Name of Policy: **Individual Service Plan** **Policy Number**: 3364-160-CR-105 **Approving Officer**: Chief Executive Officer **Responsible Agent**: Chair, Department of Psychiatry Administrative Director **Scope**: Outpatient Clinic - Psychiatry	UTOLEDO HEALTH **Effective date:** July 2025 **Original effective date**: January 1998
Key words: psychiatry, treatment plan, assessment, needs, outcomes, goals, progress	

	New policy proposal		Minor/technical revision of existing policy
	Major revision of existing policy	X	Reaffirmation of existing policy

(A) Policy statement

An individual service plan (ISP) will be developed for each patient and will become part of the individual patient record.

(B) Purpose of Policy

The individual service plan is used to monitor progress during the course of treatment.

(C) Procedure

(1) The development of the individual service plan is a collaborative process between the patient and service provider(s) based on a diagnostic assessment, a continuing assessment of needs, and the successful identification of interventions/services. The individual service plan shall document, at minimum, the following.

(a) A description of the specific mental health need(s) of the patient.

(b) Anticipated treatment outcomes based upon the mental health needs identified. Such outcomes shall be mutually agreed upon by the provider and the patient. If these outcomes are not mutually agreed upon, the reason(s) needs to be fully documented in the patient record.

(c) Name(s) and/or description of all services being provided. Such service(s) shall be linked to a specific mental health need and treatment outcome.

(d) Evidence that the plan has been developed with the active participation of the patient. As appropriate, involvement of family members, parents, legal guardians/custodians, or significant others shall also be documented.

(e) As relevant, the inability or refusal of the patient to participate in service planning and the reason(s) given.

(f) The signature(s) of the clinical staff member(s) responsible for developing the individual service plan, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable.

(2) The individual service plan must be completed within five sessions or one month of admission, whichever is longer.

(3) The individual service plan shall be periodically reviewed at the patient's request, when clinically indicated, and/or when a recommended service is terminated, denied, or no longer available to the client. Documentation of results of such periodic review shall occur at least annually, and shall include:

(a) Evidence that the plan has been reviewed with the active participation of the patient, and, as appropriate, with involvement of family members, parents, legal guardians/custodians or significant others.

(b) As relevant, the inability or refusal of the patient to participate and the reason(s) given.

(c) The signature(s) of the clinical staff member(s) responsible for completing the review, the date on which it was completed; and documented evidence of clinical supervision of staff completing the review, as applicable.

Approved by:

/s/
Daniel Barbee, MBA, BSN, RN, FACHE
Chief Executive Officer

Date

/s/
Robert Smith, MD, PhD
Chair, Department of Psychiatry

Date

/s/
Stephanie Calmes, Ph.D., LPCC-S, LICDC-CS
Administrative Director

Date

Review/Revision Completed by:
Department of Psychiatry Administration

Policies Superseded by this Policy:

- ***ODMH-CR-105***

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