:	☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Emotional/Behavioral/Psychiatric ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated	**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Emotional/Behavioral/Psychiatric issues will not interfere with completion of the detoxification program. ☐ Other:	
Objectives:	☐The person's emotional, behavioral, and/or psychiatric issues will be assessed and monitored. ☐Other:	

Therapeutic Intervention(s)/ Method(s)	**Frequency**	**Responsible: (Type of Provider)**
☐ Person will meet with counselor to review any emotional, behavioral, and/or psychiatric issues that need to be monitored during treatment.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:		☐M.D. ☐Nurse ☐Counselor ☐Other:

Individualized Action Plan: Detoxification
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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Treatment Area: Acceptance ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated		**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Substance use will be accepted as a problem and participation in recovery program & services will be active. ☐ Other:		
Objectives:	☐ Person will complete a continuing recovery care plan by the third session. ☐ Person will identify 3 personal consequences that result from substance use disorder and 3 positive results of recovery. ☐Other:		
Therapeutic Intervention(s)/ Method(s)		**Frequency**	**Responsible: (Type of Provider)**
☐ Person will attend groups focusing on the importance of accepting substance use as a problem.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Person will meet with counselor to review level of acceptance of treatment.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:			☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Recurrence Potential ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated		**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Recurrence prevention techniques will be used to prevent potential recurrence of substance use. ☐ Other:		
Objectives:	☐ Person will identify 2 personal urges, 2 cravings, and 2 high risk situations that could lead to recurrence. ☐ Person will learn recurrence prevention process through identifying 2 coping strategies. ☐Other:		
Therapeutic Intervention(s)/ Method(s)		**Frequency**	**Responsible: (Type of Provider)**
☐ Person will attend recurrence/relapse prevention group.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Person will review recurrence prevention techniques with clinical staff and complete a recurrence prevention plan.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:			☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Recovery Environment ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated		**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Environment will be supportive of recovery. ☐ Other:		
Objectives:	☐Person will complete a continuing recovery care plan by the third session. ☐Person will identify 3 opportunities to improve his or her recovery environment. ☐Person will identify 3 community resources available that provide a recovery environment that is conducive to abstinence. ☐Person will identify continuing care recovery plan components and strategies he or she believes will help in recovery. ☐Other:		
Therapeutic Intervention(s)/ Method(s)		**Frequency**	**Responsible: (Type of Provider)**
☐ Person will attend groups focusing on importance of stability and support in recovery environment and will review his or her own environment for changes that can be made.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ The program will assess the person's need for continuing care recovery planning services.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Person will meet with his or her clinician/counselor to develop the continuing care recovery plan.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:			☐M.D. ☐Nurse ☐Counselor ☐Other:

Individualized Action Plan: Detoxification
Revision Date: *3-7-09*

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Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Treatment Area: Other: ☐Active ☐Referred ☐Monitoring ☐None Indicated	**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Other:	
Objectives:	☐ Other:	

Therapeutic Intervention(s)/ Method(s)	Frequency	Responsible: (Type of Provider)
☐		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐		☐M.D. ☐Nurse ☐Counselor ☐Other:

Person Understands Stated Goals and Objectives? ☐ Yes ☐ No / **Person Agrees?** ☐ Yes ☐ No / **Person's Initials:**

Person's strengths and skills and how they will be used to meet goals:
Supports and Resources needed to meet goals (include anticipated collateral and consultation contacts):
Potential Barriers to meeting these goals:
Legal Requirements – *describe any legal requirements, ordered restitution, court ordered treatment:* ☐ N/A
Discharge Plan/ Aftercare Plan:

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**

Criteria - *How will the provider/person served/parent/guardian know that level of care change is warranted?*
(Check All that Apply):

☐ Per physician's order, the person completed medical detoxification from the substance(s) from which he or she was withdrawing upon entering the program.

☐ Person completed a continuing recovery care plan developed with the multi-disciplinary team.

