Section

3

Using the NYSCRI Individualized Action Plan (IAP) Documentation Processes/Forms

This section provides a sample of each Action Plan form type, guidelines for the use of each form, and instructions for completion of the forms, including definitions for each data field.

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Note: Forms utilized in this section of the manual have been modified in both height and width to accommodate the format of the MSDP Training Manual. Please utilize electronic versions of actual forms for reproduction and use within the program.

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Organization Name:		**Program Name:**	
Individual's Name (First / MI / Last):		**Record #:**	**DOB**:
Admission Date:	**Effective Date of the Initial IAP:**	**Next Review Date:**	

Goal #

Linked to 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 for this Assessed Need in Individual's Words:

Goal (State Goal Below in Collaboration with the Individual Served/Reframe Desired Outcomes):

Individual's Strengths and Skills that will be Utilized to Meet This Goal:

Supports, Resources, Organizations, & Individuals 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)

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Individual's Name (First / MI / Last):	**Record #:**	**D.O.B.:**

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 #:**	**D.O.B.:**

Methadone Programs Only – Attendance Schedule: **/ Daily Dosage:**

PROS / ACT PROGRAMS Only - Relapse Prevention Plan Must Be Attached

Transition/ Discharge Criteria	**For COA Programs Only: Estimated length of treatment and stay:**
How will the provider/individual/guardian know that level of care change is warranted?	

Discharge Plan - *Indicate the anticipated plan for discharge, including Tx., support services, community resources. For OASAS programs, include a description of a substance abuse relapse prevention plan.*

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Individual's Name (First / MI / Last):	**Record #:**	**D.O.B.:**

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/Other Name ☐ (N/A):	**Parent/Guardian/Other Signature:**	**Date:**
Plan Prepared By - Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Supervisor/ Professional Staff/ Qualified Health Professional Name/Credentials ☐ (N/A):	**Supervisor/ Professional Staff/ Qualified Health Professional Signature:**	**Date:**
Print NPP Name/Credentials ☐ (N/A):	**NPP Signature:**	**Date:**
Print Psychiatrist/MD/DO 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:**

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.

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

Goal #

Linked to 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 for this Assessed Need in Individual's Words:

Goal (State Goal Below in Collaboration with the Individual Served/Reframe Desired Outcomes):

Individual's Strengths and Skills that will be Utilized to Meet This Goal:

Supports, Resources, Organizations, & Individuals 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)

Individualized Action Plan-Goal Page
Revision Date: *11-25-10*

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Individual's Name (First / MI / Last):	**Record #:**	**D.O.B.:**

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)

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**
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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.**
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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.

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Organization Name:		**Program Name:**	
Individual's Name (First / MI / Last):		**Record #:**	**DOB**:
Review/Revision Date:			
☐ **Review** ☐ **Revision**	**Next Review Due By:**		

Goal & Objective Status *(Continued/New/ Discontinued/Attained/Revised)*	**Evidence of Progress, Barriers, and/or Rationale for Attainment, Addition of New Goal/Discontinuation of Goal, Revision or Continuation:**
☐ **Goal #:** **Goal Keyword or Goal Statement:**	☐ Continued ☐New - *Linked to Assessed Need # _____ From Form Dated: _____* ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:
☐ **Goal #:** **Goal Keyword or Goal Statement:**	☐ Continued ☐New - *Linked to Assessed Need # _____ From Form Dated: _____* ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:
☐ **Goal #:** **Goal Keyword or Goal Statement:**	☐ Continued ☐New - *Linked to Assessed Need # _____ From Form Dated: _____* ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:
☐ **Goal #:** **Goal Keyword or Goal Statement:**	☐ Continued ☐New - *Linked to Assessed Need # _____ From Form Dated: _____* ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R ☐ Obj. __ ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:

Individualized Action Plan Revision/Review
Revision Date: *11-25-10*

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Individual's Name (First / MI / Last):	**Record #:**	**D.O.B.:**

Methadone Programs Only – Attendance Schedule: / Daily Dosage:

For ACT programs only, indicate the changes in individual's status in assessed domains:

Transition / Discharge Criteria (☐ No Change)	**For COA Only**: Estimated Length of Treatment and Stay:

How will the provider/individual/parent guardian know that level of care change is warranted?

