

Minnesota Department of Human Services

Rule 79: Children's Mental Health

CMH Individual Family Community Support Plan

Child:		Date of Birth:	
Address:		ICWA:	
		Next Review Date:	/ /
		Plan Dates:	/ / - / /
Worker Name:		Worker Phone:	

Parent/Legal Guardian Information			
Name:	Address:	Cell Phone:	
		Work Phone:	
		Home Phone:	
Name:	Address:	Cell Phone:	
		Work Phone:	
		Home Phone:	

Reason for Agency Involvement

Plan Development

SOCIAL WORKER met with WHO DATE to jointly make this plan.

In the development of this plan, SOCIAL WORKER consulted with:

If either the identified client or parents/legal guardians were not involved in the development of this plan, please explain:

Current Diagnosis

Axis I:	Code	Start Date	End Date
		/ /	/ /
		/ /	/ /

Axis II:	Code	Start Date	End Date
		/ /	/ /
		/ /	/ /

Axis III:

Axis IV:

Axis V:

Diagnosing Mental Health Professional:

Date of Diagnosis:

/ /

Medications

Medication	Dosage Amount	Dosage Form
Prescribed By	Start Date	Psychotropic
Reason		
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

	/ /	
	/ /	

Medication Notes:

Standardized Assessments

Assessment		
	Current	Previous
Date of Assessment	/ /	/ /
Total Score		
Level of Service Intensity		
Acceptance and Engagement		
Co-Morbidity		
Co-Occurrence		
Environmental Stress		
Environmental Support		
Functional Status		
Involvement in Services		
Resiliency		
Risk of Harm		
	Current	Previous
Date of Assessment	/ /	/ /
Total Score		
Level of Service Intensity		
Acceptance and Engagement		
Co-Morbidity		
Co-Occurrence		
Environmental Stress		
Environmental Support		
Functional Status		
Involvement in Services		
Resiliency		
Risk of Harm		

Mental Health

(Symptomatology and Functionality)

Strengths related to this area:

Service needs or struggles:

Goal:

- Goal status:
- | | |
|---|---|
| <input type="checkbox"/> Achieved | <input type="checkbox"/> Not achieved |
| <input type="checkbox"/> Partially achieved | <input type="checkbox"/> No longer needed |

Activities and Services / Frequency / Providers:

Evaluation of Services:

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Goal Progress:

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Physical/Chemical Health and Insurance

Insurance Provider	Contact Number	Primary/Secondary
Health Plan/Type	Policy Number	Group Number

Insurance Provider	Contact Number	Primary/Secondary
Health Plan/Type	Policy Number	Group Number

Insurance Provider	Contact Number	Primary/Secondary
Health Plan/Type	Policy Number	Group Number

Additional insurance information:

Strengths related to this area:

Service needs or struggles:

Goal:

Goal status:

Achieved

Not achieved

Partially achieved

No longer needed

Activities and Services / Frequency / Providers:

Evaluation of Services:

Goal Progress:

Family Functioning and Cultural Needs

Strengths related to this area:

Service needs or struggles:

Goal:

Goal status:

Achieved

Not achieved

Partially achieved

No longer needed

Activities and Services / Frequency / Providers:

Evaluation of Services:

Goal Progress:

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Health Exams

Exam Type	Exam Date	Health Care Provider
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Interpersonal Relationships

(family, peers, other adults)

Strengths related to this area:

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Service needs or struggles:

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Goal:

Goal status: Achieved Not achieved
 Partially achieved No longer needed

Activities and Services / Frequency / Providers:

Evaluation of Services:

Goal Progress:

Educational, Vocational, Recreational Functioning

Individual Education Plan: Yes No

School Name:

Grade:

School Comments:

Strengths related to this area:

Service needs or struggles:

Goal:

Goal status:

Achieved

Not achieved

Partially achieved

No longer needed

Activities and Services / Frequency / Providers:

Evaluation of Services:

Goal Progress:

Daily Living Skills

Strengths related to this area:

Service needs or struggles:

Goal:

Goal status: Achieved Not achieved
 Partially achieved No longer needed

Activities and Services / Frequency / Providers:

Evaluation of Services:

Goal Progress:

Transportation, Housing, and Employment

Strengths related to this area:

Service needs or struggles:

Goal:

Goal status: Achieved Not achieved
 Partially achieved No longer needed

Activities and Services / Frequency / Providers:

Evaluation of Services:

Goal Progress:

Unmet Service Needs

Unmet service needs of the child and/or child's family (services needed by not available):

Responsibilities

Case Manager

1. **Complete a written functional assessment and develop the child's Individual Family and Community Support Plan (IFCSP) based on the child's diagnostic assessment and functional assessment within 30 days of the first meeting with the child.**
2. Review and update IFCSP at least every 180 days.
3. **Coordinate family community support services needed by the child and the child's family with other services that the child and the child's family are receiving.**
4. **Arrange for a standardized assessment by a physician chosen by the child's parent, legal representative, or the child (if eligible) of the side effects related to the administration of the child's psychotropic medications.**
5. Attempt to meet with the child at least once every 30 days.
6. **Be available to meet with the child's parent or legal representative upon the request of the parent or representative.**
7. Actively participate in discharge planning for the child, and to the extent possible, coordinate the services necessary to **assure a smooth transition to the child's home or foster home, school, and community-based services** if the child is in a residential treatment facility, correctional facility, or other residential placement, or inpatient hospital for mental health services.
8. **At least six (6) months before the child's 18th birthday, assist the child and, as appropriate, the child's parent or legal representative in assessing the child's need for continued mental health and case management services.**

Client and Family

1. Parents, client and family will cooperate in completing requested functional and diagnostic assessments.
2. Parents, client and family will cooperate in developing the Individual Family Community Support Plan.
3. Parents, client and family will provide the opportunities for assigned worker to meet face-to-face with them at a minimum of one time per month.
4. **Parents, client and family will communicate with assigned worker as changes in their family's structure, level of functioning and needs change.**
5. Parents, client and family will participate in the activities identified in this plan.

Acknowledgements and Understandings

The child and family have the following rights and responsibilities:

1. The right and responsibility to accept or refuse case management services.
2. The right and responsibility to accept services as specified in this plan.
3. The right to have this plan formally reviewed every 90 days, if requested, and minimally every 180 days.
4. The right to be referred to the appropriate services as specified in this plan.
5. The right to appeal under Minnesota Statutes, Section 245.4887. I acknowledge that the appeals process has been explained and reviewed annually or as requested and I have received a copy of the appeals process.
6. The rights to protected data under the Minnesota Government Data Practices Act, Minnesota Statute, Chapter 13.
7. **The right to know the case manager's responsibilities.**
8. The right to receive notice of Privacy Practice both verbally and in writing and signed by the recipient of the service or legally authorized representative.

Dual Case Management

Type of dual case management:

Reasons for dual case management:

How and who will coordinate and monitor each service?

When applicable, state the frequency with which contact between the case managers will occur for the purpose of coordinating services.

Treatment Team Members

Provider Name:	Agency:	
Phone:	Start Date:	End Date:
Address:	Service:	

Provider Name:	Agency:	
Phone:	Start Date:	End Date:
Address:	Service:	

Provider Name:	Agency:	
Phone:	Start Date:	End Date:
Address:	Service:	

Provider Name:	Agency:	
Phone:	Start Date:	End Date:
Address:	Service:	

Provider Name:	Agency:	
Phone:	Start Date:	End Date:
Address:	Service:	

Provider Name:	Agency:	
Phone:	Start Date:	End Date:
Address:	Service:	

Signature	Date	This plan was explained to me	I received a copy of this plan
		<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	<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
		<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

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.