CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

# Child and Family Team Meeting Action Plan – Client Plan of Care

Client Name

Date of Meeting

Did client attend meeting? ☐ Yes ☐ No ☐ Under age 5; did not attend  Did client participate in plan creation? ☐ Yes ☐ No ☐ No; under age 5

Intensive Care Coordinator: _____  Caregiver: _____

Does client have an open Child Welfare care? ☐ Yes ☐ No  If so, name of CFS Social Worker: _____

List of Participants:

☐ **Participants were informed of confidentiality requirements and agreed to privacy and confidentiality.**

| **Family Visions and Hopes:** |
| --- |
| |
| **What is working well?** |
| |
| **What are your worries and needs?** |
| |

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| IHBS Referral Determination: | | | |
|---|---|---|---|
| ☐ Yes, team discussed eligibility to receive IHBS, current needs and timing of adding IHBS.<br>☐ Yes, IHBS being provided or ☐ Referral to be submitted or ☐ not needed at this time.<br>☐ Youth and family have declined IHBS at this time. Team to reassess as needed. | | | |
| **Objectives/Goals** | **What needs to happen next?** | **Who makes it happen?** | **Progress** |
| | | | Completed: _____ |
| | | | Completed: _____ |
| | | | Completed: _____ |
| | | | Completed: _____ |
| | | | Completed: _____ |

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| How does this action plan support the child/youth's treatment goals? |
|---|
| |
| **How does this plan support the child/youth's increased health and wellbeing?** |
| |
| **Transition Plan (When the client has achieved goals and transitioning out of services.)** |
| |
| **Date and time of follow-up CFT Meeting:** _____ **Location:** _____ |