Child and Family Team Care Plan

Specialty Services: **(Indicate which service the client will be/is receiving)**

- ☐ Intensive Care Coordination
- ☐ Intensive Home-Based Service
- ☐ Therapeutic Behavioral Services
- ☐ Therapeutic Foster Care

Date of CFT:

CFT Participants (Name and role on team):

Follow up on action plans from previous CFT meeting:

Family and client strengths:

Family and client driven plan:

Identified needs: (include CANS items rated 2/3, describe needs the client and family team would like to focus on, describe changes in needs since last CFT)

Client Name: MR#:

Action plan and next steps: (include which person(s) is/are responsible for next steps and each part of the action plan)

Step Down Plan for end stages of IHBS and TBS: (note amount of decrease in service hours)

Next CFT meeting date/time:

Client Name: MR#: