#### **DEPARTMENT OF HEALTH SERVICES**

Division of Care and Treatment Services F-22687 (03/2017)

#### STATE OF WISCONSIN

Completion of this form meets the requirements of Chapter 46.56, Section 14(c) of the Wis. Stats.

# COLLABORATIVE SYSTEMS OF CARE (CSOC) PLAN OF CARE

Personally identifiable information is collected for monitoring the development of CSOC projects. All information gathered is confidential **Instructions**: Complete the Plan of Care within 60 days of enrollment

Name – Child (Last, First, Middle Initial)		Telephone Number	Date of Birth	Social Security Number
Address – Home				County of Residence
	CHILD AND FAMIL	Y TEAM MEMBERS		
Team Member		Role		SIGNATURE*
				_
	* I agree with the Plan of Care and ha	ve participated in the plannin	g process.	
Name – Service Coordinator (Case Manage	r)	Dates Updated	1	
Date of Enrollment	Date Plan of Care Completed			

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TEAM GOAL / MISSION STATEMENT
CHILD, FAMILY, AND TEAM MEMBER STRENGTHS Instructions: List all strengths identified during the Summary of Strengths & Needs Assessment process. These strengths should then be used to address identified needs in this Plan of Care.
Strengths, Interests, and Successful Strategies

Page 3

DOMAIN KEY:	CS = Crisis/Safety MH = Mental Health CU = Cultural	MD = Medical LS = Living Situation AODA = Alcohol & Other Drug Ab	SP = Spiritual FA = Family buse ED = Educational	BNF = Basic Needs/Financial SR = Social & Recreational LE = Legal
Domain (See key below)		Needs Rated	"4" or "5"	Planning Priority (1, 2, 3, etc.)
a team, prioritize the	v Life Domain Areas from the Summ	t Needs" as Identified in the Summary of Strengths and Needs Assessment cont corresponding needs will be the focus of the t	aining needs that scored Likert ratings of "4"	and "5" (in addition to Crisis/Safety Domain). Then, as

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## **GOALS AND ACTIVITIES**

Instructions: Complete a "Goals and Activities" page for each of the top three or four Life Domain Areas prioritized by the family team on page three.

Domain to be Addressed:

Identified Need (from page 3)	Strengths Related to Need (from page 2)	Outcome/Goal	Activities (Include who, what, by when, and how paid for)	Progress Tow (Use key b	ard Goal elow)
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PROGRESS KEY

NA = No longer a need or goal

1 = Unresolved or worse; not attained

2 = Unchanged; still a need or goal

**4** = Unresolved or partially attained, but improved

3 = Progress made but still a need 5 = Resolved or attained satisfaction

Taken from: Dunst, C.J.; Trivette, C.M.; & Deal, A.G. (1988). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline

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#### **CRISIS RESPONSE PLANNING**

"A crisis occurs when adults don't know what to do." - Carl Shick

Each child and family team should develop safety plans to address possible safety/crisis situations at *home* and in *school*. Teams may choose to create additional plans if needed (e.g., bus crisis response plan, community crisis response safety plan). Consider the following when developing your safety plans...

- Expect that a child with multiple needs living in the community will experience crisis
- Consider the most challenging act(s) that could happen and create the intervention
- Review historical strength-based information regarding strategies that have worked
- Pre-plan the interventions *with* people and/or agencies who may be involved in the safety issue resolution. Include an outline of responsibilities and communication procedures.
- Develop a protocol of who will be notified, and in what time frames.
- Develop a process for evaluating the safety plan use/effectiveness

Name –Child (Last, First MI)	Crisis Response Plan for (home, school, etc.):	Date Plan Prepared
Past Behaviors/Situations Considered Crises or Safety Concerns		
December 1: to flat and the December 2 October 0: to City of	Control of a selection of the interest for the interest of	
Progressive List of Interventions to Respond to a Crisis/Safety Situation responsibilities)	(include description of the intervention, who is involved, conta	act information &
responsibilities)		
	Service Costs	

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Service Code *	Service Description	Vendor (Service Provider)	Units Projected	Unit Description **	Unit Cost	Total Cost	Paid for By ***
					Total:		
		* Sorvice Codes					

### \* Service Codes

MEDICAL SERVICES	MENTAL HEA	LTH SERVICES	PLACEMENT SERVICES
5000 Assessments Outpatient	5100 Individual Therapy	5220 Consultation with Other Professionals	5300 Crisis Home/Beds
5010 Assessments Inpatient	5101 Individual AODA Therapy	5221 Child and Family Team Meeting/Planning	5310 Treatment Foster Care
5020 Medication Trial Inpatient	5110 Family Therapy	5230 Crisis Case Planning	5320 Therapeutic Group Home
5030 Medication Trial Outpatient	5120 Group Therapy	5240 Behavior Management Services	5330 Partial Hospitalization
5050 Psychiatric Reviews/Medication Checks	5121 Group AODA Therapy	5229 Other Mental Health Services	5340 Residential Treatment/Child Caring Institutional Placement
5099 Other Medical Services	5130 Special Therapy	SOCIAL/RECREATIONAL COSTS	5350 Psychiatric Hospitalization
SUPERVISION SERVICES	5140 Crisis Intervention	5527 Membership Costs	5360 Assessment Home
5530 Community Supervision	5050 Crisis Counseling	5528 Recreational Equipment Costs	5370 Foster Day Care
5540 Intensive Supervision	5160 In-Home Treatment	5529 Social Activities Cost	5380 Shelter Care
5541 Education Costs	5170 Day Treatment	5520 Recreational Reimbursement Costs	5390 Foster Home Care
CASE AIDE SERVICES	5180 Evaluation Services	5550 Supported Independent Living	5400 Group Home Care
5521 Teacher's Aide	5200 Therapeutic Community Support Services	5560 Supported Work Environments	5499 Other Placement Services
5522 Parent Aide	5201 Reintegration Treatment Services	5570 Transportation	OTHER SERVICES
5523 Supervision	5210 Reintegration Treatment Services	5580 Discretionary Funds	5410 Respite Services
5524 Mentoring	CORRECTIONAL PLACEMENTS	5590 Other Case Aide Services	5500 Case Management
5525 Recreation	5420 Detention	9999 Non-Covered Services	5501Case Management-Treatment Foster Care
5526 Life Coach	5430 Corrections		5502 Training Expenses
** Unit Descriptions ***Paid for By Codes		r By Codes	
Per Hour Per Month	CY = County PS = Public S	chool System ST = State	
Per Day Total Amount	PR = Program FR = Free	PI = Private Insurance	
Per Week	FA = Family (1 <sup>st</sup> Party) MC = Medicaid	NA = Not Applicable	