

ICC/IHBS Child and Family Team (CFT) Client Care Plan and Meeting Minutes

Section A

Client Name:		Meeting Date	Next Meeting Date			
Intensive Care Coordinator	CFT Facilitator		Provider Agency			
Most recent CANS completion date:						
As of meeting date, does client meet Katie A. Subclass/ICC criteria?			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Team Members Present		Relationship		Phone and/or Email		

The ICC Coordinator will distribute a copy of the completed Client Care Plan to the participants listed above. Each provider must save an electronic copy of the Client Care Plan in the client's chart.

Section B

HOPE STATEMENT – YOUTH AND FAMILY GOAL/DESIRED OUTCOME

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STRENGTHS: What strengths in the child/youth (or caregiver) help inform a strengths-based approach? What are the protective factors? Highlight actionable items. (Minimum 2)

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CHALLENGES - What areas of a child/youth's life are impacted (e.g. family, social, community and academic) as a result of the client's behaviors and symptoms? Highlight actionable needs. (Minimum 2)

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PREVIOUS TASK REVIEW

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REFER FOR IHBS:	
<input type="checkbox"/>	Team discussed eligibility to receive IHBS, current needs and timing of adding IHBS
<input type="checkbox"/>	IHBS being provided
<input type="checkbox"/>	Client and family have declined IHBS at this time. Team to reassess, as needed
<input type="checkbox"/>	Referral not needed at this time
<input type="checkbox"/>	Referral to be submitted. List behaviors to be addressed:

SAFETY/RISK: A separate Safety Plan is required if there is a significant risk/concern in past 90 days

DISCUSSION ITEMS: Specific agenda items gathered from team members. This may include brainstorming, decision-making, and key discussion points.

Specify who else client or family would want at NEXT CFT Meeting

Section C: Goals reviewed during CFT Meeting

Area of Need Social, Education, Vocation, Physical or Mental Health, Independent Living, etc.	Does it require a change to CANS action item?		Goals/Objectives to address need (must be measurable)	Date Added to Plan	Task to address need Next steps	Who/When	Progress Status Completed, New, or In-Progress
	Yes	No					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>					

Transition Plan from ICC/IHBS Services (Please be specific)	
Anticipated Discharge Date	

Section D Indicate if the following are coordinated with this Client Care Plan

PROBLEM LIST / SERVICE PLAN	Yes	No	N/A	If No, explanation:
Problem List(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CANS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child Welfare Case Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Education (e.g. IEP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Probation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	