Discharge Plan - Indicate the anticipated plan for discharge, including Tx., support services, community resources. For OASAS programs, include a description of the substance abuse relapse prevention plan:

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/Other Name ☐ (N/A):	**Parent/Guardian/Other Signature:**	**Date:**
Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Supervisor/Professional Staff/Qualified Health Professional Name/Credentials:	**Supervisor Signature:**	**Date:**
Print NPP Name/Credentials ☐ (N/A):	**NPP Signature:**	**Date:**
Print Psychiatrist/MD/DO 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:**

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.

Individualized Action Plan: Psychopharmacology
Revision Date: 11-25-10

Organization Name:	**Program Name:**	
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:

Goals and Objectives:

☐ 1. Maximize individual's independence by reducing/managing disabling psychiatric symptoms.
Linked to 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 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 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 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:

Supports, Resources, Organizations, & Individuals Needed to Meet This Goal:

Individualized Action Plan: Psychopharmacology
Revision Date: 11-25-10

Individual's Name (First / MI / Last):	**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

Methadone Programs Only – Attendance Schedule: / Daily Dosage:

Transition/Discharge Criteria	**For COA Programs Only: Estimated Length of Treatment and Stay:**
How will the provider/individual/guardian know that level of care change is warranted?	

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:**
Print NPP Name/Credentials ☐ (N/A):	**NPP Signature:**	**Date:**
Print Psychiatrist/MD/DO 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:**

Individualized Action Plan: Psychopharmacology

This form is designed to be used for Individuals who are receiving psychopharmacology services only. This IAP-Psychopharmacology form only is to be completed by the primary provider of psychopharmacology services.

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.)

Note: For Chemical Dependency programs, the IAP-Psychopharmacology Plan can only be used in Methadone Medical Maintenance Programs.

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record Number, and D.O.B. must be completed on each page)
Organization Name/ Program Name:	Record the name of the organization and program providing the service.
Individual's Name:	Record the first name, last name, and middle initial of the Individual being served.
Record #:	Record your agency's established identification number for the Individual.
D.O.B:	Document date of birth of the Individual served.
Date Plan Initiated:	Record the date the Individual served and provider(s) will begin to work on these goal(s).
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. This indicates the anticipated duration of treatment.
Adjusted Target Date: **As per IAP Review/Revision or Progress Note dated:**	**Documentation of an adjusted target date is based on agency policy in either the IAP Review/Revision form or Progress note** 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/revision or the progress note when the target completion date was adjusted.

Data Field	Goals, Objectives, and Interventions Instructions
Desired Outcomes in Words of the Individual Served:	Document the goal in the words of the Individual served. This should reflect his or her desired outcome and can be used as a benchmark by the Individual 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.**
Goal #: **Linked to Assessed Need #_____ from form dated _____:**	Check the appropriate goal(s) in the list provided to indicate the desired outcomes of the Individual served (family/guardian as appropriate), or check *Other* and specify the goal. Indicate the assigned number associated with the assessed need. Specify the name and date of the form that identified the assessed need.
Objectives:	Check the appropriate objective(s) that will help the Individual served reach his/her identified goal(s), or check *Other* and specify the objective.
Individual's Strengths and Skills That Will be Utilized to Meet This Goal:	Document the strengths and skills that can be used to work towards accomplishing the Individual's goals. **Examples:** • **Individual is medication compliant.** • **Individual is able to self- administer medications.**
Supports, Resources, Organizations, & Persons Needed to Meet This Goal:	Document the supports, resources and collateral persons available to support the Individual served in accomplishing his/her goal. ***Examples*** • **Individual attends individual therapy on a bi-weekly basis at the Holbrook Mental Health Clinic.** • **Individual's family is still very involved and will provide support for medication management.**
Therapeutic Intervention Methods, Provider, Frequency, and Duration:	Check the appropriate Therapeutic Intervention Methods and corresponding Provider(s), Frequency, and Duration of services for each intervention. If a therapeutic intervention is not listed, check *Other* and list.
Data Field	**Referrals, Rationale, and Response Instructions**
Referrals/Additional Evaluations:	Check box(s) that best identifies additional assessment needs of the Individual served or check O*ther* and list the additional assessment needed. Check none required as applicable.
Explained rationale, benefits, risks and treatment alternatives to/for the Individual?	Check *Yes* to indicate that the rationale, benefits, risks and treatment alternatives contained in the Individualized Action Plan: Psychopharmacology were explained to the Individual served (parent/guardian/other as appropriate).

Data Field	Methadone Program Information Instructions
Methadone Programs Only – Attendance Schedule/Daily Dosage	For Methadone Programs only, document the attendance schedule and dosage of methadone.
Data Field	**Transition Discharge Criteria Instructions**
Transition/Discharge Criteria: 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 evidence of attainment of a higher level of functioning. • **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 (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.
If Individual refuses any part of the plan, describe reason and plan for continuation of services.	Indicate reason for refusal. Document recommendations for follow up services if the Individual served has not agreed to the IAP: Psychopharmacology.

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. If Yes, list the names.
Print Individual's Signature:	The Individual served should be given the option to sign the IAP-Psychopharmacology. If the Individual served does not sign, list the reasons and an explanation below.
Date:	Date of this signature.
Print Parent/Guardian Signature:	The parent/guardian/other 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 *Not applicable*.
Date:	Date of this signature.
Print NPP Name/Credentials:	**Legibly** record **NPP**'s signature and credentials, according to agency policy, and date. Check if *Not applicable*.
Date:	Date of this signature.
Print Psychiatrist/MD/ DO/ Credentials:	**Legibly** record **Psychiatrist/MD/DO's** signature and credentials, according to agency policy, and date. Check if *Not applicable*.
Date:	Date of this signature.
If Applicable, Additional Staff Sign Below:	Any additional staff involved in the development of the IAP-Psychopharmacology plan should legibly record their name and credentials and date. Check if *Not applicable*.

Individualized Action Plan Revision/Review-Psychopharmacology
Revision Date: *11-25-10*

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

Review/Revision Date:	☐ Review ☐ Revision	**Next Review Due By**:

Goal & Objective Status *(Continued/New/ Discontinued/Attained/Revised)*	**Evidence of Progress, Barriers, and/or Rationale for Attainment, Addition of New Goal/Discontinuation of Goal, Revision or Continuation:**
☐ **Goal #1: Maximize Individual's independence by reducing/managing disabling psychiatric symptoms.**	☐ Continued ☐New - *Linked to Assessed Need #* _____ *From Form Dated:* _____ ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. A ☐C ☐N ☐D ☐A ☐R ☐ Obj. B ☐C ☐N ☐D ☐A ☐R ☐ Obj. C ☐C ☐N ☐D ☐A ☐R ☐ Obj. D ☐C ☐N ☐D ☐A ☐R ☐ Obj. E ☐C ☐N ☐D ☐A ☐R ☐ Obj. F ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:
☐ **Goal # 2: Maintain chemical dependence recovery for improved mental and physical health.**	☐ Continued ☐New - *Linked to Assessed Need #* _____ *From Form Dated:* _____ ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. A ☐C ☐N ☐D ☐A ☐R ☐ Obj. B ☐C ☐N ☐D ☐A ☐R ☐ Obj. C ☐C ☐N ☐D ☐A ☐R ☐ Obj. D ☐C ☐N ☐D ☐A ☐R ☐ Obj. E ☐C ☐N ☐D ☐A ☐R ☐ Obj. F ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:
☐ **Goal # 3: Reduce (or Discontinue) Medication Regime.**	☐ Continued ☐New - *Linked to Assessed Need #* _____ *From Form Dated:* _____ ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. A ☐C ☐N ☐D ☐A ☐R ☐ Obj. B ☐C ☐N ☐D ☐A ☐R ☐ Obj. C ☐C ☐N ☐D ☐A ☐R ☐ Obj. D ☐C ☐N ☐D ☐A ☐R ☐ Obj. E ☐C ☐N ☐D ☐A ☐R ☐ Obj. F ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:
☐ **Goal # 4:**	☐ Continued ☐New - *Linked to Assessed Need #* _____ *From Form Dated:* _____ ☐Discontinued – actual date of goal discontinuation: ☐ Attained– actual date of goal attained: ☐Revised - Goal sheet attached
☐ Obj. A ☐C ☐N ☐D ☐A ☐R ☐ Obj. B ☐C ☐N ☐D ☐A ☐R ☐ Obj. C ☐C ☐N ☐D ☐A ☐R ☐ Obj. D ☐C ☐N ☐D ☐A ☐R ☐ Obj. E ☐C ☐N ☐D ☐A ☐R ☐ Obj. F ☐C ☐N ☐D ☐A ☐R	**Summary of Progress**:

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Name (First / MI / Last):	**D.O.B.:**

Transition / Discharge Criteria (☐ No Change)	For COA **Only**: Estimated Length of Treatment and Stay:
How will the provider/individual/parent guardian know that level of care change is warranted?	
Discharge Plan - Indicate the anticipated plan for discharge, including Tx., support services, community resources. For OASAS programs, include a description of the substance abuse relapse prevention plan. :	

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/Other Name ☐ (N/A):	**Parent/Guardian/Other Signature:**	**Date:**
Print NPP Name/Credentials ☐ (N/A):	**NPP Signature:**	**Date:**
Print Psychiatrist/MD/DO 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:**

Individualized Action Plan Review/Revision for Psychopharmacology

The Individualized Action Plan Review/Revision for Psychopharmacology 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 for Psychopharmacology form to update or modify the IAP-Psychopharmacology 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-Psychopharmacology 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 should 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-Psychopharmacology page 1. The adjustment of a target completion date for a goal and/or an objective can only be indicated once on the IAP-Psychopharmacology. If there are additional adjustments made to the target completion date, a new IAP-Psychopharmacology 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 IAP-Psychopharmacology forms and IAP-Psychopharmacology 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-Psychopharmacology, any IAP-Psychopharmacology revisions should be completed in collaboration with the Individual served.

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record #, 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-psychopharmacology 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	**Status and Evidence/Rationale Instructions**
Goal #:	Check off each goal from the IAP-Psychopharmacology being reviewed/ revised.
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 identified 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.
Data Field	**Status and Evidence/Rationale Instructions**
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-Psychopharmacology. 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. Link progress/lack thereof to outcomes data when possible.
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 has participated in the development of this plan. **Other (s) _____ participated in the development of this plan.**	Indicate if Individual 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**
Print 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.
Print Parent/Guardian/Other Name:	The parent/guardian/other 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 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.

Relapse Prevention Plan
Revision Date: 11-25-10

Page: of

Individual's Name (First / MI / Last):	**Record #:**	**D.O.B.:**
Date of Admission:	***Date Plan Written:***	

- The purpose of the Relapse Prevention Plan is to help you figure out active ways to stay well, prevent relapse, and avoid crises.
- The Relapse Prevention Plan is something you and your counselor work on together and with anyone else you identify.
- Preventing relapse helps to keep you moving towards personal life goals.
- The plan is based on your personal needs and can include cultural, religious, and ethnic factors important to you.
- This plan can be shared with others in accordance with your preferences.
- You may want to consider designating someone in your life to be a health care agent or creating some other form of advance directive. Keep in mind that some of the strengths and supports noted in this plan are things you do or utilize to remain feeling well and should be carried over to the IAP and the goals that you are working on.

What are your early warning signs that things are too stressful, deteriorating, or not going well for you that could be a sign of relapse?	
Who, or what, are the people, places or things that contribute to increased stress and problems in your life? What steps or actions can you take when you have to deal with these people, places, and things?	
What actions can you take to manage stress, stay well, and remain focused on your goals?	
Persons you can call:	**Resources you can use:**
What things can others do that will be helpful?	
Is there anything else you would like to add to the Relapse Prevention Plan? ☐ Yes ☐ No. If Yes, add additional feedback:	

Crisis Arrangements

- Should a crisis arise, below are questions to consider to help you manage your affairs in a psychiatric emergency.
- These arrangements are not a substitute for your decision making, even in the midst of crisis. It is only a supplemental support option.

What should be done if you are in crisis?	
What should NOT be done when you are in crisis?	
Medications that are helping or have helped in the past:	**Medications that have not helped:**
Is there anything else you would like to add to these crisis arrangements? ☐ Yes ☐ No. If Yes, add additional feedback.	

Relapse Prevention Plan
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Individual's Name (First / MI / Last):	**Record #:**	**D.O.B.:**

IF I BECOME UNABLE TO HANDLE MY PERSONAL AFFAIRS, the following people have agreed to look after my personal affairs (For example: pets, housing, family/job notification):

Name	Phone	Area(s) of Assistance

Do you have a Health Care Proxy? ☐ Yes ☐ No Copy has been provided for the record ☐ Yes ☐ No Would you like more information on Health Care Proxies? ☐ Yes ☐ No	Do you have an Advance Directive in effect? ☐ Yes ☐ No Copy has been provided for the record ☐ Yes ☐ No Would you like more information on Advance Directives? ☐ Yes ☐ No

I have developed this Relapse Prevention Plan with staff and others to describe the actions that I can take to prevent relapse and crises and keep myself moving towards my personal life goals.

I was provided a copy of the plan ☐ Yes ☐ No. If No, Provide a Reason:

Individual's Signature: **Date:**

Parent/Guardian/Other Name ☐ (N/A):	**Parent/Guardian/Other Signature:**	**Date:**
Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Supervisor/ Professional Staff/ Qualified Health Professional Name/Credentials (if applicable)**:**	**Supervisor Signature:**	**Date:**
Print NPP Name/Credentials (if applicable)**:**	**NPP Signature:**	**Date:**
Print Psychiatrist/MD/DO Name/Credentials (if applicable)**:**	**Psychiatrist/MD/DO/ Signature:**	**Date:**
If Applicable, Additional Staff Sign Below		
Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Staff Name/Credentials:	**Staff Signature:**	**Date:**

Relapse Prevention Plan

The Relapse Prevention Plan is designed to be part of the IAP for Individuals served in PROS and ACT programs. The purpose of the Relapse Prevention Plan is to help the Individual served work out ways he or she can actively stay well, prevent a relapse of symptoms and avoid crises. The Relapse Prevention Plan is to be completed by the Individual served in collaboration with staff. The Relapse Prevention Plan is based on personal needs and takes into account cultural, religious, and ethnic factors important to the Individual served. Crisis arrangements separate in experience from the Relapse Prevention Plan, are included as a helpful tool to arrange additional supports for the Individual served and provide instruction for staff. It is not meant to replace decision making by the Individual served, even in crisis. It does not replace a Health Care Proxy or an Advance Directive. Information is to be provided if the Individual served requests further clarification on these documents. It is recommended the Relapse Prevention Plan is periodically reviewed and updated as needed prior to discharge and when a relapse or crisis occurs.

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record #, and D.O.B. must be completed on each page)
Individual's Name:	Record the first name, middle initial and last name of the Individual served.
Record #:	If applicable, record your agency's identification number for the Individual served.
D.O.B:	Document Individual's date of birth.
Date of Admission:	Document the date the Individual served was admitted.
Date Plan Written:	Document the date that the plan is written.

Data Field	Details of the Plan Instructions
What are your early warning signs that things are too stressful, deteriorating or not going well for you that could be a sign of relapse?	The Individual served is to describe how he/she would know that he/she is becoming symptomatic. Examples: ▪ **I do not feel like getting out of bed.** ▪ **I stop socializing with my peers and family members** ▪ **I have suicidal or homicidal thoughts**
Who, or what, are the people, places or things that contribute to increased stress and problems in your life? What steps or actions can you take when you have to deal with these people, places and things?	The Individual served is to describe people, places, things that could trigger a relapse. **Examples:** ▪ **I should not stay up all night** ▪ **I should not buy lottery tickets** ▪ **I should avoid going to my brother's house** ▪ **Abstain from activities that could trigger a relapse**

Data Field	Details of the Plan Instructions
What actions can you take to manage stress, stay well, and remain focused on your goals?	The Individual served is to describe tools, mechanisms, techniques that he/she can utilize to relieve stress, provide a sense of calm or assist him/her in feeling safe. **Examples:** • **I can take my medications as prescribed** • **I can go for a brisk walk** • **I can exercise** • **I can eat nutritionally balanced meals** • **I can talk to my counselor** • **I can utilize breathing techniques to relieve my anxiety**
Persons you can call:	The Individual served is to describe persons that they have identified as being a support to him/her in the prevention of a relapse. **Example:** • **My brother John** • **My therapist/ staff at the program**
Resources you can use:	The Individual served is to describe resources that he/she has identified as being a support to him/her in the prevention of a relapse. **Example:** • **Wellness Group on Tuesdays** • **Contacting my Therapist**
What things can others do that will be helpful?	The Individual served is to describe tools, mechanisms, techniques that can be provided by others as a support to him/her in keeping him/her safe. **Example:** • **Contact brother John when I am feeling overwhelmed** • **Remove myself from the situation that is unsafe for me**
Is there anything else you would like to add to the Relapse Prevention Plan? If yes, add additional feedback.	The Individual served is to add additional information if he/she chooses to do so.

Data Field	Details of the Plan Instructions
Crisis Arrangements **Should a crisis arise, below are questions to consider to help you manage your affairs in a psychiatric emergency.** **These arrangements are not a substitute for your decision making, even in the midst of crisis. It is only a supplemental support option.**	Individual served is to identify what actions to take when he/she is in crisis.
What should be done if you are in crisis?	Individual served identifies what should be done if he/she is in crisis and include the Individual's treatment preferences. **Example:** • **Contact therapist** • **Contact family member** • **Individual would prefer to go to Stony Brook Medical Center instead of Brookhaven Medical Center.**

What should be done if you are NOT in crisis?	Individual served identifies what should NOT be done if he/she is in crisis.
Medications that are helping or have helped in the past:	The Individual served is to describe the medications that are helping or have helped him/her in the past in preventing a relapse.
Medications that have not helped:	The Individual served is to describe the medications that have **not** helped him/her in the past in preventing a relapse.
Is there anything else you would like to add to these crisis arrangements? If yes, add additional feedback.	The Individual served is to add additional information if he/she chooses to do so.
If I become unable to handle my personal affairs..:	Individual served is to list name, contact information, and how the identified person can assist him/her. **Example:** ▪ **Take care of my pets** ▪ **Pay my bills on time**
Data Field	**Details of the Plan Instructions**
Health Care Proxy	Individual served is to indicate in the Yes/No box if he/she has a completed Health Care Proxy and if a copy has been provided for the record. Individual served is to indicate if he/she would like additional information on Health Care Proxies.
Advance Directives	Individual served is to indicate in the Yes/No box if a copy of the Advance Directives is in effect and if a copy has been provided for the record. Individual served is to indicate if he/she would like additional information on Advance Directives.
Data Field	**Signature/Confirmation Instructions**
I have developed this Relapse Prevention Plan… **I was provided a copy of the plan. If No, Provide a Reason** **Individual's Signature:**	The Individual served is to sign his/her name acknowledging that this plan is specific to him/her. The Individual served should be given a copy of the Relapse Prevention Plan. A reason should be provided if a copy wasn't given.
Data Field	**Signatures Instructions**
Print Parent/Guardian/Other Name:	The parent/guardian/other 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:	**Legibly** record signature and credentials, according to agency policy, of the staff who prepared the plan.
Date:	Date of this signature.
Print Supervisor/Professional Staff/Qualified Health Professional Name/Credentials (if applicable):	If applicable, **legibly** record signature and credentials of supervisor. Check if *N/A*. **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
Print NPP Name/Credentials (if applicable):	If applicable, **legibly** record signature and credentials.
Date:	Date of this signature.
Print Psychiatrist/MD/DO Name/ Credentials (if applicable):	If applicable, **legibly** record signature and credentials.
Date:	Date of this signature.
If Applicable, Additional Staff Sign Below	Any additional staff involved in the development of the IAP-Psychopharmacology plan should legibly record their name and credentials and date. Check if *Not applicable*.

Discharge Summary/Plan
Revision Date: ***11-25-10***

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

Legal Status – ☐ **Not applicable**
☐ **Incarcerated** ☐ **Court Ordered Treatment** ☐ **Probation** ☐ **Parole** ☐ **Other:**
Legal Status Details:

Reason for Discharge:

☐ Decreased level of care needed
☐ Increased level of care needed
☐ Goals met, no services needed
☐ Individual terminated services
☐ Individual refused referral for other services
☐ Individual moved
☐ Individual died
☐ Involuntary discharge, Individual informed of right to appeal
☐ Individual did not return/was non-responsive to outreach attempts
☐ Other:

Additional Comments: (Specify reason for discharge):

Summary of Services/Treatment Provided:

Outcomes (Summarize progress on **ALL** goals since admission, include current level of functioning and any significant bio-psychosocial changes since last admission):

Strengths, abilities, preferences of Individual at time of discharge:

Sobriety Status: ☐ **Not applicable**

List the collateral and/or providers involved during the course of treatment: ☐ **None Involved**

Agency/Name:	**Relationship**

Individual's Name (First / MI / Last):	**D.O.B.:**

Diagnosis At Discharge			
Check Primary	**Axis**	**Code**	**Narrative Description**
☐	Axis I		
☐			
☐			
☐	Axis II		
☐			
☐	Axis III		
☐	Axis IV		
☐	Axis V	Current GAF:	



Individual's Name (First / MI / Last):	**D.O.B.:**

Referrals		
If no referrals were made, provide reason:		
Referred To (Agency/Program Name, Location, and Contact Information):	For (describe services/supports):	**Date(s)/Time(s) of Appts.:**

Aftercare and Resource Options (Include information on symptoms Individual should watch for, options available if these symptoms recur, and/or additional services needed and community resources available to the individual and/or family and significant others):

For Applicable OASAS *programs only*, Substance Abuse Relapse Prevention Plan must be included. This does not apply to Methadone Maintenance programs.

Medications (including OTC) at time of Discharge: ☐ None Reported			
Medication Name	**Dose/ Frequency**	**Prescribed by**	**Amount / RX Given**
1			# of Pills / ☐ Yes ☐ No
2			# of Pills / ☐ Yes ☐ No
3			# of Pills / ☐ Yes ☐ No
4			# of Pills / ☐ Yes ☐ No
5			# of Pills / ☐ Yes ☐ No
6			# of Pills / ☐ Yes ☐ No
7			# of Pills / ☐ Yes ☐ No
8			# of Pills / ☐ Yes ☐ No
9			# of Pills / ☐ Yes ☐ No
10			# of Pills / ☐ Yes ☐ No
11			# of Pills / ☐ Yes ☐ No
12			# of Pills / ☐ Yes ☐ No

Individual's Name (First / MI / Last):	**D.O.B.:**

Financial Status - ☐ **Not Applicable**
Indicate the current benefit status and/or the monies returned to the Individual at the time of discharge if applicable:

Individual's response in his/her own words to Discharge Plan:

I have participated in the development of this plan ☐ Yes ☐ No
I was provided a copy of the plan ☐ Yes ☐ No
If No, Provide a Reason:

Individual's Signature:	**Date:**

Parent/Guardian/Other Name ☐ (N/A):	**Parent/Guardian/Other Signature:**	**Date:**
Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Print Supervisor/Professional Staff/Qualified Health Professional Name/Credentials ☐ **(N/A):**	**Supervisor/Professional Staff/Qualified Health Professional Signature:**	**Date:**

Discharge Summary/Plan

The Discharge Summary/Plan is designed to encapsulate the course of treatment, outcomes, reasons for discharge, and plans for discharge. It is to be completed in accordance with program requirements.

Data Field	Identifying Information Instructions (*Fields for Individual's Name, Record #, and D.O.B. must be completed on each page)
Individual's Name:	Record the first name, last name, and middle initial of the Individual served.
Record #:	If applicable, record your agency's identification number for the Individual served.
D.O.B:	Document Individual's date of birth.
Program Name:	Document the name of the program that the Individual served has been discharged from.
Admission Date:	Document the date the Individual served was admitted.
Last Contact:	Document the last date of contact with the Individual served.
Discharge Date:	Document the date that the Individual served is discharged.
Legal Status:	If the Individual served has legal status involvement at the time of discharge, check the appropriate box and provide details. Check if N/A.
Data Field	**Reason for Discharge Instructions**
Reason for Discharge:	Check to indicate reason(s) for discharge. Provide further information to justify/explain reason for discharge.
Data Field	**Summary of Treatment Instructions**
Summary of Services/Treatment Provided:	Provide a narrative summary of the Individual's presenting issues, services and treatment that were provided.
Outcomes:	Summarize progress on all goals/objectives since admission. Include the Individual's current level of functioning and any significant bio-psychosocial changes since his/her admission.
Strengths, abilities, preferences of Individual at time of discharge:	Include information regarding the Individual's strengths, abilities and preferences.
Sobriety Status:	Indicate Individual's current sobriety status and ongoing support system. If Individual served is not sober, detail current use. Check N/A if no history of substance use/abuse.