☐ 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:

Person's Signature:			**Date:**
Was the person served provided copy of the IAP? ☐ **Yes** ☐ **No, Reason:**			**Person's Initials to confirm:**
Parent/Guardian Signature (if applicable): ☐ N/A	**Date:**	**Supervisor Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Provider Signature/Credentials:	**Date:**	**Physician Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Nurse Signature/Credentials (if applicable): ☐ N/A	**Date:**	**Other Signature/Credentials (if applicable):** ☐ N/A	**Date:**

Individualized Action Plan: Detoxification

Treatment Planning is a collaborative process and per best practice guidelines, regulatory requirements, and accreditation standards, must demonstrate active participation of the person served and/or his or her parent/guardian. The title, "Individualized Action Plan," has been identified to capture all of the work or "actions", which may be utilized in the course of treatment for persons served by a variety of programs. The Individualized Action Plan (IAP) must be completed for every person served and be linked to the treatment recommendations/assessed needs from the Comprehensive Assessment or other approved document. This form has been designed to facilitate active participation and plan development with the person served and/or his or her parent/guardian and to document the goals and objectives identified collaboratively with the person served, as well as steps that will be taken by the person served, parent/guardian/community, and other providers to achieve the desired goal(s).

The Detox Plan documents the Individualized Action Plan for persons in detoxification programs and should be completed per program protocol by the person or person(s) responsible for planning and delivering care. The form design is based on the **American Society of Addiction Medicine's** (**ASAM**) Patient Placement Criteria and includes six standardized dimensions. The form is designed to incorporate these specific treatment components into the development of individualized action plan.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
Person's Name:	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number:	Record your agency's established identification number for the person.
D.O.B:	Document date of birth of the person served.
Organization Name:	Record the organization for whom you are delivering the service.
Date of Admission:	Record date of admission.
Anticipated Discharge Date:	Record anticipated discharge date of the person served.
Date Plan Initiated:	Record date the IAP was initially developed, including month, date, and year. This is the date the person served signs the plan.
Plan Completed by:	Record the name of the person completing the IAP, his or her title, and the program(s) for which the plan is being developed.

Data Field	Linkage and Desired Outcomes Instructions
Linked to Assessed Need(s) # ____ from form dated _____:	List the number of the treatment recommendation/assessed needs from the date of an approved form. Check or indicate the *Other* form name that contains the treatment recommendation/assessed need identified. **Example:** **Treatment Recommendations # 1 and 2 from form dated 01/08/07: Assessment**
Desired Outcomes for this Assessed Need in Person's Words:	Document in the words of the person served his or her desired outcomes for the assessed need(s). This statement will be utilized in formulating goals and objectives and can be used as a benchmark by the person served and provider for determining success in achieving the goal as treatment progresses. **Examples:** • **I want to stop drinking.** • **I need to find a positive recovery environment.**

Data Field	Treatment Area Goals/Objectives/ Interventions Instructions
Treatment Area:	Check if the treatment area for each dimension is considered Active, Referred, Monitoring, or Not Clinically Appropriate. • Active means this area will be addressed during the treatment episode. • Referred is for problems that will not be addressed during the treatment episode, but are issues the clinician will assist the person with as part of the continuing care process. Example: Making an appointment for outpatient mental health treatment for after the person has left the program. • Monitoring means there is a treatment issue that will not be directly addressed during this treatment episode, but will be monitored while in treatment. Example: The nursing staff is monitoring the person's diabetes during treatment. • Not Clinically Appropriate means the treatment area is not applicable or appropriate at this time and no action will be taken.
Goal Target Date:	Record the anticipated date the person will attain his or her goals.
Adjusted Target Date:	A revised goal target date in the event that changes need to be made with the original anticipated goal target date. The rationale for changes to the goal target date is to be documented in the progress note.
Goal:	Check the appropriate box that lists the goal in each treatment area. Each goal section has space that allows the provider to create an individualized goal for the person.
Objectives:	Check the appropriate box that lists the objectives in each treatment area. The objectives are designed to assist the person with meeting the goals in each treatment area. Each objective section has space that allows the provider to create an individualized goal for the person.
Therapeutic Intervention(s)/Method(s):	Describe the actual therapeutic interventions/methods the clinician/trained other staff will provide to support/facilitate the person served in achieving the stated objective. *This is not the type or modality of the service (i.e. do not write "CBT" or "individual therapy" alone. The statement should be descriptive of the actual methods).* *Examples:* • **Teach/build relapse prevention skills.** • **Help person identify strengths and interests.** • **Use CBT to assist person served in identifying triggers .** • **Connect person served to available community resources.**
Frequency:	Indicate how often this service/activity will occur. For some services, the total number of hours ordered may need to be included. Please refer to agency-specific guidelines.
Responsible: (Type of Provider)	Indicate the credentials and title of the program staff, not the specific individuals responsible for providing the services listed. If the types of providers listed are not eligible to provide the service according to regulation or payer rules, the service may not be billable. If services are provided in a team format, the primary provider type should be listed. **Examples:** • **Internal Medicine** • **Nurse** • **Therapist** • **Case manager**

