



Organization Name:		Program Name:	
Individual's Name (First / MI / Last):		Record #:	DOB:
Admission Date:	Effective Date of the Initial IAP:	Next Review Date:	Page: of
Goal #			
Linked to Prioritized Assessed Need # ____ from form dated ____: ☐ CA ☐ CA Update ☐ RFA ☐ Psych Eval. ☐ Other:			
Start Date:	Target Completion Date:	Adjusted Target Date: as per IAP Review Form Dated:	
Desired Outcomes in Individual's Words (Required for CARF & OMH Parts 594/595):			
Goal (State Goal for this Assessed Need in Collaboration with the Individual Served):			
Individual's Strengths and Skills that will be Utilized to Meet This Goal:			
Description of Outside Services, Supports, and Plan of Coordination Needed to Meet this Goal:			
Potential Barriers to Meeting This Goal:			
GOAL # ____ OBJECTIVE ____:			
Start Date:	Target Completion Date:	Adjusted Target Date: as per IAP Review Form Dated:	
Intervention(s) / Method(s) / Action(s)		Service Description/ Modality	Frequency
			Responsible: (Type of Provider)
GOAL # ____ OBJECTIVE ____:			
Start Date:	Target Completion Date:	Adjusted Target Date: as per IAP Review Form Dated:	
Intervention(s) / Method(s) / Action(s)		Service Description/ Modality	Frequency
			Responsible: (Type of Provider)
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Individual's Name (First / MI / Last):		Record #:	DOB:
PROS / ACT PROGRAMS Only – Relapse Prevention Plan Must Be Attached			
ACT Programs Only – Describe use of service dollars:			
Transition/ Discharge Criteria		For COA Programs Only: Estimated length of treatment and stay:	
Criteria - How will the provider/individual/guardian know that care has been completed or that a transition to a lower level of care change is warranted? <i>(For OMH Housing Programs for Children and Adolescents, Include a description of the skills needed to return home or into the community / Check All that Apply):</i> ☐ 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:			
OASAS Required /OMH Optional	Individual's Diagnosis:		
	Individual has participated in the development of this plan ☐ No ☐ Yes, provide reason: Other (s) participated in the development of this plan ☐ No ☐ Yes - If Yes, List Names:		
Individual Served:		Individual Served Signature:	Date:
Parent/Guardian/Other Name ☐ (N/A):		Parent/Guardian/Other Signature:	Date:
If lacking signature of Individual/Parent/Guardian, provide reason for non-participation:			
Completed By - Print Staff Name/Credentials:		Staff Signature:	Date:
Supervisor/ Professional Staff/ QHP/ Team Leader – Print Name/Credentials ☐ (N/A):		Supervisor/ Professional Staff/ QHP/ Team Leader - Signature:	Date:
NPP - Name/Credentials ☐ (N/A):		NPP Signature:	Date:
Psychiatrist/MD/DO - Print Name/Credentials ☐ (N/A):		Psychiatrist/MD/DO Signature:	Date:
If Applicable, Additional Staff Sign Below			
Print Staff Name/Credentials ☐ (N/A):		Staff Signature:	Date:
Print Staff Name/Credentials ☐ (N/A):		Staff Signature:	Date:
Print Staff Name/Credentials ☐ (N/A):		Staff Signature:	Date:
Print Staff Name/Credentials ☐ (N/A):		Staff Signature:	Date:



Individual's Name (First / MI / Last):	Record #:	DOB:
REQUIRED FOR OASAS PROGRAMS - Plan was reviewed in a case conference dated: Participants:		
Print Staff Name/Credentials ☐ (N/A):	Staff Signature:	Date:
Print Staff Name/Credentials ☐ (N/A):	Staff Signature:	Date:
Print Staff Name/Credentials ☐ (N/A):	Staff Signature:	Date:
Print Staff Name/Credentials ☐ (N/A):	Staff Signature:	Date: