Initial Individualized Action Plan and Individualized Goal Page

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

The Initial IAP is completed according to agency policy and regulatory standards. The IAP Goal page is used if more than one goal is being created. The first goal must be documented on the **Initial IAP** form. The form titled **IAP Goal Page** must be used to document each additional goal within the Initial IAP. All subsequent goals or objectives should be documented on the IAP Goal page only.

The Initial IAP and IAP Goal page have 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. Use as many IAP Goal pages as necessary to capture the total number of identified goals and objectives. The "objective sheet" (page 2), which provides space for two objectives can also be used as necessary if more space is needed for additional objectives. In addition, a section is provided at the end of the Initial IAP to specify the Transition/Discharge Criteria, a mandatory element of the treatment planning process. The Transition/Discharge Criteria is also at the end of the IAP/Review/Revision which would be completed when goals or objectives are added or revised.

Note:

For Clinic programs, indicate in the "Intervention" field the expected location of services, including the need to provide services in the individual's home if the individual has been determined as "homebound", and any special linguistic arrangements that may be required.

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 (this information can be included in the "Intervention(s)/ Method(s)/ Action(s)" section). For JCAHO include interaction with the criminal or juvenile justice system if applicable. (This information can be included in the "Supports, Resources, Organizations, & Individuals Needed to meet this Goal" section.)

For OMH Children's Residential Programs, it is important to emphasize in the Transition/Discharge Criteria section the skills that the child needs to acquire before returning to the community/home.

For PROS Programs, when goals and interventions are being developed, the following issues should be incorporated:

- For goals

Please note that goals for PROS programs deal with attainment and retention of community based

life roles, i.e. integrated employment, housing, parent role, etc. As such, PROS goals should be stated in a manner in which the individual is identifying the life goal or in some instances goals they are going to be working on at that time in the PROS program. Specific steps to overcome barriers to that goal would be worked upon as objectives.

- For Interventions

For PROS therapeutic interventions refer to the specific PROS services that are going to be provided to address specific barrier(s) and help the Individual meet the identified objective identified in the plan. Please note that individual barriers are normally met with multiple layers of service interventions designed to help the Individual utilize strengths to overcome barriers, learn new skills, modify learned skills for success in identified life roles and develop compensatory supports. Only services listed in PROS regulation and used to overcome assessment identified barriers are considered reimbursable PROS services and should be considered as a PROS service. All other activities are considered a part of what happens during program participation time.

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record Number, and D.O.B. must be completed on each page)
Organization/Program Name:	Record the name of the organization/program that is providing the services.
Individual's Name:	Record first name, middle initial, and last name of the Individual served.
Record #:	If applicable, record agency's identification number for the Individual served.
D.O.B:	Document date of birth of the Individual served.
Admission Date:	Record date the Individual served was admitted.
Effective Date of Initial IAP:	Record date that the Initial IAP was developed, including month, date, and year.
Next Review Date:	Record the due date of the next review.

Data Field	Goals/Desired Results/Target Date Instructions
Goal #:	To identify goals, number sequentially. **Example: Goal # 1**
Linked to Assessed Need # ____ from form dated _____:	Indicate the assigned number associated with the assessed need. Specify the name and date of the form that identified the assessed need. **Example:** **Assessed Need # 1 from form dated 10/08/09: Comprehensive Assessment**
Start Date:	The date the Individual served and provider(s) will begin to work on this goal.
Target Completion Date:	Record the date by which the Individual served would like to accomplish the goal or the date by which the Individual served and provider(s) believe the goal can be completed.
Adjusted Target Date: **As per IAP Review Form Dated:**	Record the new target date for the completion of the goal. For example, if the team decides at a review that the goal needs to be continued beyond the initial target completion date, the new target date would need to be indicated. Record the date of the review when the target completion date was adjusted.

Desired Outcomes for this Assessed Need in Individual's Words:	Document in the words of the Individual 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 Individual 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 me to stop fighting.** • **I want to stop drinking.**
Goal: **(State below in Collaboration with the Individual Served/Reframe Desired Outcomes)**	Reframe the desired outcome stated above by describing the goal from a clinical perspective in collaboration with the Individual 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	Individual's Strengths/Skills/Supports Instructions
Individual's Strengths and Skills that will be Utilized to Meet this Goal:	Document the strengths and skills the Individual has that can be used to work towards and accomplish this goal. **Examples:** • **Individual can read at the high school level.** • **Individual's family is still very involved and will provide support for medication management, transportation, and opportunities for socialization.** • **Individual has group of close friends from residence with whom he can socialize.** • **Individual currently works in a fast food restaurant and can follow fairly complex instructions.** • **Individual is healthy and is not on any medications for medical conditions.**
Supports, Resources, Organizations, & Individuals Needed to Meet this Goal:	List supports, resources, organizations, and persons that will be needed to accomplish the goal. Include natural and community supports as well as cultural and linguistic needs of the Individual served 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 wheelchair** • **Peer support worker** • **Case manager from Federation**
Potential Barriers to Meeting This Goal:	Record any potential barriers to meeting the goal, which the Individual served identifies or that were identified while developing the comprehensive assessment or IAP. **Examples:** • **Individual served does not have driver's license** • **Individual served does not have a stable recovery environment**

Data Field	Objectives Instructions
Goal # / Objective:	Indicate each objective letter and link to the appropriate goal **Examples:** • **Goal #1/Objective A** • **Goal #1/Objective B**
Objective:	Describe in measurable terms an objective that will assist the Individual served in reaching the identified goal. NOTE: If additional objectives are needed for a specific goal, insert an additional objective sheet, page 2. **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 Individual served would like to accomplish the objective or the date by which the Individual served and provider(s) believe the objective can be completed.
Adjusted Target Date: **As per IAP Review form dated:**	Record the new target date for the completion of the objective. For example, if the team decides at a review that the objective needs to be continued beyond the initial target completion date, the new target date would need to be indicated. Record the date of the review when the target completion date was adjusted.

Data Field	Interventions and Service Description Instructions
Intervention(s)/Method(s)/ Action(s):	Describe the actual therapeutic or rehabilitative interventions/methods the clinician/trained staff will provide to support/facilitate the Individual 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 anger management techniques.** • **Educate on available community resources.** • **Role play how to express needs and/or wants in a calm voice.** • **Teach coping techniques to manage symptoms.** • **Instruct on how to open a bank account.** • **Educate on purposes and side effects of prescribed medications.**

Service Description/ Modality:	Indicate the types of services the Individual will receive. **Examples:** • **Family Therapy** • **Individual therapy** • **Couples therapy** • **Group therapy** • **Psychopharmacology** • **Case management** • **Substance Abuse Services** • **Symptom Management** • **Medication Administration Methadone program** • **Health Service (Screening)** • **IR (PROS)** • **CRS (PROS)**
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 credentials or title of the program staff, not the specific staff 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** • **Peer Specialist**
Data Field	**Methadone, PROS, ACT Information Instructions**
Methadone Programs Only – Attendance Schedule/Daily Dosage:	For Methadone Programs only, document the attendance schedule and dosage of methadone.
PROS/ACT Programs Only Relapse Prevention Plan Must Be Attached:	For all PROS and ACT programs only, the Relapse Prevention Plan must be attached to the IAP.

Data Field	Transition/Discharge Criteria Instructions
Transition/Discharge Criteria:	Transition/discharge planning should begin as early as possible in the treatment process and documentation of the planning is required. Include a brief summary that supports when a level of care change is warranted. Examples: • Reduction in symptoms as evidenced by: improvement in withdrawal symptoms • Services are no longer medically necessary as evidenced by: completion of methadone protocol • Reduction in symptoms as evidenced by: client self-report and staff observation that symptoms have decreased • Services are no longer medically necessary as evidenced by: individual's ability to function with increased independence. • 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
For COA programs only: Estimated length of treatment and stay:	For COA programs only: Record the date of anticipated transition/discharge based on Individual's belief of when the criteria for such transition would be met and/or provider assessment.
Discharge Plan:	Indicate the anticipated plan for discharge, including treatment support services, community resources. For OASAS programs include a description of the substance abuse relapse prevention plan. For example, John will attend the Holbrook Mental Health clinic for all psychiatric services and will receive case management services from Federation of Organizations. He will also be encouraged to attend support groups in the community related to his substance abuse issues.
Data Field	**Signatures/Confirmation Instructions**
Individual has participated in the development of this plan. **Other (s) _____ participated in the development of this plan.**	Indicate if Individual served participated in the development of the plan. If the Individual did not participate, provide reason. Check Yes or No to indicate if other persons participated in the development of the plan. If Yes, list the names.
Data Field	**Staff Signatures Instructions**
Individual's Signature:	The Individual served should be given the option to sign the Initial IAP. If the Individual served does not sign, list the reasons and an explanation below and document the reason in a Progress Note and include date of Progress Note above.
Date:	Date of this signature.
Parent/Guardian/Other Name:	The parent/guardian signature is necessary if Individual 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 Individual served if he/she wishes them involved in process. Check if N/A.
Date:	Date of this signature.
Plan Prepared By: **Staff Signature/Credentials:**	Print **legible** signature and credentials, according to agency policy, of the staff member who prepared the plan. **For Clinic Programs**, if the IAP was not completed by the Individual's assigned primary provider then the primary provider must review and sign the IAP using one of the signature lines provided.

Date:	Date of this signature.
Supervisor/ Professional Staff/ Qualified Health Professional Name/Credentials:	**Legible** signature and credentials of supervisor. Check if N/A. **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
NPP Credentials:	**Legible** provider's signature and credentials if required by agency policy. Check if N/A.
Date:	Date of this signature.
Psychiatrist/MD/DO/Credentials:	**Legible** provider'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.
Print Staff Name/Credentials:	Legible signature and credentials of additional staff involved in the plan development Check if N/A.