MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION
72 HOUR FAMILY SUPPORT TEAM MEETING

RESET

Family Name_____ Date_____

CONFIDENTIALITY STATEMENT: We the undersigned are participants in the FSTM for the _____ family. We understand we have the family's permission to share information here today that will help the family meet their goals. We also understand and agree to keep this information confidential pursuant to the confidentiality laws and policies of the State of Missouri. This form should be signed by all participants at the beginning of the meeting. At the conclusion of the meeting, participants should indicate whether or not they agree with the plan by checking yes or no in the appropriate box.

Participant Invited	Relationship to Family	*Agree with Plan?	Signature Signifying Attendance and Agreement with Confidentiality Statement
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

*If indicated do not agree with the case plan, specifically state the nature of disagreement:

Participant's Name	Nature of Disagreement

Date/Time of Next Meeting	Location of Next Meeting

FST-2 (REV3/13)

Family Name_____ Date_____

☐ Adoption and Safe Families Act Explained

☐ Indian Child Welfare Act

- Does the child have Indian Ancestry? ☐ Yes ☐ No

Reason for Removal/Identified Threats of Danger: _____

PROGRESS NOTES:

Child Education:

Child Health/Mental Health/Child Vulnerability:

Parents' Health/Mental Health/Caregiver Protective Capacity:

Special Needs of the Family (if applicable):

Diligent Search (absent parent, relatives, kin):

Family Name_____ Date_____

Resource Provider:

Services/Treatment Needs:

☐ **Review of Court Order to Assure Compliance:**

VISITATION RECOMMENDATIONS:

Who Will Visit	Supervised Yes/No	If Supervised by Whom	Frequency/Duration/Location
☐ Mother	☐ Yes ☐ No		
☐ Father	☐ Yes ☐ No		
☐ Sibling	☐ Yes ☐ No		
☐ Other:_____	☐ Yes ☐ No		

RECOMMENDATIONS:

☐ **The child will remain in alternative care with the following provider:** _____

☐ **The child will return home on a Trial Home Visit with** ☐ Mother / ☐ Father / ☐ Other _____

☐ **An Intensive In-Home Services (IIS) referral will be made.**

Task	Who will do task?	Timeframe