



Organization Name:		Program Name:	
Individual's Name (First / MI / Last):		Record #:	DOB:
Review/Revision Date:	<input type="checkbox"/> Review <input type="checkbox"/> 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:	
<input type="checkbox"/> Goal #1: Maximize Individual's independence by reducing/managing disabling psychiatric symptoms.		<input type="checkbox"/> Continued <input type="checkbox"/> New - <i>Linked to Prioritized Assessed Need # _____ From Form Dated: _____</i> <input type="checkbox"/> Discontinued – actual date of goal discontinuation: <input type="checkbox"/> Attained– actual date of goal attained: <input type="checkbox"/> Revised - Goal sheet attached	
<input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R		Summary of Progress:	
<input type="checkbox"/> Goal # 2: Maintain chemical dependence recovery for improved mental and physical health.		<input type="checkbox"/> Continued <input type="checkbox"/> New - <i>Linked to Prioritized Assessed Need # _____ From Form Dated: _____</i> <input type="checkbox"/> Discontinued – actual date of goal discontinuation: <input type="checkbox"/> Attained– actual date of goal attained: <input type="checkbox"/> Revised - Goal sheet attached	
<input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R		Summary of Progress:	
<input type="checkbox"/> Goal # 3: Reduce (or Discontinue) Medication Regime.		<input type="checkbox"/> Continued <input type="checkbox"/> New - <i>Linked to Prioritized Assessed Need # _____ From Form Dated: _____</i> <input type="checkbox"/> Discontinued – actual date of goal discontinuation: <input type="checkbox"/> Attained– actual date of goal attained: <input type="checkbox"/> Revised - Goal sheet attached	
<input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R		Summary of Progress:	
<input type="checkbox"/> Goal # 4:		<input type="checkbox"/> Continued <input type="checkbox"/> New - <i>Linked to Prioritized Assessed Need # _____ From Form Dated: _____</i> <input type="checkbox"/> Discontinued – actual date of goal discontinuation: <input type="checkbox"/> Attained– actual date of goal attained: <input type="checkbox"/> Revised - Goal sheet attached	
<input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R		Summary of Progress:	



Name (First / MI / Last):	D.O.B.:
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Transition / Discharge Criteria <input type="checkbox"/> No Change)	For COA Only: Estimated Length of Treatment and Stay:
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How will the provider/individual/parent guardian know that level of care change is warranted? *(For OMH Children's Residential Programs, Include a description of the skills needed to return home or into the community):*

Criteria - How will the provider/individual/guardian know that care has been completed or that a transition to a lower level of care change is warranted? *(For OMH Housing Programs for Children and Adolescents, Include a description of the skills needed to return home or into the community / Check All that Apply):*

- Reduction in symptoms as evidenced by:
- Attainment of higher level of functioning as evidenced by:
- Treatment is no longer medically necessary as evidenced by:
- Other:

OASAS Required /OMH Optional	Individual's Diagnosis:
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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 <input type="checkbox"/> (N/A):	Parent/Guardian/Other Signature:	Date:

If lacking signature of Individual/Parent/Guardian, provide reason for non-participation:

NPP - Print Name/Credentials <input type="checkbox"/> (N/A):	NPP Signature:	Date:
Psychiatrist/MD/DO - Print Name/Credentials: <input type="checkbox"/> (N/A):	Psychiatrist/MD/DO Signature:	Date:

If Applicable, Additional Staff Sign Below

Print Staff Name/Credentials <input type="checkbox"/> (N/A):	Staff Signature:	Date:
Print Staff Name/Credentials <input type="checkbox"/> (N/A):	Staff Signature:	Date:
Print Staff Name/Credentials <input type="checkbox"/> (N/A):	Staff Signature:	Date:
Print Staff Name/Credentials <input type="checkbox"/> (N/A):	Staff Signature:	Date: