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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **FAMILY SUPPORT TEAM MEETING** | | | | | | | | | | |
| Type of FST: | |  | | | | | Date of FST: | | |  | |
|  | | | | | | | | | | | |
| SIGN IN/CONFIDENTIALITY STATEMENT | | | | | | | | | | | |
| CONFIDENTIALITY STATEMENT: We the undersigned are participants in the FSTM for the | | | | | | | | |  | | family. |
| We understand the family’s confidential information will be discussed here today and agree to keep this information confidential in accordance with applicable laws and the Department’s Privacy Practices. A copy of the Department’s Privacy Practices will be provided to you upon request, or can be found at <http://dss.mo.gov/hipaa/>. | | | | | | | | | | | |
| INFORMED CONSENT: Children’s Division, as legal custodian for children in state custody, is primarily responsible for giving or denying informed consent for medical treatment to include prescription of psychotropic medication.   * Any member of the Family Support Team has the right to ask to be named as the person responsible for informed consent for a child regarding their medical care, to include psychotropic medications. * The Children’s Division may ask the team member to put the request in writing, along with reasons to support that request. * The Children’s Division will, when allowed to do so by the Court, inform the Court of this request and ask that the team member be given an opportunity to be heard. * The Children's Division does not have to support the request, if it does not appear to be in the children’s best interest, but will inform the Court and the parties about the request. | | | | | | | | | | | |
| At the beginning of the meeting, this form should be signed by all participants.  At the conclusion of the meeting, all participants should indicate whether they agree with the plan or not by checking yes or no. | | | | | | | | | | | |
| Attendee | | | | 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 | |  | | | |
| \*If indicated do not agree with the case plan, specifically state the nature of disagreement: | | | | | | | | | | | |
| Participants Name | | | Nature of disagreement | | | | | | | | |
|  | | |  | | | | | | | | |
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| Date/Time of Next Meeting:       -      - | | | | | Location of Meeting: | | | | | | |
| Recommended Case Goal: | | | | | | | | | | | |
| Recommended Concurrent Goal: | | | | | | | | | | | |
| Visitation Plan: | | | | | | | | | | | |
| Agreed upon services for permanency: | | | | | | | | | | | |
| Current Placement: | | | | | | | | | | | |
| Recommended Placement: | | | | | | | | | | | |