This form must be completed and sent to the SSW by the 15th of each month.

MONTH ENDING 4-30-09

DCBS CASE MANAGER Sue Seenitall

CHILD NAME: Ben A. Kidd DOB: 4-7-93

SSN NUMBER:111-22-3333 PROVIDER/ FACILITY: A GOOD HOME

Date of Current DPP-1293 Approval: 2/5/09

Date of Next Six Month Review: 8/5/09

**TREATMENT SUMMARY:**

OVERALL GOALS/OBJECTIVES OF REHABILITATIVE SERVICES PLAN:

DPP-1293 in development

Remains the same as described in the rehabilitative services plan of care, DPP-1293

Have been changed as indicated on the attached revised DPP-1293

* Reference the **DPP-1293-Rehabilitative Services Plan of Care Approval Form** to complete the following sections.

PROGRESS NOTES:

1. **TREATMENT PLANNING AND SUPPORT-** Describe representative treatment planning and support activities performed over the last month in support of the goals and objectives of the rehabilitative services plan of care:

* Information should be relative to the goals and objectives of the DPP-1293.

**DATE**- Indicates the date a particular service was provided; more than one date can be used if service occurred more than one time.

**PROVIDER-** Indicates the provider of the service. Eg: If the case manager made visit to the foster home then provider would be PCC.

**DESCRIPTION-** Provide a description of the service and document how it relates to the goals and objectives. Eg: Case manager conducted face to face visit with foster parents and youth. Youth is doing well at Elmwood High School as evidenced by his progress report. Foster parents report no issues with the current weekend visitation with birth mother. Youth stated that visits are going ok, but he continues to struggle with avoiding the old friends with whom he got in trouble.

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1. **LIVING SKILLS DEVELOPMENT -** Describe representative skills training and development activities performed over the last month in support of the goals and objectives of the rehabilitative services plan of care:

* **DESCRIPTION-**  List examples of skills training and activities that youth has performed or observed in the previous 30 days that support the goals and objectives of the plan. Eg: Youth cleaned his room, attended a 30 minute session at the health dept on eating healthy, and worked with foster mother to plan menu for the week and created a shopping list.

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1. **THERAPY, EVALUATION AND ASSESSMENT-** Describe Counseling, Therapy, Evaluation and Assessment activities performed over the last month in support of the goals and objectives of the rehabilitative services plan of care:

* Information should be relative to the goals and objectives of the DPP-1293.

**DATE**- Indicates the date a particular service was provided; more than one date can be used if service occurred more than one time.

**PROVIDER-** Indicates the provider of the service. Eg: If therapy is provided by the PCC the Provider would be the PCC. However, If a specialty therapy is needed and is provided by an outside resource such as the local Comprehensive Care Center (CCC), then the CCC would be listed as the provider.

**DESCRIPTION-** Provide a description of the service and document how it relates to the goals and objectives. Eg: Youth participated in 3 group counseling sessions related to his diagnosis of Oppositional Defiance Disorder (ODD). He attended one individual counseling session to address issues related to past physical abuse. Dr. Better recommends increasing individual therapy to twice monthly to address youth’s adjustment back into his old neighborhood setting.

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**CASE STATUS SUMMARY**

1. SUMMARIZE CHILD’S/YOUTH’S ADJUSTMENT TO FACILITY:

* Document both foster parent’s and youth’s statements on how youth is adjusting. Give specific examples. Eg: Foster Parents state that youth has adjusted to their house well. He completes chores with little prompting and participates in family conversations at the dinner table. Youth states he likes the foster home but that the curfew and obtaining consequences when he breaks a rule, is frustrating. Youth states he does not think it is fair that he lost his computer time for being caught on the computer after 9:00pm.

1. SERVICES PROVIDED TO CHILD/YOUTH AND CHILD’S/YOUTH’S FAMILY:

* Document what services are being provided to family. Include who, what, when, how. Eg: 4/04, 4/28 PCC therapist provided two family counseling sessions with youth, birth mother and brother. Discussion of what boundaries mother needs to set when youth is on home visits. Youth made list of activities he could do instead of hanging out with his old friends. Discussion about how altercations between youth and sibling would be handled and youth was reminded that any serious infractions could result in home visit being terminated early.

1. PROGRESS TOWARD RETURN OF CHILD/YOUTH TO THE HOME OR COMMUNITY (IF APPLICABLE):

* Document any efforts or progress to return child home if return is the permanency plan. Eg: Youth continues to have weekend, overnight visitation with birth mother. Issues around youth returning to neighborhood with his old friends are still being discussed in therapy. Youth has obtained information about sports teams and YMCA activities that could possibly fill some of his time with when he returns home.

1. PERMANENCY GOAL FOR CHILD/YOUTH:

* Document permanency goal per permanency plan. Eg: Return to parent.

NAME AND TITLE OF PERSON COMPLETING FORM:

(PLEASE PRINT)

SIGNATURE:

SUPERVISOR’S NAME AND SIGNATURE (IF REQUIRED):

DISTRIBUTION: Original—Social Services Worker (case record), *may be faxed, mailed or e-mailed*

Copy—Facility / Provider File (if applicable)

* Form to be completed and sent to DCBS worker by **15th calendar day** of the month following the month of review. Eg: April review due to SSW by 5/15.
* Form can be mailed or faxed but should be received by SSW by 15th calendar day of the month.