Data Field	Client Review/Goal Agreement Instructions
Person Understands?	The person served indicates whether or not he/she understands the goal and a mark is placed in the appropriate checkbox. If the person served does not understand, an explanation should be written in a progress note for the date of the IAP.
Person Agrees?	If the person served agrees with goal check *Yes*. If the person served does not agree with goal, check *No* and document the content of the discussion and outcome in a progress note on the date of the IAP.
Person's Initials:	Person served should initial to document active participation in goal development.

Data Field	Person's Strengths/Skills/Supports Instructions
Person's Strengths and Skills and How They Will be Used to Meet Goals:	Document the strengths and skills that can be used towards accomplishing the goals. **Examples:** • **Person served can read at the high school level.** • **Person's family is still very involved and will provide support for medication management, transportation, and opportunities for socialization.** • **Person has group of close friends from residence with whom he can socialize.** • **Person served currently works in a fast food restaurant and can follow fairly complex instructions.** • **Person served is healthy and is not on any medications for medical conditions.**
Supports and Resources Needed to Meet Goals:	List supports and resources needed to accomplish goals. Include natural and community supports; cultural and linguistic needs of the person; and any reasonable accommodations/modifications to policies or practices that will be made. Be sure to consider supports beyond the behavioral health system to facilitate recovery and resiliency. **Examples:** • **AA meetings, church, community support meetings** • **An interpreter, written materials in another language** • **Meeting space in an area accessible by wheel chair** • **Peer support worker**
Potential Barriers to Meeting Goals:	Record any potential barriers to meeting goals, which the person served identifies or were identified in the development of the Individualized Action Plan. **Examples:** • **Person served does not have drivers license.** • **Person served does not have a stable recovery environment.**

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date:	Record the anticipated date transition/discharge based on the person's belief of when the criteria for such transition would be met, and/or on the provider assessment.
How will the provider/person served/parent/ guardian know that level of care change is warranted?	Check all that apply and document evidence, which supports or describes any criteria checked.

Data Field	Signatures/Confirmation Instructions
Person's Signature:	The person served should be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a progress note and list the date here.
Date:	Date of person's signature.
Was the Person Served Provided with Copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If *No*, document reason.
Client's Initials to Confirm:	Person should initial to document that he or she has been offered a copy of the IAP, and has either accepted a copy or elected not to receive a copy.
Parent/Guardian Signature:	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives. Check if *N/A*.
Date:	Date of parent/guardian signature.

Data Field	Staff Signatures Instructions
Provider Signature/Credentials:	**Legibly** record the signature and credentials (according to agency policy) of the primary provider of services, coordinator of services, or the author of the plan.
Date:	Date of signature.
Supervisor's Signature/Credentials	**Legibly** record the signature and credentials of the supervisor. Check if *N/A*. **Example: Jerry Smith, LMHC**
Date:	Record the date of signature.
Physician Signature/Credentials:	**Legibly** record the physician's signature and credentials if required by agency policy. Please note that certain payers do require a physician's signature. Check if *N/A*.
Date:	Record the date of signature.

