**** **Initial** **Subsequent CFT meeting**

COUNTY OF ORANGE

**CHILD AND FAMILY TEAM (CFT) PLAN**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Time:** | | | **Location:** | | | | | |
| **Facilitator:** | | **Coordinator:** | | | | | | **Language:** | |
| **Child/Non-Minor Dependent (NMD) Name:** | | | **Child/NMD DOB:** | | | **Child’s CWS 19 digit number:** | | | **DL Number:** |
| **Other Associated Child(ren) and DOB(s):** | | | | | | | | | |
| **Parent/Guardian:** | | | | | **Caregiver:** | | | | |
| **Social Worker:** | | | | | | | **Social Worker Phone:** | | |
| **Deputy Probation Officer:** | | | | | | | **DPO Phone:** | | |
| **Educational Liaison:** | | | | | | | **Liaison Phone:** | | |

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| **Mental Health Info *(If Applicable)*** | | | | | | | |
| **Provider Name:** | |  |  | **Agency:** |  | |  |
| **Address:** |  | |  | **Phone Number:** | |  |  |
| **Pathways to Well-Being (Katie A.) Eligibility Status:**  Eligible No Longer Eligible Referred/Awaiting Assessment Not Applicable | | | | | | | |
| **Check all interventions that apply:**  Intensive Care Coordination (ICC)  Pathways to Well-Being Child and Family Team  Intensive Home-Based Service (IHBS)  Short Term Residential Therapeutic Program (STRTP)  Therapeutic Foster Care (TFC)  Other: | | | | | | | |
| **For children placed in out-of-home care:**  Court Authorization obtained for the sharing of the child’s mental health information with the parent(s)/guardian(s) | | | | | | | |
| Identified Goal (Permanency Plan) / Safety Plan/Family Vision: | | | | | | | |
|  | | | | | | | |
| Identified Placement Plan: | | | | | | | |
| If recommending step-up or down from a Short-Term Residential Therapeutic Program (STRTP) placement, complete and attach *Inter-Agency Placement Committee Referral for STRTP Placement (F063-25-807)*. | | | | | | | |

**Future Communication:** Schedule next CFT meeting to occur no later than 180 days, prior to updating case plan.

*Exception*: If child/NMD is receiving ICC/IHBS/TFC, schedule next CFT meeting to occur in 90 days or less.

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| **Select topic areas for CFT meeting** | | |
| Safety/Risk  Visitation/Trial Visit  Money Matters  Fun/Recreational  Cultural/Spiritual  Reunification Barriers/Permanency | Placement  Emotional/Behavioral  Housing/Living Environment  Health/Medical  Presumptive Transfer | Family/Social Relationships  School/Educational  Social Relationships  Work/Vocational  Other |

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| *Recommended Supports and Services  (To achieve permanency and enable the child(ren) to be placed in the least restrictive family setting)* | | |
| **Provider/ Responsible Party** | Service | Status (New, Pending, Existing, Changed) |
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| **Safety/Action Steps** | | |
| **Who?** | What? | When? |
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**SIGNATURE PAGE**

By my signature below, I acknowledge that I participated in the Child and Family Team (CFT) meeting to provide input into the development of a child/NMD and family plan, the placement decisions made by the Placing Agency, and the services to be provided in order to support the child(ren)/NMD. I understand that I will receive a copy of this CFT Plan, that in certain circumstances the CFT plan may be changed by the Placing Agency, and that I will be informed of such changes. Further, I was informed of the provisions of Welfare and Institutions Code section (§) 832 that information exchanged among the CFT is confidential and may not be further disclosed except to the Juvenile Court or as otherwise required by law. Civil and criminal penalties may apply to the inappropriate disclosure of information held by the CFT.

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| Invitee Name (Print)/ **Signature** | | Relationship | Contact | Present | Not present, but provided input |
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*This page is available for optional use, and is not required to be completed.*

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| **Strengths (What is working well?)** |
|  |
| **Issues (What are the worries? What’s not working?)** |
|  |
| **Youth’s Action Plan** |
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