Data Field	Collaterals/ Providers Involved Instructions
List the collateral and/or providers involved during the course of treatment	Document all collateral and/or providers (outside of the current program) that have been involved with the IAP. If there is not any other collateral and/or providers involved, check the box none involved.
Data Field	**Diagnosis Instructions**
Axes I – V:	Spaces are provided to capture the information at time of discharge. Indicate Axes I-V from most recent psychiatric evaluation. Indicate the diagnostic code and conditions for Axes I – III according to the instructions from the diagnostic manual being used. For Axis IV, include the relevant categories of psychosocial or environmental problems/stressors as indicated in the evaluation. For Axis V, log the GAF score from the most recent psychiatric evaluation.
Data Field	**Referrals Instructions**
If no referrals were made, provide reason:	If no referrals were made, provide reason, e.g., Individual served voluntarily left without informing others, etc.
Referred To:	List all internal and external services/programs to which the Individual served is being referred at the point of discharge. This includes referrals made by additional providers. Specify agency/program name, location, and any other contact information the Individual served or parent/guardian/other will need to ensure continuity of care.
For:	Specify the types of services or programs, or reason why the Individual served is being referred for each particular listing.
Date(s)/Time(s) of Appointments:	Indicate any specific dates and/or times of appointments that have been set up for the Individual served.
Aftercare and Resource Options:	Indicate information on symptoms; including early warning signs / indications of relapse the individual should watch for, options available if these symptoms recur, or additional services needed and individual/community resources available to the Individual served and/or family and significant others.
For Applicable OASAS programs only, Substance Abuse Relapse Prevention Plan must be included. This does not apply to Methadone Maintenance Programs.	Individual served will list his/her personal relapse concerns and then identify strategies / resources he/she could use to help manage those concerns (e.g. Loneliness: "I will call someone in my support group when I feel lonely"). The completed individualized Substance Abuse Relapse Prevention Plan must be documented in the Discharge Summary/Plan.
Data Field	**Medications Instructions**
Medications (including OTC) at time of Discharge:	List medication name, dose, and frequency. Record the name of the prescriber as reported by the individual at the time of discharge. List the number of pills for each medication given to individual at the time of discharge. Also, indicate all prescriptions (RX) given at time of discharge. Check box if None Reported.
Data Field	**Financial Status Instructions**
Financial Status:	Indicate the current benefit status and/or the monies returned to the Individual served at the time of discharge if applicable.

Data Field	Individual Response & Participation/Copy Instructions
Individual's response in his/her own words to Discharge Plan:	Document Individual's response to discharge.
I have participated in the development of this plan or I was provided a copy of the plan: **Individual's Signature/Date:**	Indicate either Yes or No that the Individual served has participated in the development of the Discharge Summary/Plan. Indicate either Yes or No that the Individual served has received a copy of the Discharge Summary/Plan. Individual's signature and date reflects his/her participation in the development of the plan. If the Individual served does not sign or receive a copy of the Discharge Summary/Plan, list the reason.
Data Field	**Staff Signatures Instructions**
Print Parent/Guardian/Other Name:	The parent/guardian/other 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.
Print Staff Name/Credentials:	**Legibly** record signature and credentials, according to agency policy, of the staff who prepared the Discharge Summary/Plan.
Date:	Date of this signature.
Print Supervisor/Professional Staff/Qualified Health Professional Name/Credentials	If applicable, **legibly** record signature and credentials of supervisor. Check if *N/A*. **Example: Jerry Smith, LMHC**
Date:	Date of this signature.