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|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Child and Family Team (CFT) Care Plan** | | | | | | | YOUTH’S NAME | | | ADSA | | |
| MEETING LOCATION | | | DATE | | |
| FAMILY VISION | | | | | | | | | | | | | |
| TEAM MISSION | | | | | | | | | | | | | |
| **Meeting invitations and attendance** | | | | | | | | | | | | | |
| NAME OF PERSON AND ROLE / RELATIONSHIP | | | ACCEPTED | | DECLINED | ATTENDED | NAME OF PERSON AND ROLE / RELATIONSHIP | | | ACCEPTED | DECLINED | | ATTENDED |
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| **Provider Reports on File** | | | | | | | | | | | | | |
| Behavior Support Plan Last received:  Behavior Plan Progress Report Last received:  School / IEP Last received: | | | | | | | Other DDA Service Last received:  Other Mental Health Last received:  Other (explain below) Last received: | | | | | | |
| COMMENTS / FOLLOW-UP | | | | | | | | | | | | | |
| **Notable updates since last visit (celebrations, changes in medication, behavior, etc.)** | | | | | | | | | | | | | |
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| **What are some of the current needs of the youth, family, and team members?** | | | | | | | | | | | | | |
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| **What DDA Waiver Services are being utilized?** | | | | | | | | | | | | | |
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| **Are additional waiver services being requested? If yes, what services and is any supporting documentation needed?** | | | | | | | | | | | | | |
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| **Action Items** | | | | | | | | | | | | | |
| RESPONSIBLE PERSON | | ACTIVITY TO BE COMPLETED | | | | | | | | | | DUE BY (DATE) | |
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| **Service Planning** | | | | | | | | | | | | | |
| PLAN YEAR | | | | PRIOR APPROVALS | | | | | | | | | |
| Start date: End date:  Respite balance: hours | | | | TYPE | | | | | EXPIRES | | | | |
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