MSDP *PILOT*

Multi-Disciplinary Team Review/Response
Revision Date: *3-7-09*

Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

MDT Review Date:	**Plan Completed by (Name, Title, Program):**
Date(s) of Individualized Action Plan(s) Reviewed:	
Reason/Type of Review: ☐ Initial ☐90 Day ☐Annual ☐ Major Clinical Change ☐ Discharge ☐Other:	

MDT Summary:
☐ **IAP reviewed and approved**
☐ **IAP reviewed and the following corrective actions are necessary:**
☐ **Comments/questions:**

MDT Signature/Credentials:	**Date:**	**MDT Signature/Credentials:**	**Date:**
MDT Signature/Credentials:	**Date:**	**MDT Signature/Credentials:**	**Date:**

Treating Provider Response to MDT Review:

☐ **Not Applicable – No corrective actions indicated**
☐ **Corrective actions in process. Describe:**
☐ **Corrective actions completed**
☐ **Comments/questions:**

Treating Provider Signature/ Credentials:	**Date:**
Supervisor Signature/Credentials (if applicable): ☐ N/A	**Date:**
Psychiatrist/MD/DO Signature/Credentials (if applicable): ☐ N/A	**Date:**

Multi-Disciplinary Team Review/Response

This form is utilized to document review and response of Individualized Action Plans by a multi-disciplinary team (MDT). The intent is for the team to provide feedback to the treating provider to ensure that Individualized Action Plans are high quality and meet the needs of the person served. This process is designed to ensure there is a completed feedback loop where the MDT reviews plans, provides feedback to the treating provider, and adjust plans based on the team review. The review and response process will be determined by individual agency protocol.

Data Field	Identifying Information Instructions
Person's Name:	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record number:	Record your agency's established identification number for the person.
D.O.B:	Document person's date of birth.
Organization Name:	Record the organization for whom you are delivering the service.
MDT Review Date:	Document the date of the review.
Plan Completed by:	Identify the treating provider including name, title, and program.
Date(s) of Individualized Action Plan(s) Reviewed:	Record the date(s) of the Individualized Action Plan(s) being reviewed.
Reason/Type of Review:	Check box indicating the reason for the particular review – *Initial, 90 day, Annual, Major Change, Discharge or Other*.

Data Field	MDT Summary
Individualized Action Plan(s) reviewed and approved:	Check this box if the MDT approves the IAP. If there are no comments/questions, proceed to the signature section.
Individualized Action Plan(s) reviewed and the following corrective actions are necessary:	Check this box if the MDT deems corrective actions are necessary. Document clear, concise and specific corrective actions the treatment provider must do in order for the plan to be approved.
Comments/questions:	Document any specific comments or questions for the treating provider.

Data Field	Signatures Instruction
MDT Signature/ Credentials:	All persons completing the MDT review must sign with name and credentials.
Date:	All persons completing the MDT review must date next to his/her signature.

Data Field	Treating Provider Response to MDT Review
Not Applicable:	Check this box to indicate there are no corrective actions indicated.
Corrective Action in Process:	Check this box if corrective actions are planned or are in process based on the results of the MDT review. Describe the corrective actions in detail and provide estimated timeframe for completion. **For example,** if the MDT determined a medication evaluation was necessary, document the date of the evaluation or plans for ensuring an evaluation is going to occur.
Corrective Action Completed:	Check this box if the corrective action outlined by the MDT has been completed. **For example,** if the MDT cited the treatment plan as needing an additional objective for one of the goals, checking the box indicates the additional objective was added.

Comments/ questions:	The treating provider may use this space to document any further comments/questions in response to the MDT review. **For example,** this may include questions regarding a corrective action listed or documentation of steps taken to prevent recurrence of a specific record keeping issue in the future.
Treating Provider Signature/Credentials	**Legibly** record signature and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.

