

CARE PLAN

Name: _____ CHIF # _____ Child's DOB _____ CV/OV HV TV
 Primary Caregiver/Guardian (ie parent/grandparent/foster parent): _____ Date: _____ Initial Interim Final

Growth and Development

K 1 2 3 4 5 **B** 1 2 3 4 5 **S** 1 2 3 4 5 **Not Applicable or Unable to Address Today (circle one)**

Signs and Symptoms	Category	Target	Client Specific Information	Notes
<input type="checkbox"/> Abnormal results of developmental screening tests	S	Bonding/attachment	Parent/child interaction	
<input type="checkbox"/> Abnormal weight/height/head circumference in relation to growth/age standards	S	Growth/Devel. Care	Developmental tasks for age, developmental test scores	
<input type="checkbox"/> Age-inappropriate behavior	S	Rest/sleep	For age/condition, consistent patterns	
<input type="checkbox"/> Inadequate achievement/maintenance of developmental tasks	S	S/S physical	Physical growth/ variations	
<input type="checkbox"/> Other	S	S/S physical	Voiding and stooling	
	S	S/S mental/emotional	Behavior concerns	
	CM	S/S mental/emotional	Intervention programs for behavioral health	
	CM	S/S physical	HC provider, WIC, Lactation Consultant, community support group	
	CM	Growth/Devel. Care	Education/developmental resources	

Abuse

K 1 2 3 4 5 **B** 1 2 3 4 5 **S** 1 2 3 4 5 **Not Applicable or Unable to Address Today (circle one)**

<input type="checkbox"/> Harsh/excessive discipline	S	S/S mental/emotional	Behavioral extremes	
<input type="checkbox"/> Attacked verbally	S	S/S physical	Unexplained injuries; evidence of abuse	
<input type="checkbox"/> Welts/bruises/burns/questionable injuries				
<input type="checkbox"/> Fearful/hyper vigilant behavior				
<input type="checkbox"/> Violent environment				
<input type="checkbox"/> Consistent negative messages				
<input type="checkbox"/> Assaulted sexually				
<input type="checkbox"/> Other	CM	Legal system	Child Protective Services, Law enforcement	

Signature _____	County _____	Revised: 12/15/2010
-----------------	--------------	---------------------

CARE PLAN

Name: _____ CHIF # _____ Child's DOB _____ CV/OV HV TV
 Primary Caregiver/Guardian (ie parent/grandparent/foster parent): _____ Date: _____ Initial Interim Final

Neglect

	K	1	2	3	4	5	B	1	2	3	4	5	S	1	2	3	4	5	Not Applicable or Unable to Address Today (circle one)	
<input type="checkbox"/> Lacks adequate physical care							S						S/S physical						Hygiene, skin condition, medical/dental conditions	
<input type="checkbox"/> Lacks emotional support							S						S/S mental/emotional						Affect/behavior	
<input type="checkbox"/> Inappropriately left alone																				
<input type="checkbox"/> Inadequate/delayed medical care																				
<input type="checkbox"/> Lacks necessary supervision																				
<input type="checkbox"/> Other							CM						Legal system						Child Protective Services, Law enforcement	

Health Care Supervision

	K	1	2	3	4	5	B	1	2	3	4	5	S	1	2	3	4	5	Not Applicable or Unable to Address Today (circle one)	
<input type="checkbox"/> <i>Usually goes to a specific place or provider for medical treatment/advice when ill</i>							S						Continuity of care						Medical home/access to care	
<input type="checkbox"/> <i>Has a personal doctor/nurse that knows client well and is familiar with client's health history</i>							S						Medical/dental care						Follows/receives when scheduled	
<input type="checkbox"/> <i>Medical provider usually makes referrals and coordinates health services as needed.</i>							S						Wellness						Immunizations/routine preventive health care	
<input type="checkbox"/> Fails to obtain routine/preventive health care							S						Sickness/injury care						Follows/receives when needed	
<input type="checkbox"/> Fails to seek care for symptoms requiring evaluation/treatment							CM						Medical/dental care						Coordinate/schedule services	
<input type="checkbox"/> Fails to return as requested to health care provider							CM						Sickness/injury care						Refer to HC provider	
<input type="checkbox"/> Inability to coordinate multiple appointments/treatment plans																				
<input type="checkbox"/> Inconsistent source of health care																				
<input type="checkbox"/> Inadequate source of health care																				
<input type="checkbox"/> Inadequate treatment plan																				
<input type="checkbox"/> Other							CM						Medication coordination/ordering						Assistance accessing/obtaining medications	

Signature _____	County _____	Revised: 12/15/2010
-----------------	--------------	---------------------

CARE PLAN

Name: _____ CHIF # _____ Child's DOB _____ CV/OV HV TV
 Primary Caregiver/Guardian (ie parent/grandparent/foster parent): _____ Date: _____ Initial Interim Final

Income																				
	K	1	2	3	4	5	B	1	2	3	4	5	S	1	2	3	4	5	Not Applicable or Unable to Address Today (circle one)	
<input type="checkbox"/> Low/no income <input type="checkbox"/> Uninsured medical expenses <input type="checkbox"/> Difficulty with money management <input type="checkbox"/> Able to buy only necessities <input type="checkbox"/> Difficulty buying necessities <input type="checkbox"/> Other							S						Finances						Income vs expenses; use of available resources	
							S						Finances						Health insurance	
							S						Education						Access educational resources/Follows educational plan	
							TGC						Finances						Crisis intervention/short-range planning; budgeting; community resources	
							CM						Finances						All available resources: food bank, clothing bank, energy assistance	
							CM						Legal system						Office of Support Enforcement; Guardian; Free legal assistance	
							CM						Education						Educational options, Financial aid	

