Care Coordination

FAMILY RECORD

FOR

_____

"Begin with the end in mind!"

My Family Vision is:

_____

_____

_____

Care Coordination Family Record ("CCFR")

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Note: This document does not contain all of the required and optional Care Coordination forms – including the Care Coordination "Referral Form" and the [Optional] "CC POC Supplement Worksheet", which are available as separate documents.

The TANF Eligibility Form, PSDCRS database Forms, and Ohio Scales (which are not part of the CCFR) may be found at: http://www.ct.gov/dcf/cwp/view.asp?a=3588&Q=441272&PM=1

Refer to the "CCFR Instruction Manual" for instructions in the use of the CCFR.

Youth Name: _____

FAMILY STORY

_____
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INITIAL FAMILY VISION (In the Family's Own Words): _____
_____
_____
_____

Care Coordinator Signature: _____ Date: _____

Care Coordination
REACTIVE CRISIS/SAFETY PLAN

Youth Name: _____ Age: _____ Date: _____

What is your family's definition of crisis?

_____

_____

What are potential risk factors/triggers for your youth/family?

_____

_____

What are your family's strengths that can be utilized during a crisis?

_____

_____

_____

What helps you (parent/caregiver) during a crisis?

_____

_____

_____

Family's natural and community supports with contact Info:

_____

_____

_____

_____

List the steps to be **taken during a crisis** (List in order of least intrusive to most):

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Parent/Guardian Signature: _____ Date: _____

Youth Signature: _____ Date: _____

Care Coordinator Signature: _____ Date: _____

To contact Emergency Mobile Psychiatric Services (EMPS) 24 hours per day 7 days per week: CALL "2-1-1"

CARE COORDINATION ENROLLMENT CHECKLIST

Youth Name: _____

- ❑ _____Discussed Care Coordination & Wraparound Process
  (Date)
- ❑ _____Discussed Child and Family Team Meeting Process
- ❑ _____Discussed and/or Referred Family to FAVOR
- ❑ _____Confidentiality
- ❑ _____Mandated Reporting Requirements
- ❑ _____Grievance Process
- ❑ _____Local Community Collaborative Information Given
- ❑ _____Initial OHIO Scales Completed
- ❑ _____Releases Completed and Signed
- ❑ _____TANF Eligibility Determination Form Completed
- ❑ _____Enrollment Form (PSDCRS Data forms) Completed
- ❑ _____Obtain/Review/Develop Crisis Plan
- ❑ _____Follow up Appointments Scheduled
- ❑ _____Date for Initial Child and Family Team Meeting Set
  Meeting Date: _____
  Location: _____
  Time: _____
- ❑ _____Other _____

Care Coordinator Signature: _____
Date: _____

STRENGTHS DISCOVERY

Functional Strengths to help meet the Family's Needs

(Life Domains: Family/Home Environment, Social/Recreational, School/Work, Mental/ Behavioral Health, Cultural/Spiritual, Legal, Medical, Other – *continue on back if needed.*)

Youth:_____

_____

_____

_____

_____

Siblings:_____

_____

_____

_____

_____

Parent/Guardian: _____

_____

_____

_____

_____

Family/Kin:_____

_____

_____

_____

_____

Community: _____

_____

_____

_____

_____

Potential Team Members: _____

_____

_____

_____

_____

Youth Name: _____

Care Coordinator Signature: _____

Date: _____

NEEDS DISCOVERY

Identifying Needs and Barriers to Achieving Family Vision

(Life Domains: Family/Home Environment, Social/Recreational, School/Work, Mental/ Behavioral Health, Cultural/Spiritual, Legal, Medical, Other – *continue on back if needed.*)

Youth:_____

_____

_____

_____

_____

Siblings:_____

_____

_____

_____

Parent/Guardian:_____

_____

_____

_____

Family/Kin:_____

_____

_____

_____

Community:_____

_____

_____

_____

PRIORITY NEEDS (As Stated by the Family):_____

_____

_____

_____

_____

SAFETY NEEDS (To Inform the Reactive/Proactive Plans):_____

_____

_____

_____

Youth Name: _____

Care Coordinator Signature: _____

Date: _____

PRE-CFT CHECKLIST

Youth Name: _____

- ❑ _____ Enrollment Checklist / Items Completed
  (Date)
- ❑ _____ Family Story and Initial Vision Completed
- ❑ _____ Strengths Discovery Completed
- ❑ _____ Needs Discovery Completed
- ❑ _____ Potential Team Members Identified with Family
- ❑ _____ Team Meeting Date/Time/Location Set by Family
  Meeting Date: _____
  Time: _____
  Location: _____
- ❑ _____ Team Members Contacted Re: Purpose/ Process
  _____
  _____
  _____
- ❑ _____ Other _____

Notes:_____
_____
_____
_____
_____
_____

Care Coordinator Signature: _____

Date: _____

CHILD & FAMILY TEAM MEETING PARTICIPATION & PRIVACY AGREEMENT

Youth Name: _____ Date of CFT: _____

I understand that the information shared in today's Child & Family Team meeting is personal and private. I agree not to share this information outside the team meeting and not to talk about what happens at the team meeting with people who are not part of the Child & Family Team.

Print Name	Phone	Role/Position
Signature	Address/Email	
Print Name	Phone	Role/Position
Signature	Address/Email	
Print Name	Phone	Role/Position
Signature	Address/Email	
Print Name	Phone	Role/Position
Signature	Address/Email	
Print Name	Phone	Role/Position
Signature	Address/Email	
Print Name	Phone	Role/Position
Signature	Address/Email	

CHILD & FAMILY TEAM MEETING
NOTES FOR PLAN OF CARE

Youth Name: _____

Family Vision: _____
_____
_____
_____
_____

Functional Strengths: _____
_____
_____
_____
_____
_____
_____

Updates: _____
_____
_____
_____
_____
_____
_____
_____

New Team Members Identified: _____
_____
_____
_____
_____
_____

Next Meeting Date/Time/Location: _____
_____
_____

Youth Name: _____

CHILD & FAMILY TEAM MEETING ASSIGNMENT WORKSHEET

Need #	WHO will help?	WHAT will they do to help?	WHEN will they begin/end?

CARE COORDINATION PLAN OF CARE (POC)

Youth Name:		DOB:
Enrollment Date:	POC Date:	POC #

Who is on the Child and Family Team (present or not)?

Name:	Relationship:	Formal/Informal Support:	Phone:

What are the Functional Strengths?

Youth:

Siblings:

Parent/Guardian:

Family/Kin:

Community:

Team:

Youth Name: _____

Our family vision is . . .

_____

SAFETY NEEDS / PROACTIVE SAFETY PLAN

What are the identified Safety Needs?

Start Date: Target Date:

Domain(s):

What are the Team and Community Strengths to help meet this need?

What strength-based strategies will help to meet this need? Who is responsible?

1) Strategy:
Person Responsible:

2) Strategy:
Person Responsible:

3) Strategy:
Person Responsible:

4) Strategy:
Person Responsible:

Progress Toward Meeting Need (1=no progress/5=need met):
Date Need Met:
Updates/Notes:

Youth Name: _____

Our family vision is . . .

_____

OTHER NEEDS (make additional copies of this page as needed)

What is an identified need to reach the family vision?

Start Date: Target Date:

Domain(s):

What are the Team and Community Strengths to help meet this need?

What strength-based strategies will help to meet this need? Who is responsible?

1) Strategy:
Person Responsible:

2) Strategy:
Person Responsible:

3) Strategy:
Person Responsible:

4) Strategy:
Person Responsible:

Progress Toward Meeting Need (1=no progress/5=need met):
Date Need Met:
Updates/Notes:

Youth Name: _____

Our family vision is . . .

_____

OTHER NEEDS (final page with signatures)

What is an identified need to reach the family vision?

Start Date: Target Date:

Domain(s):

What are the Team and Community Strengths to help meet this need?

What strength-based strategies will help to meet this need? Who is responsible?

1) Strategy:
Person Responsible:

2) Strategy:
Person Responsible:

3) Strategy:
Person Responsible:

4) Strategy:
Person Responsible:

Progress Toward Meeting Need (1=no progress/5=need met):
Date Need Met:
Updates/Notes:

_____ _____
Parent/Guardian Signature Care Coordinator Signature

_____ _____
Youth Signature Supervisor Signature

Date _____

CARE COORDINATION DIS-ENROLLMENT CHECKLIST

Youth Name: _____

- ❑ _____ Discussed Dis-Enrollment at CFT
  (Date)
- ❑ _____ Final Plan of Care Completed & Reviewed
- ❑ _____ Final Plan of Care distributed to Team members
- ❑ _____ Review/Update Crisis/Safety Plan
- ❑ _____ Copies of Important Documents given to Family
- ❑ _____ Local Community Collaborative Information Given
- ❑ _____ OHIO Scales Completed
- ❑ _____ Verification of Flex Funds Form (if applicable)
- ❑ _____ Follow-Up CFT Meeting Set (if appropriate)
  Meeting Date/Time: _____
  Location: _____
  Facilitator: _____
- ❑ _____ PSDCRS Database "Discharge Worksheet" completed
- ❑ _____ Satisfaction Survey given to family to complete
- ❑ _____ Other: _____

Care Coordinator Signature: _____

Date: _____