



Individualized Action Plan Revision/Review
Revision Date: 11-1-12

Page: of

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 <i>(Continued/New/Discontinued/Attained/Revised)</i>		Evidence of Progress, Barriers, and/or Rationale for Attainment, Addition of New Goal/Discontinuation of Goal, Revision or Continuation:	
<input type="checkbox"/> Goal #: Goal Keyword or Goal Statement:		<input type="checkbox"/> Continued <input type="checkbox"/> New-Linked to Prioritized Assessed Need # _____ From Form Dated: _____ <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	
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Individual's Name (First / MI / Last):	Record #:	D.O.B.:
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For ACT programs only, indicate the changes in individual's status in assessed domains:

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:

Completed By - Print Staff Name/Credentials:	Staff Signature:	Date:
Supervisor/ Professional Staff/ QHP/ Team Leader – Print Name/Credentials <input type="checkbox"/> (N/A):	Supervisor/ Professional Staff/ QHP/ Team Leader – Signature <input type="checkbox"/> (N/A):	Date:
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: