



Health Identification and Planning System (HIPS) Action Plan

Name:

DMH-ID Number:

Agency:

Service Coordinator:

Identified Completion Date of Action Plan:
(Unless otherwise indicated below with specific planned action)

Significant Findings Category 1 = IMMEDIATE Need (document action taken) Category 2= ESSENTIAL Need	Action Taken &/or To Be Taken	Completion S.C. Date/Initial
1. *Category: Circle One 1 2	1. Responsible Person:	
2. *Category: Circle One 1 2	2. Responsible Person:	
3. *Category: Circle One 1 2	3. Responsible Person:	
4. *Category: Circle One 1 2	4. Responsible Person:	

5.	5.	
*Category: Circle One 1 2	Responsible Person:	

Additional Comments	

QE RN Signature for Action Plan Significant Findings: _____ **Action Plan Significant Findings Report Date:** _____

Findings Provided to:

Name & Title	Date

Signatures for Completion of HIPS Action Plan:

_____ **Provider Representative Signature** _____ **Date**

_____ **Service Coordinator** _____ **Date** _____ **Quality Enhancement RN** _____ **Date**

Entered into APTS: Initials_____