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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **FAMILY SUPPORT TEAM MEETING** | | | | |
| Family Name: | |  | | Date: |  |
| CONFIDENTIALITY STATEMENT: We the undersigned are participants in the FSTM for the | | |  | | |
| family. We understand we have the family’s permission to share information here today that will help the family meet their goals. We also understand and agree to keep this information confidential pursuant to the confidentiality laws and policies of the State of Missouri. This form should be signed by all participants at the beginning of the meeting. At the conclusion of the meeting, participants should indicate whether or not they agree with the plan by checking yes or no in the appropriate box. | | | | | |

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| **Participant Invited** | | | | | **Relationship to Family** | | | **\*Agree with Plan?** | | | **Signature Signifying Attendance and Agreement with Confidentiality Statement** | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
|  | | | | |  | | | Yes  No | | |  | | | | |
| \*If indicated do not agree with the case plan, specifically state the nature of disagreement: | | | | | | | | | | | | | | | |
| Participant’s Name | | | | Nature of Disagreement | | | | | | | | | | | |
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| **Date/Time of Next Meeting** | | | | | | | **Location of Next Meeting** | | | | | | | | |
| Family Name: | |  | | | | | | | | | | | Date: | |  |
| **TYPE OF MEETING:** | | | | | | | | | | | | | | | |
| 24 Hour 30 Day 60 Day90 Day 6 Month/PPRTReview Progress  Placement ChangeGoal Change Revise Service Agreement At the parent’s request | | | | | | | | | | | | | | | |
| Other: |  | | | | | | | | | | |  | | | |
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| **PURPOSE OF MEETING** | | | | | | | **GROUND RULES** | | | | | | | | |
| Assessing safety of the child | | | | | | | Be respectful of each other | | | | | | | | |
| Determine if the child can be reunited | | | | | | | One person speaks at a time | | | | | | | | |
| Discuss case goal and need for permanency | | | | | | | Focus on the purpose | | | | | | | | |
| Determine service and treatment needs | | | | | | | Everyone has a chance to speak and be heard | | | | | | | | |
| Review placement options and appropriateness | | | | | | | It is ok to disagree | | | | | | | | |
| Develop/Review/Revise case plan | | | | | | | Speak to each other, not about each other | | | | | | | | |
| Evaluate case progress | | | | | | | Encourage honesty without blaming or shaming | | | | | | | | |
| Review of services needed/in place | | | | | | | No idea is a bad idea | | | | | | | | |
| Develop/Review visitation plan | | | | | | | Ideas should not be judged | | | | | | | | |
| *Adoption and Safe Families Act* discussed. | | | | | | | | | | | | | | | |
| *Indian Child Welfare Act* | | | | | | | | | | | | | | | |
| * Does the child have Indian Ancestry?  Yes  No | | | | | | | | | | | | | | | |
| **Reason for Removal/Identified Threats of Danger:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **SUMMARY OF PROGRESS** | | | | | | | | | | | | | | | |
| **Child Education:** | | | | | | | | | | | | | | | |
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| **Child Health/Mental Health/Child Vulnerability:** | | | | | | | | | | | | | | | |
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| **Parents’ Health/Mental Health/Caregiver Protective Capacity:** | | | | | | | | | | | | | | | |
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| **Special Needs of the Family (if applicable):** | | | | | | | | | | | | | | | |
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| **Diligent Search (absent parent, relatives, kin):** | | | | | | | | | | | | | | | |
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| **Resource Provider Update:** | | | | | | | | | | | | | | | |
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| **Progress/Services/Treatment Needs Necessary to Achieve Permanency:** | | | | | | | | | | | | | | | |
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| **Written Service Agreement:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Review of Court Orders:** | | | | | | | | | | | | | | | |
| **VISITATION RECOMMENDATIONS:** | | | | | | | | | | | | | | | |
| **Who Will Visit** | | | **Supervised**  **Yes/No** | | | **If Supervised**  **by Whom** | | | | **Frequency/Duration/Location** | | | | | |
| Parent #1 | | | Yes  No | | |  | | | |  | | | | | |
| Parent #2 | | | Yes  No | | |  | | | |  | | | | | |
| Sibling | | | Yes  No | | |  | | | |  | | | | | |
| Other: | | | Yes  No | | |  | | | |  | | | | | |
| **PERMANENCY PLAN:** | | | | | | | | | | | | | | | |
| Reunification Adoption Guardianship  Placement with Fit and Willing Relative  Another Planned Permanent Living Arrangement | | | | | | | | | | | | | | | |
| **CONCURRENT PLAN:** | | | | | | | | | | | | | | | |
| Adoption Guardianship Placement with Fit and Willing Relative  Another Planned Permanent Living Arrangement | | | | | | | | | | | | | | | |
| **RECOMMENDATIONS:** | | | | | | | | | | | | | | | |
| **The child will remain in alternative care with the following provider:** | | | | | | | | |  | | | | | | |
| **The child will return home on a Trial Home Visit with**  Mother /  Father /  Other | | | | | | | | | | | | | |  | |
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| **RESIDENTIAL REAUTHORIZATION ATTACHMENT** | | | | | | |
| **REASON FOR RESIDENTIAL PLACEMENT** (List specific behaviors that lead to residential placement): | | | | | | |
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| **LIST SPECIFIC SERVICES IN PLACE:** | | | | | | |
|  | | | | | | |
| **SERVICE** | | | | | **FREQUENCY (weekly, bi-weekly, monthly)** | |
| Individual Therapy | | | | |  | |
| Family Therapy | | | | |  | |
| Group Therapy – List specific group participation: | | | | |  | |
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| Art Therapy | | | | |  | |
| Substance Abuse Treatment | | | | |  | |
| Sexual Offender Services | | | | |  | |
| Other | | | | |  | |
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| The FST should be choosing the services/therapies the child is involved in to ensure they are directly relating to the problem/reason for referral. | | | | | | |
| Are the services in place still necessary to address the problem/reason for referral? YesNo | | | | | | |
| **RFA Payment Level** | | | | | | |
| Level IILevel IIILevel IVLevel IV+ | | | | | | |
| Is the child receiving the correct amount of services for the payment level? YesNo  Level II – services one time per week  Level III – services six times per month  Level IV – services twice per week | | | | | | |
| CSPI score:­­­­ | |  |  | | | |
| Rehab Begin Date in FACES: | | |  | | |  |