Plan of Care

Youth Name (First, MI, Last):		**Enrollment Date:**	**Date of CFT:** **Date POC written:**
Guardian Name:	**DOB:**	**Phone:**	**Address:**
CFT Meeting Type: ☐ Initial ☐ Review ☐ Emergency ☐ Discharge		**Initial CFT Date:**	**Target Disenrollment Date**:
Assigned Care Coordinator:			
Authorized Level of Service (I, II, III): ____		**Authorized 1915(i):** ☐ Yes ☐ No	
Vision/Mission/Strengths			
Family Vision:			
Progress Towards Family Vision (Scale 1-5):			
Team Mission:			
Successes for the Month:			
List Strengths of Each CFT Member:			

Diagnosis *(ICD-10 Code and Name)*:

Medications *(Name, Dose, Frequency/Time)***:**
(See Contact Notes for details regarding medication changes between CFT Meetings)

Brief History:

Triggers:

Potential Crises *(include reason for referral, if applicable)***:**

Action Steps for home, school, community, etc.:

Person's Responsible and phone numbers:

-
-
-
- Assigned Care Coordinator Phone: _____
- Local Crisis and/or Police Department Phone: _____

Crisis Plan Review (note areas updated in most recent review)**:**

Needs Statements/Strategies			
Needs Statement: **1**			Date need introduced: Date expected to be achieved:
Desired Outcome:			
Progress Towards Outcome	**Baseline:**	**Current:**	

Life Domain Area of Need:

☐ Family ☐ Social ☐ Residence ☐ Education/Vocation ☐ Medical ☐ Community ☐ Psychological/Emotional/Behavioral ☐ Safety

Brainstorming & Discussion:

Strategies (Intervention Codes: Achieved-A; Changed-C; Discontinued-D; Ongoing-O)

1.
2.
3.
4.

For 1915(i) referrals & participants

a. description of 1915(i) service:
b. service start date:
c. estimated duration:
d. frequency and units of service:
e. specific need or goal that service is related to:
f. provider name(s) and contact info:

Medical Needs/Follow-Up

Primary Care Physician: _____ Last Attended Appointment: _____
Address: _____ Next Scheduled Appointment: _____
Phone: _____ Required Follow-Up: _____
Identified supports (i.e., transportation, reminders, etc.): _____
_____

Dental: _____ Last Attended Appointment: _____
Address: _____ Next Scheduled Appointment: _____
Phone: _____ Required Follow-Up: _____
Identified supports (i.e., transportation, reminders, etc.): _____
_____

Vision: _____ Last Attended Appointment: _____
Address: _____ Next Scheduled Appointment: _____
Phone: _____ Required Follow-Up: _____
Identified supports (i.e., transportation, reminders, etc.): _____
_____

Hearing: _____ Last Attended Appointment: _____
Address: _____ Next Scheduled Appointment: _____
Phone: _____ Required Follow-Up: _____
Identified supports (i.e., transportation, reminders, etc.): _____
_____

Other Heath Care Provider: _____ Last Attended Appointment: _____
Address: _____ Next Scheduled Appointment: _____
Phone: _____ Required Follow-Up: _____
Identified supports (i.e., transportation, reminders, etc.): _____
_____

Immunizations Up to Date: ☐ Yes ☐ No
Miscellaneous Appointments attended since last CFT (includes hospital visits, unplanned medical appointments, urgent patient care clinics, etc.): _____
_____
_____

Team Members/Resources

Support Name	Contact and Organization	Role	Present for Meeting

Review/Signature(s):
By signing, I confirm that I participated in the development of this POC and had a choice in the selection of services, providers and interventions, when possible, in the care coordination process of building the POC.

Next CFT Date:

Youth Signature:	Date:
Parent/Guardian Signature:	Date:
Care Coordinator Signature:	Date:
Supervisor Signature:	Date: