Individualized Action Plan Review/Revision

The Individualized Action Plan Review/Revision form has been created to document review (s) or revision(s) which demonstrates evidence and/or rationale for revision of treatment goals and objectives.

Use the IAP Review/Revision form to update or modify the IAP in any of the following ways:

- Revisions – to add a new goal; change goals, objectives or interventions; or change the frequency or duration of services;
- Reviews – to record the progress of the Individual served. 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 and attached to the Review/Revision.

Specific instruction for goal/objectives that are being revised, established, or continued.

- For revisions to a goal/objective aside from the adjustment of a target completion date, complete a new goal/objective sheet. The revised goal/objective sheet needs to be attached to the review form.

- For a newly established objective that already has a current goal plan in place, a new objective sheet page needs to be completed and attached to the review.

- For a newly established goal, a new goal and objective sheet is needed and it needs to be attached to the review.

- For a goal/objective that is being continued, discontinued, or attained and is within the established target completion date, document the progress and provide justification for the goal/objective that is being continued.

If a goal or objective needs to be continued beyond the initial target completion date, indicate the new target date with an explanation on the IAP page 1. The adjustment of a target completion date for a goal and/or an objective can only be indicated once on the IAP. If there are additional adjustments made to the target completion date, a new IAP needs to be completed.

It is suggested that if an individual does not achieve a goal or objective within the established target completion date, the team should assess the individual's skill and/or the description of the goal/objective to ensure that he/she can successfully attain the goal/objective.

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. For OMH residential programs, the Functional Assessment needs to be updated.

It is recommended that the IAPs and IAP Review/Revisions are filed in one section of the Individual's chart in chronological order. Filing the treatment planning documents in chronological order captures the ongoing progress of the Individual served.

It is important to remember that as with the IAP, any IAP revisions should be completed in collaboration with the Individual served. The IAP review should incorporate family members' views of progress, current needs and services as applicable.

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 program that is providing the services.
Individual's Name:	Record the first name, last name, and middle initial of the Individual being served.
Record #:	If applicable, record your agency's identification number for the Individual served.
D.O.B:	Document date of birth of the Individual served.
Review/Revision Date:	Record date that the review/revision is occurring.
Review/Revision:	Check the review/revision box when the IAP is being reviewed or revised and complete both pages 1 and 2.
Next Review Due By:	Record the date that the next review is due by.
Data Field	**Goal/Objective Status Instructions**
Goal #: **Goal Keyword or Goal Statement:**	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.
Continued/New/ Discontinued/Attained/ Revised:	Indicate whether the goal is Continued, New, Discontinued, Attained, or Revised by checking the appropriate box. • If "Continued" check box and indicate progress towards meeting the goal. • If "New" check to indicate new goal and/or objective. Indicate the assigned number associated with the assessed need. Specify the name and date of the form that captures the assessed need. **Example: Assessed Need # 1 from form dated 10/08/09: Comprehensive Assessment** • If "Discontinued" indicate actual date of goal discontinuation. • If "Attained" indicate actual date of goal completion. • If "Revised" check to indicate revision.
Objective Status:	Under each identified goal, check off and indicate the appropriate letter of the current objective being reviewed/ revised. Indicate whether the objective is Continued, New, Discontinued, Attained, or Revised by checking the appropriate box.

Summary of Progress:	Use this space to document information regarding the Individual served and his or her treatment, which provides evidence and/or rationale for revisions and/or addition/discontinuation of goals on 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 Individual's difficulty or inability to attain goals/objectives. Example: • John has experienced an increase in psychiatric symptoms that has resulted in a change in his medication regimen and the addition of a symptom management group to his action plan. • Steve tested positive for marijuana after being sober for a year. He will attend an additional relapse prevention group and he will submit to weekly toxicology screenings. The IAP will be revised to reflect the submission of toxicology screenings and staff will educate Steven about relapse prevention techniques.
Data Field	**Methadone, ACT Information Instructions**
Methadone Programs Only – Attendance Schedule : /Daily Dosage:	For Methadone Programs only, document the attendance schedule and dosage of methadone.
For ACT programs only, indicate the changes in individual's status in assessed domains:	Indicate change in Individual's status in any assessed domains.
Data Field	**Transition/Discharge Criteria Instructions**
Transition/Discharge Criteria (No Change)	Check if there has been no change to the Transition/Discharge Criteria.
For COA programs only: Estimated length of treatment and stay:	For COA (Council on Accreditation) 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.
How will the provider/individual/ guardian know that level of care change is warranted?	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

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 served 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	**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**
Print Staff Name/ Credentials:	**Legible** signature and credentials, according to agency policy, of the individual who prepared the plan.
Date:	Date of this signature.
Print Supervisor/Professional Staff/Qualified Health Professional Name/Credentials:	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
Print NPP Name/Credentials:	**Legible** provider's signature and credentials if required by agency policy. Check if N/A.
Date:	Date of this signature.
Print Psychiatrist/MD/DO Name/Credentials:	**Legible** provider's signature and credentials if required by agency policy. 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.