

TRINITY COUNTY COORDINATED CASE PLANNING FORMS



Trinity County Health & Human Services LINKAGES Coordination Worksheet

Date of Meeting: _____

Family Name	Concerns/Actions	Responsible Employee	Due Date

TRINITY COUNTY COORDINATED CASE PLANNING FORMS



**Trinity County Health and Human Services
Trinity County Linkages Project**

Coordinated Case Plan

Case Plan: Initial Amended

Case No: _____ / _____ Dated: _____ See Court Report Dated: _____

<p>CASE PLAN GOAL:</p> <p>FM To safely maintain minor(s) in the home with parent(s) while maintaining participation in the CalWORKs program. <input type="checkbox"/></p> <p style="margin-left: 20px;">All minors <input type="checkbox"/> Specific minor(s) <input type="checkbox"/> Participants Name</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>FR To successfully reunify minor(s) with parent(s) while maintaining participation in the CalWORKs program. <input type="checkbox"/></p> <p style="margin-left: 20px;">All minors <input type="checkbox"/> Specific minor(s) <input type="checkbox"/> Participants Name</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>OR Other (specify) <input type="checkbox"/></p> <p style="margin-left: 20px;">All minors <input type="checkbox"/> Specific minor(s) <input type="checkbox"/> Participants Name</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">PLAN PARTICIPANTS: (Write Social Security Numbers)</p> <p>01 Mother _____</p> <p>02 Mother _____</p> <p>03 Father _____</p> <p>04 Father _____</p> <p>05 Father _____</p> <p>06 Caretaker _____</p> <p>07 Needy Caretaker _____</p> <p>08 Minor _____</p> <p>09 Minor _____</p> <p>10 Minor _____</p> <p>11 Minor _____</p> <p>12 Minor _____</p> <p>13 Other _____</p> <p>14 Other _____</p> <p>Reference: CW WTW = Child(ren) & Participant(s) is the same as CWS = Minor(s) & Parent(s)</p> <p>Needy Caretaker is a reference for CW WTW</p>
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OBJECTIVES/SERVICES: (Each action must be dated to show the anticipated date of referral)

Participants Number (Write Participants Number in the boxes below)	Will participate and successfully complete the Objective/Services below	Anticipated Referral Date	Anticipated Completion Date
	Substance abuse & recommended treatment		
	Drug Testing		
	Anger management/domestic violence counseling		
	Parenting Class		
	Mental Health assessment/recommended tx		
	Resolve sanction		
	Obtain and maintain stable/suitable housing		
	Other (Specify)		
	Other (Specify)		

Social /Employment Training Worker will maintain at least monthly contacts with parent(s) and provide the following case management services. Social Worker Employment Training Worker Other _____

Participant Number (Write Participants Number in the boxes below)	Case Management Services	Responsibility WTW / CWS	Anticipated Completion Date
	Childcare		
	Transportation		
	Ancillary		
	Maintain monthly contact		
	Other		
	Other		

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Case No: _____ / _____ Dated: _____ See Court Report Dated: _____

Projected review date for Child Welfare Services (6 months from today's date) : _____

ASSESSMENT

Initial Assessment

The initial assessment requires a clear statement identifying problems. Probable cause and need for intervention. (Include relevant social, cultural, psychological and physical factors). Identify previous services offered and results. Identify family strengths and resources.

Reassessment

A reassessment must give a review of the current family situation: previous assessments, effectiveness of service plans and agreements. Were stated objectives met?

Participants Signature: _____ Date: _____

Participants Signature: _____ Date: _____

Linkages Liaison (SSRS) Signature: _____ Date: _____

CWS Worker Signature: _____ Date: _____

ET Worker Signature: _____ Date: _____

Other: _____ Title: _____ Date: _____

Other: _____ Title: _____ Date: _____