|  |  |
| --- | --- |
| **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) |
|  |

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| --- |
| **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. |  |  |  |  |

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| --- |
| **DIAGNOSIS** |
| **Primary Diagnosis(es)** |  |
| **Secondary Diagnosis(es)** |  |
| **Community Support / Recovery Support has been offered to me and I choose:**□ **YES**, I do want to participate (see Support Implementation Plan for Recovery/ Resiliency)\_\_\_\_\_\_(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, DateLPC, PA, QMRP, Alzheimer’s Day Program Supervisor |