INDIVIDUAL PLAN REVIEW

Review Dates:

__________________ __________________

__________________ __________________

Name:____ Program:____

CHOICE Meeting Date:________________ 90 Day Review:________________ 180-Day Review:_______________

***Priority Rank**	**LTO#:________**	**Current Step/ Quarterly Progress**	**Progress Summary/ Factors Effecting Progress/ Response of Person Served**	**Recommendations**
		1st Quarter____________________		
		2nd Quarter____________________		
		3rd Quarter____________________		
		Annual__________________		

Priority Rank	LTO#:________	Current Step/ Quarterly Progress	Progress Summary/ Factors Effecting Progress/ Response of Person Served	Recommendations
		1st Quarter____________________		
		2nd Quarter____________________		
		3rd Quarter____________________		
		Annual__________________		

(1st)________________________
Signature/Position/Date

(2nd)________________________
Signature/Position/Date

(3rd)________________________
Signature/Position/Date

(Annual)________________________
Signature/Position/Date

Name:____

BEHAVIOR MANAGEMENT PROGRAM

Criteria	Carryover/ Quarterly Progress (Good days %)	Progress on LTO	Progress Summary/ Factors Effecting Progress/ Response of Person Served	Recommendations
	1st Quarter____________________			
	2nd Quarter____________________			
	3rd Quarter____________________			
	Annual__________________			

(1st)______________________
Signature/Position/Date

(2nd)______________________
Signature/Position/Date

(3rd)______________________
Signature/Position/Date

(Annual)______________________
Signature/Position/Date

INDIVIDUAL PLAN REVIEW

Name:______________________________ Program:____

CHOICE MEETING DATE:________________ 90 Day Review:_______________ 180 Day Review:_______________

SERVICES

Service:_________________________ Due Date:________ Staff Responsible for Implementation:____________________

Action Taken	Results	Follow-Up

Service:_________________________ Due Date:________ Staff Responsible for Implementation:____________________

Action Taken	Results	Follow-Up

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Action Taken	Results	Follow-Up

Service:_________________________ Due Date:________ Staff Responsible for Implementation:____________________

Action Taken	Results	Follow-Up

Service:______________________________ Due Date:__________ Staff Responsible for Implementation:________________________

Action Taken	Results	Follow-Up

Service:______________________________ Due Date:__________ Staff Responsible for Implementation:________________________

Action Taken	Results	Follow-Up

Overall Program Review Summary (To Be Completed By Individual Program Coordinator)

1. Major Factors and Events Impacting Person Served (illness, injury, site move, vacation, job change, etc.)

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2. Specific Evidence of Response by Person Served to Overall Program

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3. Overall Status of IHP Implementation

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4. Recommendations

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Interim Needed? Yes:______ No:______

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Signature/Position/Date