

PREVENTION FAMILY WELL-BEING PLAN FOR PROBATION

Below is the Prevention Family Well Being Plan, designed to serve as guidance to the services and supports as identified by your family. Consider how you care for yourself, your children, and your family, who can offer support, and where to obtain those various supports. This plan can be changed at any time, based upon individual strengths and needs.

Youth's Name:	DOB:
<input type="checkbox"/> Initial Case Plan <input type="checkbox"/> 6 Month Review <input type="checkbox"/> 12 Month Review <input type="checkbox"/> Change in Family Well Being Plan	
Family Well Being Plan Approval Date: _____	

Race: <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Hispanic / Latin(o/a)(x) <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Mixed Race: <input type="checkbox"/> Other:	Ethnicity: <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Hispanic / Latin(o/a)(x) <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other:	Spirituality: (optional)
Tribal Affiliation: (optional, if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	(optional) Tribal Representative/Advocate <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity (optional): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other:	

Family / Household Members

People important and supportive to you and your family - parent, guardian, siblings, others	Relationship (Parent, Aunt, Uncle, Grandparents, Faith Leader/Pastor, Teacher/Mentor, Coach, Neighbor Other)	Date of Birth	Contact Information
Name:			
Name:			
Name:			
Name:			
Name:			
Name:			

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Describe the circumstances and services needed to be eligible for prevention services.

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Strengths and Needs:

These are identified to support you, focusing on your strengths in relationships, problem-solving skills, and where you may need some additional support, based on some your strengths and needs.

<p>Economic Stability <i>Steady income, budgeting help, childcare or transportation support</i></p>	<p><input type="checkbox"/> I have regular income and can pay my monthly bills and rent on time.</p> <p><input type="checkbox"/> I do not have regular income and have difficulty paying monthly bills and rent on time.</p> <p><input type="checkbox"/> I have regular income, but I'm worried my financial situation may change soon</p>
<p>Education <i>School stability, attendance support, tutoring, IEP/504 help</i></p>	<p><input type="checkbox"/> My children attend school/daycare with no issues</p> <p><input type="checkbox"/> My children are having trouble with school, i.e. poor grades, missing classes etc.</p> <p><input type="checkbox"/> My children could use some supports with school</p>
<p>Social Community /Neighborhood / People to reach out to <i>Community centers, sports/mentoring groups, faith/cultural community</i></p>	<p><input type="checkbox"/> I feel safe and have supports where I live and work, i.e. helpful neighbors and understanding employer</p> <p><input type="checkbox"/> I feel safe and have supports but could use some additional help</p>
<p>Healthcare Access and Quality <i>Medical checkups, dental care, mental health therapy, Medi-Cal support</i></p>	<p><input type="checkbox"/> I have access to affordable healthcare</p> <p><input type="checkbox"/> I have access to healthcare, but can't afford to pay for it</p> <p><input type="checkbox"/> I don't know where to get affordable, needed care</p>
<p>I Have Social and Family Supports <i>Trusted friends, mentors, extended family, church or community groups</i></p>	<p><input type="checkbox"/> I have supportive friends/family who can help me when I need it</p> <p><input type="checkbox"/> I have supportive friends/family but not always available when I need them</p> <p><input type="checkbox"/> I have few supportive friend / family who can help me when I need it</p>
<p>My basic needs are being met <i>Housing, transportation, food, clothing</i></p>	<p><input type="checkbox"/> I have access to food, transportation and clothing</p> <p><input type="checkbox"/> I have limited access to food, transportation and clothing</p> <p><input type="checkbox"/> I have access to food, transportation and clothing but struggle from week to week</p>
<p>Youth's Social Emotional Competence <i>Coping skills, emotional regulation, communication skills</i></p>	<p><input type="checkbox"/> My children communicate well and have positive friends</p> <p><input type="checkbox"/> My children communicate well but could improve and have some friends who get into trouble</p> <p><input type="checkbox"/> My children don't communicate well and have friends who get into trouble</p>

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Family Well Being Goal(s) and Services:

Well-Being Plan Goal 1: _____

Projected Goal End Date: _____

Who is service for:

List who will be responsible for achieving this goal?		What is a strength you bring to meeting this goal?	What are you needing to be able to achieve this goal?
Who is the service for:			
Relationship to Youth:	Objective:	Identified Strength(s):	Identified Need(s):

Services, Activities	Services Provider	Date Referred

Please describe the change you would like to see and how will they know change has occurred:

How will those involved be contributing to achieving this goal:

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Well-Being Plan Goal 2: _____

Projected Goal End Date: _____

Who is service for:

List who will be responsible for achieving this goal?		What is a strength you bring to meeting this goal?	What are you needing to be able to achieve this goal?
Name: Relationship to Youth:	Objective:	Identified Strength(s):	Identified Need(s):

Services, Activities	Services Provider	Date Referred

Please describe the change you would like to see and how will they know change has occurred:

How will those involved be contributing to achieving this goal:

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Signatures

I have participated in building this plan and understand what it says. I also understand that the services are being offered are voluntary and are there to assist me and my family.

Youth

Date

Parent/Guardian

Date

Parent/Guardian

Date

Caseworker

Date

Supervisor

Date