MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION
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

Family Name_____ Date_____

TYPE OF MEETING:

☐ 24 Hour ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 120 Day ☐ 6 Month/PPRT ☐ Review Progress
☐ Placement Change ☐ Goal Change ☐ Revise Service Agreement ☐ At the parent's request
☐ Other _____

PURPOSE OF MEETING	GROUND RULES
Assessing safety of the child	Be respectful of each other
Determine if the child can be reunited	One person speaks at a time
Discuss case goal and need for permanency	Focus on the purpose
Determine service and treatment needs	Everyone has a chance to speak and be heard
Review placement options and appropriateness	It is ok to disagree
Develop/Review/Revise case plan	Speak to each other, not about each other
Evaluate case progress	Encourage honesty without blaming or shaming
Review of services needed/in place	No idea is a bad idea
Develop/Review visitation plan	Ideas should not be judged

Reason for Removal/Identified Threats of Danger: _____

☐ Adoption and Safe Families Act Discussed

SUMMARY OF PROGRESS

Child Education:

Child Health/Mental Health/Child Vulnerability:

Parents' Health/Mental Health/Caregivers Protective Capacity:

Special Needs of the Family (if applicable):

Family Name_____ Date_____

Diligent Search (absent parent, relatives, kin, lifelong connections):

Resource Provider(s) Update:

Progress/Services/Treatment Needs Necessary to Achieve Permanency:

Compliance with Written Service Agreement:

☐ **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		

PERMANENCY PLAN:

☐ Reunification ☐ Adoption ☐ Guardianship ☐ Placement with Fit and Willing Relative
☐ Another Planned Permanent Living Arrangement

CONCURRENT PLAN:

☐ Adoption ☐ Guardianship ☐ Placement with Fit and Willing Relative
☐ Another Planned Permanent Living Arrangement

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: _____

RESIDENTIAL REAUTHORIZATION ATTACHMENT

REASON FOR RESIDENTIAL PLACEMENT (List specific behaviors that lead to residential placement):

_____

_____

_____

_____

LIST SPECIFIC SERVICES IN PLACE:

SERVICE	FREQUENCY (weekly, bi-weekly, monthly)
☐ Individual Therapy	
☐ Family Therapy	
☐ Group Therapy – List specific group participation:	
_____	
_____	
_____	
_____	
☐ Art Therapy	
☐ Substance Abuse Treatment	
☐ Sexual Offender Services	
☐ Other	

The FST should be choosing the services/therapies the child is involved in to ensure they are directly relating to the problem/reason for referral.

Are the services in place still necessary to address the problem/reason for referral? ☐ Yes ☐ No

RFA Payment Level

☐ Level II ☐ Level III ☐ Level IV ☐ Level IV+

Is the child receiving the correct amount of services for the payment level? ☐ Yes ☐ No

Level II – services one time per week
Level III – services six times per month
Level IV – services twice per week

CSPI score: _____

Rehab Begin Date in FACES: _____