

Child and Family Team Meeting (CFTM) Summary and Action Plan

To be shared with all members of the CFT and attached to the court report once completed

AGENCY INVOLVEMENT (check all that apply):

CFWB BHS Provider Probation

Meeting Date:		Child/Youth Name(s):	
Assigned SW:		Assigned Probation Officer:	
Date of Last Meeting:	Current Placement:	Enhanced Youth (<i>Katie A. ICC/IHBS</i>) (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Determined	
Facilitator/Agency:	Caregiver Name:		
ICWA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inquiring		Child's Tribal Affiliation:	
Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list person or provider:			
Meeting Location (check all that apply): <input type="checkbox"/> In Person <input type="checkbox"/> Video/Teleconference			
Date of Next CFT Meeting:		Date of Next Court Hearing:	

List All CFT Members (child/nonminor dependent, family members and supports, caregivers, tribal representative, educational rights holder, and others) - Check box if present at meeting

Name	Relationship to Child/Family	Preferred Method of Contact (Phone or Email)	Present
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
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			<input type="checkbox"/>
			<input type="checkbox"/>

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SECTION 1: Agenda
<input type="checkbox"/> Initial CFTM <input type="checkbox"/> Follow up <input type="checkbox"/> 3 Month CFTM <input type="checkbox"/> 6 Month Review <input type="checkbox"/> Other:
Discussion Items to be reflected in Action Plan: <ul style="list-style-type: none"> <input type="checkbox"/> Placement (If CFT/Placing Agency is recommending STRTP level of care complete Section 6) <input type="checkbox"/> Presumptive Transfer <input type="checkbox"/> Services <input type="checkbox"/> Youth/Family's Behavioral Health Needs <input type="checkbox"/> Youth/Family's compliance with Probation requirements <input type="checkbox"/> Youth/Family's educational needs including sexual health education 10+ <input type="checkbox"/> Visitation <input type="checkbox"/> Permanent Plan <input type="checkbox"/> CANS/Case Plan/Case Review <input type="checkbox"/> Transition Plan <input type="checkbox"/> Case Closing <input type="checkbox"/> Other:

SECTION 2: Team Agreements	
<input type="checkbox"/> We agree to keep the information shared in this meeting confidential.	
<input type="checkbox"/> Recognize Tribal Sovereignty and ICWA (for Indian children)	

SECTION 3: Child and Adolescent Needs and Strengths (CANS)	
Date of Assessment:	Date of Last Assessment:
Identified Strengths:	
Actionable Needs:	
Did CFT members agree on ratings of the strengths and needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please describe any disagreements:	
If the CANS was not discussed, provide reason:	
What's working well (additional strengths, existing supports and action items completed)?	

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SECTION 6: Short-Term Residential Therapeutic Program (STRTP)	
Complete items 1-9 of this section for children and NMDs placed in a Short-Term Residential Therapeutic Program (STRTP) (WELF. & INST. CODE, § 361.22, 727.12, 706.6, 16501.1):	
1.	Please explain how the social worker/probation officer made reasonable and good faith efforts to identify and include all required members in the CFT.
2.	If reunification is the permanency goal, provide information on how the parent(s) from whom the child was removed provided input on who should be members of the CFT.
3.	Please describe how the location and time of the CFTM was determined. Was the meeting held at a time and place convenient for the family (please elaborate)?
4.	<i>Complete after the assessment by the Qualified Individual.</i> Please describe how the determination by the QI was conducted in conjunction with the CFT.
5.	Please list the placement preferences of the child/nonminor dependent, the family and the CFT.
6.	<i>Complete after the assessment by the Qualified Individual.</i> Are the placement preferences of the child/NMD, the family, and the CFT the same or different from the QI recommendations? If they differ, please summarize the rationale provided by the QI.

AFTERCARE SERVICES (QI and CFT Recommendations)	
Complete when planning for discharge and aftercare	
7.	Prior to a child/NMD's discharge from an STRTP, please provide a description of the type of home and community-based services that will encourage the safety, stability, and appropriateness of the next placement. Include description of home-based services recommended by the QI and the CFT, when applicable.
8.	Please provide the plan for the provision of aftercare support services to the youth and family. (The placing agency should develop this plan in collaboration with the STRTP.)
9.	Youth will be referred to High Fidelity Wraparound aftercare services 90 days prior to STRTP discharge Date referral was submitted: Provide reason if no referral was submitted: