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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 |
|  | [ ]  | [ ]  | [ ]  |  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  |  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  |  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  |  | [ ]  | [ ]  | [ ]  |
| **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.)** |
|  |
| **What are some of the current needs of the youth, family, and team members?** |
|  |
| **What DDA Waiver Services are being utilized?** |
|  |
| **Are additional waiver services being requested? If yes, what services and is any supporting documentation needed?** |
|  |
| **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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