CARE PLAN

Name: _____ CHIF # _____ Child's DOB _____ CV/OV HV TV
 Primary Caregiver/Guardian (ie parent/grandparent/foster parent): _____ Date: _____ Initial Interim Final

Caretaking/Parenting																				
K	1	2	3	4	5	B	1	2	3	4	5	S	1	2	3	4	5	Not Applicable or Unable to Address Today (circle one)		
<input type="checkbox"/> Difficulty providing physical care/safety <input type="checkbox"/> Difficulty providing emotional nurturance <input type="checkbox"/> Difficulty providing cognitive learning experiences and activities <input type="checkbox"/> Difficulty providing preventive and therapeutic health care <input type="checkbox"/> Expectations incongruent with stage of growth and development <input type="checkbox"/> Dissatisfaction/difficulty with responsibilities <input type="checkbox"/> Difficulty interpreting or responding to verbal/non verbal communication <input type="checkbox"/> Neglectful or abusive <input type="checkbox"/> Other	S		Bonding/attachment															Mutual responsiveness; eye contact		
	S		Caretaking/parenting																Infant/child care	
	S		Growth/development																Realistic expectations	
	S		Safety																Appropriate supervision; presence of safety hazards, infant sleep, emergency/disaster plan in place	
	S		Legal system																Hx/status of legal issues e.g. paternity, incarceration, CPS	
	S		Discipline																Methods, appropriate for age/condition	
	S		Medication admin																Schedule, technique, safe medication storage	
	TGC		Bonding/attachment																Activities to promote	
	TGC		Caretaking/parenting																Infant/child care, feeding techniques, bathing & hygiene	
	TGC		Growth/development																Realistic expectations, toileting	
	TGC		Growth/development																Activities to promote optimal development	
	TGC		Safety																Car seats/seat belts, safe sleep, shaken baby, emergency/disaster plan in place	
	TGC		Medical/dental care																Preventive care	
	TGC		Day care/respite																How to choose, appropriate care givers	
	TGC		Discipline																Appropriate for age	
	TGC		Dietary Management																Food choices intake/supplements/solids/WIC	
	TGC		Medication admin																Method and dose	
	TGC		Stimulation/nurturance																Tummy time, age appropriate developmental information	
	CM		Caretaking/parenting																Parenting classes	
	CM		Safety																Car seat checks, CPR and first aid	
CM		Continuity of care																Coordination among providers		

Signature _____	County _____	Revised: 12/15/2010
-----------------	--------------	---------------------

CARE PLAN

Name: _____ CHIF # _____ Child's DOB _____ CV/OV HV TV
 Primary Caregiver/Guardian (ie parent/grandparent/foster parent): _____ Date: _____ Initial Interim Final

Communication with Community Resources

	K	1	2	3	4	5	B	1	2	3	4	5	S	1	2	3	4	5	Not Applicable or Unable to Address Today (circle one)		
<input type="checkbox"/> Unfamiliar with options/procedures for obtaining services <input type="checkbox"/> Difficulty understanding roles/regulations of service providers <input type="checkbox"/> Unable to communicate concerns to provider <input type="checkbox"/> Dissatisfaction with services <input type="checkbox"/> Language, cultural, educational, transportation barriers <input type="checkbox"/> Limited access to care/services/goods <input type="checkbox"/> Unable to use/has inadequate communication devices/equipment <input type="checkbox"/> Other							S						Communication						Ability to communicate with service providers/resources		
							S						Transportation						Availability and mode		
								TGC						Communication						Procedures to communicate with service providers/resources	
								TGC						Interpreter/translator services						Procedures to obtain services	
								CM						Other community resources						Culturally specific services and groups	
								CM						Legal assistance						Client advocacy related to refugee/immigration/documentation	
								CM						Transportation						Refer to transportation services	

Residence

	K	1	2	3	4	5	B	1	2	3	4	5	S	1	2	3	4	5	Not Applicable or Unable to Address Today (circle one)		
<input type="checkbox"/> Structurally unsound; inadequate heating/cooling <input type="checkbox"/> Steep unsafe stairs/inadequate/obstructed exits & entries <input type="checkbox"/> Cluttered living space <input type="checkbox"/> Unsafe storage of dangerous objects/substances <input type="checkbox"/> Unsafe mats/throw rugs/inadequate safety devices <input type="checkbox"/> Presence of lead based paints/unsafe equipment/wiring <input type="checkbox"/> Structural barriers/homeless <input type="checkbox"/> Other							S						Home						Condition of residence, access		
							S						Home						Stability, homelessness		
								S						Safety						Home safety assessment	
								TGC						Safety						Home safety recommendations, home modifications, access	
								TGC						Home						Long range planning/decision making	
								CM						Home						Housing resources, home modifications, access	
								CM						Safety						Safety supplies and equipment	

Signature _____	County _____	Revised: 12/15/2010
-----------------	--------------	---------------------