Person's Name (First MI Last): Mary Fictitious	**Record #:** 108250	**Date of Admission:** 3/1/13
Organization/Program Name: Recovery Services, Inc	**DOB: 8/2/77**	**Gender:** ☐ Male ☐ Female ☐ Transgender

Date of Admission: 3/1/13	☐ **Annual IAP-Date: 3/13**	☐ **Revised IAP-Date:**

Linked to Assessed Need(s): #1 from form dated: 3/1/13 ☐CA ☐CA Update ☐Psych Eval. ☐Other:	**Start Date:** 3/13	**Target Completion Date:** 3/14

Desired Outcomes for this Assessed Need in Person's Words: "I don't want to experience an episode like those two again… and if I do, I want to know how to respond."

GOAL (State Goal Below in Collaboration with the Person Served/Reframe Desired Outcomes)

Mary will learn the skills and strategies needed to decrease the frequency and intensity of her anxiety as evidenced by self-report and observation. (Initial Baseline: 2 moderate-to-severe panic attacks in 1 month and overall level of anxiety reported by Mary as a 7 out of 10, with 10 being the highest).

Person's Strengths, Preferences, and Skills and How They Will be Used to Meet This Goal: Mary has skills in caring for others and being compassionate that she can use towards herself. Mary is willing to participate in treatment and wants to "get better."

Supports and Resources Needed to Meet This Goal: Her children, her primary care physician, a couple friends, her church/faith, therapist

Potential Barriers to Meeting This Goal: Mary noted that attending sessions could be difficult when school was not in session or one of her children was ill.

OBJECTIVE # 1**:** Develop skills to identify and manage triggers to her anxiety in efforts to reduce her anxiety (IBL: 7 out of 10 with 10 being highest)

Person Served Will: Consider triggers in her previous panic attacks in session; Track her levels of anxiety for a couple weeks; Practice developing the ability to recognize triggers in the moment	**Start Date:** 3/13
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)	**Target Completion Date:** 3/14

Intervention(s) / Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**
1. Provide psychoeducation and discuss with Mary common contributing factors to and forms of anxiety; Facilitate Mary in tracking her levels of anxiety and recording her experiences of panic attacks (including assessing for precipitating events, hunger, emotions beforehand, etc); Aid Mary in identifying triggers to her anxiety (including exploring negative thoughts if appropriate); Converse with Mary's primary care physician as appropriate	Individual	Weekly or every other week	LMHC
2. Provide support to Mary around considering changes with her eating, exercise, and smoking patterns.	Medical Appt	prn	MD
3.			
4.			

OBJECTIVE # 2**:** Find and develop at least 3 grounding and relaxation skills to use when experiencing anxiety

Person Served Will: Practice several coping, grounding, or relaxation skills and identify her favorites; Practice self-care activities on a daily basis; Identify and practice a better nighttime sleep routine	**Start Date:** 3/13
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)	**Target Completion Date:** 3/14

Intervention(s) / Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**
1. Evaluate with Mary her current coping strategies; Provide psychoeducation about coping, grounding, and/or relaxation skills and aid Mary in discovering which work best for her; Provide psychoeducation about self-care and sleep hygiene	Individual	Weekly or every other week	LMHC

2.			
3.			
4.			

Individualized Action Plan-Version 1
Additional Objectives

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

OBJECTIVE # :			
Person Served Will:			**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)			**Target Completion Date:**
Intervention(s) / Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**
1.			
2.			
3.			
4.			

OBJECTIVE # :			
Person Served Will:			**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)			**Target Completion Date:**
Intervention(s) / Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**
1.			
2.			
3.			
4.			

OBJECTIVE # :			
Person Served Will:			**Start Date:**
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)			**Target Completion Date:**
Intervention(s) / Method(s)	**Service Description/ Modality**	**Frequency**	**Responsible: (Type of Provider)**
1.			
2.			
3.			
4.			

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

This Section Mandatory for Outpatient Substance Abuse Counseling Only (Check Here if Not Applicable: ☐)

Medication Name	Dose	Plans for Change-Including Rate of Detox	Prescribed By
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: ☐ None Reported (☐ No Change)

Agency Name:	Contact and Title	Services Currently Provided	Release Signed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Transition/Level of Care Change/Aftercare/Discharge Plan (☐ No Change) **Anticipated Date: 3/14**

Criteria-*How will the provider/individual/parent guardian know that level of care change is warranted?*
(Check All that Apply)

☐ Reduction in symptoms as evidenced by:

☐ Attainment of higher level of functioning as evidenced by:

☐ Treatment is not longer medically necessary as evidenced by: Mary feeling capable to notice and diminish panic attacks to the level that she no longer is worried about them.

☐ Other:

Plan Completed by (Name, Title, Program):

Was the person served provided copy of the IAP/ ☐s Yes ☐ No, Reason:

Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**	**Next Appointment:** **Date: / / - Time: ☐ am ☐ pm**	