

ITASCA COUNTY CHILD WELFARE - TARGETED CASE MANAGEMENT

COUNTY ASSESSMENT

Goal 1: Facilitate access to and coordinate with needed services within a single, individualized plan which is reviewed at least annually to assess the delivery, appropriateness and effectiveness of services.

Goal 2: Facilitate maintaining children in their home communities and with family members.

Services identified as needed are checked on the following grid; those services not checked are either Not Applicable for the age of the child or already being provided through the family's efforts

Access to Services	Coordination with Services		
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health	
<input type="checkbox"/>	<input type="checkbox"/>	Habilitation Services	_____
<input type="checkbox"/>	<input type="checkbox"/>	Educational Services	
<input type="checkbox"/>	<input type="checkbox"/>	Health Services	
<input type="checkbox"/>	<input type="checkbox"/>	Vocational Services	
<input type="checkbox"/>	<input type="checkbox"/>	Recreational Services	
<input type="checkbox"/>	<input type="checkbox"/>	Volunteer Services	
<input type="checkbox"/>	<input type="checkbox"/>	Advocacy	<input type="checkbox"/> Respite Services
<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/> Alternative Placement
<input type="checkbox"/>	<input type="checkbox"/>	Legal	<input type="checkbox"/> Reunification
<input type="checkbox"/>	<input type="checkbox"/>	Maintenance of Medical Coverage	<input type="checkbox"/> Determining services needed to reduce risk

	Weekly	Monthly	Bi-monthly
Frequency of contact with child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequency of contact with family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequency of contact with providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Primary Case Manager _____ Dual Case Managers _____

Date _____ Primary CM Signature _____

Date _____ Dual CM Signature _____

Date _____ Dual CM Signature _____

Updates minimum of annually maintain the same plan except as indicated by dated inserts above.

Update _____ Primary CM Signature _____

Update _____ Primary CM Signature _____

Update _____ Primary CM Signature _____

Update _____ Primary CM Signature _____

Update _____ Primary CM Signature _____

ITASCA COUNTY
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ITASCA COUNTY SCREENING

Child Name: _____ DOB: _____

Parent: _____ PMI: _____

DETERMINATION OF ELIGIBILITY

MA or MinnesotaCare client who is under age 21 and:

- At risk of out-of-home placement or in placement as defined in MN statutes section 260C.212 sub.1
- At risk of maltreatment or experiencing maltreatment as defined in MN statutes section 626.556 sub. 10e
- In need of protection or services as defined in MN statutes section 260C.007 sub.6

FINDING Eligible Ineligible

Child is in need of protection or services as defined in MN statutes 260C.007 sub.1 due to:

This child will receive CW-TCM Services through the following provider(s):

- ICHHS Provider CMH/REACH Provider Tribal Provider

Plans coordinated with dual case managers

If multiple providers are designated, the following outlines the division of tasks to meet the needs of the child. In lieu of this statement, a grid of responsibilities can be attached.

Rationale for Multiple Service Providers:

Provider Tasks:

** See Plan on Back