|  |  |  |
| --- | --- | --- |
| **Individual**  **Service Plan** | Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Admission Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Plan Implementation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| □ New □ Re-Write □ Addendum | | |
| **INDIVIDUAL’S STRENGTHS** | | |
|  | | |
| **LONG TERM GOALS**  *(include hopes/dreams/goals)* | | **SHORT TERM GOALS** |
|  | |  |
| **IDENTIFIED BARRIERS**  (Based on Functional Assessment) | | |
|  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INDIVIDUAL’S AREAS OF NEED** | | | | |
|  | | | | |
| **INDIVIDUALIZED PLAN FOR SERVICES** | | | | |
| **Objective #1:** | | | | |
| **Interventions** | **Service Area Assigned** | **Criteria / Outcomes for Completion** | **Initiation Date:** | **Target Date:** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| **Objective #2:** | | | | |
| **Interventions** | **Service Area Assigned** | **Criteria / Outcomes for Completion** | **Initiation Date:** | **Target Date:** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| **Objective #3:** | | | | |
| **Interventions** | **Service Area Assigned** | **Criteria / Outcomes for Completion** | **Initiation Date:** | **Target Date:** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |

|  |  |
| --- | --- |
| **DIAGNOSIS** | |
| **Primary Diagnosis(es)** |  |
| **Secondary Diagnosis(es)** |  |
| **Community Support has been offered to me and I choose:**  □ **YES**, I do want to participate (see Recovery Support Plan)  \_\_\_\_\_\_(initials of individual receiving services)  □ **NO**, I do NOT want to participate  \_\_\_\_\_\_ (initials of individual receiving services) | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Individual Receiving Services Date Parent / Legal Guardian Date | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Signature / Credentials Date Signature / Credentials Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Signature / Credentials Date Signature / Credentials Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Signature / Credentials Date Signature / Credentials Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Signature / Credentials Date Signature / Credentials Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Signature / Credentials Date Signature / Credentials Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Physician / Clinical Psychologist / Nurse Practitioner, LCSW, LMFT, Date  LPC, PA, Alzheimer’s Day Program Supervisor | |