IAP-Goal Page

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record Number, and D.O.B. must be completed on each page)
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.
D.O.B:	Document date of birth of the Individual served.

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 served has that can be used to work towards and accomplish this goal. **Examples:** • **Individual served 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 served currently works in a fast food restaurant and can follow fairly complex instructions.** • **Individual served is healthy and is not on any medications for medical conditions.**
Supports, Resources, Organizations, & Persons 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 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 the prescribed medications.**
Service Description/ Modality:	Indicate the types of services the Individual served 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	**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 served did not participate, provide reason. Check Yes or No to indicate if other persons participated in the development of the plan. List the names.
Data Field	**Signatures Instructions**
Individual's Signature:	The Individual served should be given the option to sign the IAP. If the Individual served does not sign, list the reasons and an explanation below.
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.
Data Field	**Staff Signatures Instructions**
Plan Prepared By: **Provider Signature/Credentials:**	**Legible** signature and credentials, according to agency policy, of the individual 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	Legible signature and credentials of additional staff involved in the plan

Name/Credentials:	development Check if N/A.