Individualized Action Plan Review/Revision

The Individualized Action Plan Review/Revision form has been created to document information from ongoing review(s), revision(s) of treatment goals and objectives and/or periodic rewrites. This form has been designed to minimize duplication of effort in creating subsequent action plans and maximize the documentation of information, which demonstrates evidence and/or rationale for revision.

Use the IAP Review/Revision form to update or modify the IAP in any of the following ways: 1) Revisions – to add a new goal; change goals, objectives or interventions; or change the frequency or duration of services; 2). Reviews – to record the progress of the person served and 3) Rewrites - annually, after three interim revisions, or per agency protocol, a "rewrite" of the actual IAP is warranted. 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. If you are adding a new goal or objective, attach the goal and/or objective page(s) from the IAP form to the IAP Review/Revision form.
When a Rewrite is being completed, page 1 of the IAP Review/Revision should be used and the new IAP should be attached.

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.

Please note that this form does not have a billing strip. If you are reviewing progress in a way that is billable, e.g. meeting face-to-face with the person served to discuss progress and update the IAP, you also must complete a progress note that describes the service and refers the reader to the IAP update. Use the billing strip on the bottom of progress note to bill for the service.
This form should be placed in date order (or according to internal policy and procedure) with the original IAP and any other updates. Together these documents will constitute the current IAP from which services are provided and billed. It is important to remember that as with the IAP, any IAP revisions should be completed in collaboration with the person served. This form requires evidence of collaboration in a number of ways. In all cases, if a person refuses to collaborate, does not agree to goals, or will not review goals, a separate progress note should be written to describe the person's participation and the plan for moving forward.

Data Field	Identifying Information Instructions (*Fields for Client Name, Number, and D.O.B. must be completed on each page)
***Person's Name:**	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
***Record Number:**	Record your agency's established identification number for the person.
***D.O.B:**	Document date of birth of the person served.
Organization Name	Record the organization for whom you are delivering the service.
Review/Revision Date:	Record date that the review/revision is occurring.
Individualized Action Plan Date:	Record date of the IAP you are reviewing, including month, date, and year.
Reviewed by:	Record the name of the person completing the review/revision his or her title, and the program(s) for which the plan has been developed.

Data Field	Purpose Instructions
Review/Revision:	Check the review/revision box when the IAP is being reviewed or revised and complete both pages 1 and 2. In the adjacent section, identify the reason for the review by placing a check in the most appropriate box or by checking and specifying the reason after the "Other" box. Also include "Dates Covered" in the review.
Rewrite:	For Rewrites, place a check in the box, complete page 1 only of the Review/Revision form and attach the rewritten IAP. All goals and objectives should renumbered to reflect the rewritten plan.

Data Field	Status and Evidence/Rationale Instructions
Goal Status:	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. Indicate whether the goal is Active, New, Discontinued, Completed, or Revised by checking the appropriate box. • If "Active" check to indicate progress towards meeting the goal. • If "Discontinued" log actual date of goal discontinuation. • If "Completed" log actual date of goal completion.
Objective Status	Under each identified goal, check off and number the current objectives being reviewed/revised. Indicate whether the objective is Active, New, Discontinued, Completed, or Revised by checking the appropriate box.

Data Field	Status and Evidence/Rationale Instructions
Evidence of Progress, Barriers, and/or Rationale for Addition of New Goal/Discontinuation of Goal, Revision or Rewrite	Use this space to document information regarding the person served and his or her treatment, which provides evidence and/or rationale for revisions and/or addition/discontinuation of goals or rewrite of 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 person's difficulty or not meeting goals. Link progress/lack thereof to outcomes data when possible. **Example:** • **Depression has decreased as evidenced by TOP score shifting from 8 on the initial TOP to 3 on the Follow-up.** To link to relevant Progress Notes, check the box at the bottom of the section and list dates of Progress Notes. If not applicable, check the Not Applicable box.

Data Field	Identifying Information/Agencies Instructions
Other Agencies/Community Supports and Resources Supporting IAP:	List the agency name, contact person/title, and services currently being provided by external agencies/community supports and resources that are collaborating on or supporting the person's IAP. Indicate whether or not the appropriate release has been signed to allow for communication with each. Check if "None Reported" or "No Change" **Examples:** • **Other Mental Health agencies** • **State Departments (i.e. DSS, DMR, DMH)** • **Doctor/Nurse** • **Court/Probation Officer**

Data Field	Medication Information
Medications as Reported by Person Served on Date of IAP:	**NOTE: <u>This section is mandatory for outpatient substance use counseling programs only.</u>** If not applicable, check the box provided. Complete the information in the table as reported by the person served on the date that the IAP was developed. Complete all fields for each medication including name of medication, dose, plans for change (including rate of detoxification), and the person prescribing each medication. Check if "None Reported" or "No Change"

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date:	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or provider assessment.

How will the provider/person served/parent/ guardian know that level of care change is warranted?	Transition planning should begin as early as possible in the treatment process and documentation of the planning is required. To facilitate the process, checkboxes have been provided. If there has been no change since development of the initial or most recently rewritten plan, check "No Change". Otherwise, check all that apply and document evidence, which supports or describes any criteria checked. Examples: • Reduction in symptoms as evidenced by: improvement in withdrawal symptoms • Services are no longer medically necessary as evidenced by: completion of methadone protocol • Other: placement in a longer-term treatment program • Reduction in symptoms as evidenced by: client self-report that withdrawal discomfort has decreased • Services are no longer medically necessary as evidenced by: scores on the CIWA or COWS assessment • 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 • Attainment of higher level of functioning as evidenced by: person is no longer at a risk to self or others and is able to agree upon and follow a contract for safety

Data Field	Signatures/Confirmation Instructions
Person's Signature:	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date:	Date of person's signature.
Was the person served provided with copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If "No", document reason.
Client's Initials to confirm:	Person should initial to document that he or she has been offered a copy of the IAP, and either accepted a copy or elected not to receive a copy of the Treatment Plan.
Parent/Guardian Signature:	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives. Check if "N/A".
Date:	Date of Parent/Guardian Signature.

Data Field	Staff Signatures Instructions
Provider Signature/Credentials:	**Legible** signature and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date:	Date of this signature.
Supervisor's Signature/Credentials	**Legible** signature and credentials of supervisor. Check if "N/A". **Example: Jerry Smith, LMHC**
Date:	Date of this signature.
Physician Signature/Credentials:	**Legible** physician'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.