

**Plan Summary
Part 1: Background**

Completed at the time of the Family Conference.

County: _____ Form ID: (County Code, Year, and Conference #): _____

I. Family Conference Information:

Family Conference Date: ___/___/___ Referral Date: ___/___/___
Referral Source(s)/Worker: _____
Referring Agency (if applicable): _____
Length of Family Conference (in hours) _____ Coordinator: _____
Facilitator: _____ Co-Facilitator (if applicable) _____
Purpose of the Conference: _____

Participants in Family Group Conference: (Insert number attending for categories that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Child for whom conference was held | <input type="checkbox"/> Maternal Grandparent | <input type="checkbox"/> Court representative |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Paternal Grandparent | <input type="checkbox"/> CASA |
| <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Maternal Aunt/Uncle | <input type="checkbox"/> Drug & Alcohol (county) |
| <input type="checkbox"/> Father | <input type="checkbox"/> Paternal Aunt/Uncle | <input type="checkbox"/> School representative |
| <input type="checkbox"/> Brother(s) | <input type="checkbox"/> Other Maternal Relative: | <input type="checkbox"/> MH/MR (county) |
| <input type="checkbox"/> Cousin(s) | <input type="checkbox"/> Other Paternal Relative: | <input type="checkbox"/> Legal/investigating authority |
| <input type="checkbox"/> Step-father | <input type="checkbox"/> C&Y Caseworker | <input type="checkbox"/> Drug & Alcohol (private) |
| <input type="checkbox"/> Step-mother | <input type="checkbox"/> Foster family | <input type="checkbox"/> Attorney/GAL for: _____ |
| <input type="checkbox"/> Faith-based | <input type="checkbox"/> C&Y Supervisor | <input type="checkbox"/> Psychologist or psychiatrist (private) |
| <input type="checkbox"/> Foster parent | <input type="checkbox"/> Group or residential care provider | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Friend(s) | <input type="checkbox"/> JPO | |
| <input type="checkbox"/> Parent's significant other | | |

Was the family's plan accepted by the referring worker? Yes No

II. Demographic Information:

Child's Gender: (circle one) M F Child's Age:(in years) _____
Child's Race: African American Asian American Indian or Alaskan Native
(Check All that Apply) Pacific Islander White Other: _____
Child's Ethnicity: (check one): Hispanic or Latino Not Hispanic or Latino

III. Resources Involved with Child and Family: (Check all that apply)

C&Y JPO MH MR Drug & Alcohol
 Health Education Welfare/TANF
 Community/Natural Support Systems (ex: religious/scouts/clubs/groups/recreational & sports programs, etc...)
List ALL: _____
 Other: _____

IV. Placement Information:

Placement Type (check one): Court-Ordered Voluntary Placement Agreement
 Informal Not Applicable-Child at Home
Date of Removal: ___/___/___ Start Date of Current Placement: ___/___/___

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Current Placement Setting:

- | | | |
|---|---|--|
| <input type="checkbox"/> Own Home | <input type="checkbox"/> Supervised Independent Living | <input type="checkbox"/> Medical Hospital |
| <input type="checkbox"/> Trial Home Visit | <input type="checkbox"/> Family Living/Lifesharing (MR) | <input type="checkbox"/> Drug and Alcohol Treatment Facility |
| <input type="checkbox"/> Informal Kinship | <input type="checkbox"/> Residential Treatment Facility | <input type="checkbox"/> Community Residential Rehabilitation/Host Homes |
| <input type="checkbox"/> Resource Family Home | <input type="checkbox"/> Intermediate Care Facility/MR | <input type="checkbox"/> Permanent Legal Custodian |
| <input type="checkbox"/> Kinship Foster Care | <input type="checkbox"/> Detention | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Secure Facility | |
| <input type="checkbox"/> Pre Adoptive | <input type="checkbox"/> Diagnostic Treatment Facility | |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Psychiatric Hospital | |

Planned Placement Goal as a result of Conference:

- | | | |
|---|---|--|
| <input type="checkbox"/> Remain Own Home | <input type="checkbox"/> Group Home | <input type="checkbox"/> Psychiatric Hospital |
| <input type="checkbox"/> Return Home | <input type="checkbox"/> Supervised Independent Living | <input type="checkbox"/> Medical Hospital |
| <input type="checkbox"/> Trial Home Visit | <input type="checkbox"/> Family Living/Lifesharing (MR) | <input type="checkbox"/> Drug and Alcohol Treatment Facility |
| <input type="checkbox"/> Informal Kinship | <input type="checkbox"/> Residential Treatment Facility | <input type="checkbox"/> Community Residential Rehabilitation/Host Homes |
| <input type="checkbox"/> Resource Family Home | <input type="checkbox"/> Intermediate Care Facility/MR | <input type="checkbox"/> Permanent Legal Custodian |
| <input type="checkbox"/> Kinship Foster Care | <input type="checkbox"/> Detention | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Secure Facility | |
| <input type="checkbox"/> Pre Adoptive | <input type="checkbox"/> Diagnostic Treatment Facility | |

Planned Placement Date: ___/___/___

- V. Court/Legal Involvement:** (for child/youth)
- | | | |
|---|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Alleged Dependent | <input type="checkbox"/> Dependent | <input type="checkbox"/> Delinquent |
| <input type="checkbox"/> Alleged Delinquent | <input type="checkbox"/> None | <input type="checkbox"/> Both |

VI. Service History: (for child/youth)

Have there been prior substantiated reports of child abuse/neglect for child/youth? Yes No

- If yes, abuse type(s):
- | | | |
|-----------------------------------|---|---------------------------------|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Mental/Emotional | <input type="checkbox"/> Sexual |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Imminent Risk | |

Date(s) of Incidences: _____

Have there been prior substantiated reports of a criminal offense committed by the child/youth? Yes No

- If yes, crime type:
- | | | |
|---|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Informal Adjustment | <input type="checkbox"/> Misdemeanor | <input type="checkbox"/> Felony |
| <input type="checkbox"/> Other: (Please specify): _____ | | |

Date(s) of Incidences: _____

