Organization Name:	**Program Name:**	**Date**:
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:
Date Plan Initiated:	**Target Completion Date:**	
Adjusted Target Date: As per IAP Review/Revision form or Progress Note dated:		

Desired Outcomes in the Individual's words (Required for CARF & OMH Parts 594/595):

Goals and Objectives:

☐ 1. Maximize individual's independence by reducing/managing disabling psychiatric symptoms.
Linked to Prioritized Assessed Need # _____ from form dated _____: ☐ CA ☐ CA Update ☐ RFA ☐ Psych Eval. ☐ Other:

- ☐ A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- ☐ B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- ☐ C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- ☐ D. Individual will take medications as prescribed.
- ☐ E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- ☐ F. Other (Specify Objective):

☐ 2. Maintain chemical dependence recovery for improved mental and physical health.
Linked to Prioritized Assessed Need # _____ from form dated _____: ☐ CA ☐ CA Update ☐ RFA ☐ Psych Eval. ☐ Other:

- ☐ A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- ☐ B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- ☐ C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- ☐ D. Individual will take medications as prescribed.
- ☐ E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- ☐ F. Other (Specify Objective):

☐ 3. Reduce (or Discontinue) Medication Regime.
Linked to Prioritized Assessed Need # _____ from form dated _____: ☐ CA ☐ CA Update ☐ RFA ☐ Psych Eval. ☐ Other:

- ☐ A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- ☐ B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- ☐ C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- ☐ D. Individual will take medications as prescribed.
- ☐ E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- ☐ F. Other (Specify Objective):

☐ 4. Other:
Linked to Prioritized Assessed Need # _____ from form dated _____: ☐ CA ☐ CA Update ☐ RFA ☐ Psych Eval. ☐ Other:

- ☐ A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- ☐ B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- ☐ C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- ☐ D. Individual will take medications as prescribed.
- ☐ E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- ☐ F. Other (Specify Objective):

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:

Organization Name:	**Program Name:**	**Date**:
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:

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

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

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

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 is warranted? *(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):

☐ 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:

If the Individual refuses any part of the plan, describe reason and plan for continuation of services:

Individual has participated in the development of this plan ☐ Yes ☐ No, provide reason:

Other(s) _____ participated in the development of this plan ☐ Yes ☐ No, If Yes, List Names

Individual Served:	**Individual Served Signature**	**Date:**
Parent/Guardian Name ☐ (N/A):	**Parent/Guardian Signature:**	**Date:**
If lacking signature of Individual/Parent/Guardian, provide reason for non-participation:		
NPP - Print 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:**