



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 CHILDREN'S DIVISION
72 HOUR 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.

Participant Invited	Relationship to Family	*Agree with Plan?	Signature Signifying Attendance and Agreement with Confidentiality Statement
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
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		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

*If indicated do not agree with the case plan, specifically state the nature of disagreement:

Participant's Name	Nature of Disagreement

Date/Time of Next Meeting	Location of Next Meeting
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Family Name _____

Date _____

Adoption and Safe Families Act Explained

Indian Child Welfare Act

- Does the child have Indian Ancestry? Yes No

Reason for Removal/Identified Threats of Danger:

PROGRESS NOTES:

Child Education:

Child Health/Mental Health/Child Vulnerability:

Parents' Health/Mental Health/Caregiver Protective Capacity:

Special Needs of the Family (if applicable):

Diligent Search (absent parent, relatives, kin):

Family Name _____

Date _____

Resource Provider:

Services/Treatment Needs:

Review of Court Orderg:

VISITATION RECOMMENDATIONS:

Who Will Visit	Supervised Yes/No	If Supervised by Whom	Frequency/Duration/Location
<input type="checkbox"/> Parent 1	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Parent 2	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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 _____
- An Intensive In-Home Services (IIS) referral will be made.

Task	Who will do task?	Timeframe