Transition/Discharge Summary/Plan
Revision Date: *3-7-09*

Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

☐ **Transition - From (Unit/Program):**	**To:**	
☐ **Discharge**		
Admission Date:	**Last Contact:**	**Transition/Discharge Date:**

Person's location and contact information post discharge/transition: **Address:** ☐ **Unknown**
Telephone: ☐ **Unknown**

Summary of Services/Treatment Provided/Status at Last Contact:

Outcomes (Include qualitative and quantitative information regarding progress/gains achieved, strengths, abilities and preferences. Specify any standardized measures used)**:**

Sobriety Status/Description of Current Drug or Alcohol Use: ☐ Not applicable

Status Towards Meeting Goals (NM=Not Met, PM=Partially Met, M=Met, D/C=Discontinued)

Goal #	Keyword	NM	PM	M	D/C	Comments
1. ☐		☐	☐	☐	☐	
2. ☐		☐	☐	☐	☐	
3. ☐		☐	☐	☐	☐	
4. ☐		☐	☐	☐	☐	
5. ☐		☐	☐	☐	☐	
6. ☐		☐	☐	☐	☐	
7. ☐		☐	☐	☐	☐	
8. ☐		☐	☐	☐	☐	

Overall Progress In Treatment:

Diagnosis At Intake				Diagnosis At Discharge/Transfer			
Check Primary	Axis	Code	Narrative Description	Check Primary	Axis	Code	Narrative Description
☐	Axis I			☐	Axis I		
☐				☐			
☐				☐			
☐	Axis II			☐	Axis II		
☐				☐			
☐	Axis III			☐	Axis III		
☐	Axis IV			☐	Axis IV		
☐	Axis V	GAF:		☐	Axis V	Current GAF:	
Lowest GAF in Past Year (If Known):				Highest GAF in Past Year (If Known):			

Reason for Transition or Discharge:

☐ Decrease level of care	☐ Involuntary discharge, person informed of right to appeal
☐ Increase level of care	☐ Person died
☐ Goals met, no services needed	☐ Person moved
☐ Person terminated services	☐ Person did not return/was non-responsive to outreach attempts
☐ Person refused referral for other services	☐ Other:

If involuntary/administratively discharged, summary of action taken: : ☐ **Not applicable**

Person Served notified of appeal process ☐ Yes ☐ No (explain)

Transition/Discharge Summary/Plan
Revision Date: *3-7-09*

Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**

Person's Response to Treatment and Transition/Discharge:

Medications as Reported by Person at time of Transition/Discharge: ☐ **None Reported**			
Medication Name	**Dose**	**Plans for Change - Including Rate of Detox**	**Prescribed by**
1			
2			
3			
4			
5			
6			

Referred To (Agency/Program Name, Location, and Contact Information):	**For (describe services/supports, rationale, list dates/times of appointments if known):**	**Date(s)/Time(s) of Appts. If Known:**
Aftercare Options (Include information on symptoms person should watch for, options available if these symptoms recur or additional services needed):		

Provider Signature/Credentials:	**Date:**	**Supervisor Signature /Credentials** (☐N/A)**:**	**Date:**
Person Signature: (Parents/Guardians Signature If Applicable)	**Date:**	***Was person provided copy of Transition/Discharge Plan?*** ☐ Yes, person given copy ☐ Yes, Person mailed copy ☐ No, person did not receive copy (explain):	

Transition/Discharge Summary/Plan

The Transition/Discharge Summary/Plan is designed as a two-page form, encapsulating the course of treatment, outcomes, and reasons for transition or discharge. It is to be completed for persons at the time of transition or discharge and should be accompanied by the Transition/Discharge Planning. This plan should be initiated as early in the treatment as possible to ensure steps are taken to provide continuity of care.

Data Field	Identifying Information Instructions
Person Name:	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record #:	Record your agency's established identification number for the person.
D.O.B:	Document person's date of birth.
Organization Name:	Record the organization for whom you are delivering the service.
Transition From/To:	Check if person is being transitioned internally. Indicate the unit/program from which person is being transitioned and to which unit/program person will be transitioned.
Discharge:	Check if person is being discharged from the agency/program.
Admission Date:	Document the date the person was admitted.
Last Contact:	Document the last date of contact with the person.
Transition/Discharge Date:	Document the date that the person is being transitioned or discharged.
Person's location and contact information post discharge/ transition	Indicate person's physical location and contact information, including the specific address and telephone number if known, immediately after discharge. If unknown, check box. This information may be utilized for post-discharge/transition contacts including the gathering of outcomes information.

Data Field	Summary of Treatment
Summary of Services/Treatment Provided/Status at Last Contact:	Provide a narrative summary of the person's presenting issues, services and treatment that were provided. Document the status of the person at last contact and include legal status and criminal activity, if applicable, at the time of discharge.
Outcomes:	Include qualitative and quantitative information regarding the person's progress/gains achieved, strengths, abilities and preferences. Indicate names of any standardized measures used and a summary of the outcome information including vocational/educational/financial status or achievements.
Sobriety Status/Description of Current Drug or Alcohol Use:	Indicate person's current sobriety status and describe any current/continued use of alcohol or other drugs. Check if *Not Applicable*.
Goal Status:	Check the numbers of the goals addressed in treatment based on Individualized Action Plan. For each goal, identify with a keyword and indicate the status by checking whether that goal at the time of discharge has been met, partially met, not met, or discontinued. Insert any additional comments in the spaces provided.
Overall Progress in Treatment:	Document the person's overall progress in treatment.

Data Field	Diagnosis
Axis I – V:	Spaces are provided to capture the information gathered at intake and time of Transition/discharge. Indicate the diagnostic code and conditions for Axes I – III according to the instructions from the diagnostic manual being used. For Axis IV, check the relevant categories of psychosocial or environmental problems/stressors and write the specific factors. For Axis V, log the current GAF score as well as the highest and lowest functioning from the past year.

Data Field	Reason for Transition/Discharge
Reasons:	Check to indicate reason(s) for transition/discharge.
If involuntary/administratively discharged, summary of disciplinary action taken:	If not applicable, check box provided. Include reasons, as well as the decision of the grievance hearing, or if the client elected not to be heard, a clear statement of the circumstances of termination, suspension, or any lesser sanction imposed. Check whether or not the person was notified of the appeal process.

Data Field	Person's Response
Person's Response to Treatment and Transition/Discharge:	Summarize person's response to this treatment episode and how he/she feels regarding the transition/discharge.

Data Field	Medications
Medications as Reported by Person at time of Transition/Discharge:	List medication name, dose, plans for change (including rate of Detox). Record the name of the prescriber as reported by the person at the time of transition/discharge.

Data Field	Continuity of Care/Referral Instructions:
Referred To:	List all internal and external services/programs to which the person is being referred at the point of transition/discharge. Specify agency/program name, location, and any other contact information the person or parent/guardian will need to ensure continuity of care
For:	Specify the types of services or programs, or reason why person is being referred for each particular listing.
Date(s)/Time(s) of Appointments if known:	Indicate any specific dates and/or times of appointments that have been set up for the person.
Aftercare Options:	Document information on symptoms the person should watch for, options available if the symptoms reoccur, or additional services that may be needed or preferred by the person.

Data Field	Client Copy
Copy of Transition/Discharge Plan:	Indicate if a copy of the plan has been *given to the person*, *mailed to the person*, or *did not receive a copy*. If person did not receive a copy, provide explanation.

Data Field	Staff Signatures Instructions
Provider Signature/Credentials:	**Legibly** record signature and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date:	Date of this signature.
Supervisor's Signature/Credentials	If applicable, **legibly** record signature and credentials of supervisor. Check if *N/A*. **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
Person Signature:	If appropriate, **legibly** record signature of the person or his/her parent/guardian.
Date:	Date of this signature.