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| Participant Name: |  | Participant Number: |  |
| Counselor/Case Manager Name: |  | Program: | Independent Living Program |
| Intake Date: |  | Date Plan Initiated: |  | Review Date: |  |  |
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| **SERVICES** |
|  |  |  |  |
| Type of Services | Frequency/Duration | Location | Participant/Family/Staff/Program Responsible |
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Strengths, needs, abilities, and preferences (SNAP):

Discharge Criteria/Transition Information (critical goals to be met or gains to be made before discharge from the program):

Education/Career Path:

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| **Prioritized Issue:** (1 per page, # issues 1, 2 and 3 in priority order.) |
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| **Goal(s):** (1, 2, 3, etc.) |
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| **Individual Service Plan Objectives:** |
| Goal # | Objective(s) (A, B, C, etc.) (Measurable, achievable, time specific behavioral objectives to be achieved by the participant and appropriate to the service setting.) | Specific Type of Interventions | Date(s) Begun | Target Date(s) to be completed | Date Completed |
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| **Prioritized Issue:** (1 per page, # issues 1, 2 and 3 in priority order.) |
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| **Goal(s):** (1, 2, 3, etc.) |
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| **Prioritized Issue:** (1 per page, # issues 1, 2 and 3 in priority order.) |
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| **Goal(s):** (1, 2, 3, etc.) |
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| **Individual Service Plan Objectives:** |
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Please Check and Date: [ ]  New Plan [ ]  Plan Update

**I helped in the development of and agree with this plan and have been offered a copy.**

Participant’s Signature Date

Parent/Guardian Date

Counselor/Case Manager’s Signature/Title Date

Supervisor’s Signature/Title Date

Please Check and Date: [ ]  Plan Reviewed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I helped in the development of and agree with this plan and have been offered a copy.**

Participant’s Signature Date

Parent/Guardian Date

Counselor/Case Manager’s Signature/Title Date