Appendix 11

Care Plan (Sample Format)

The following is a sample care plan. Care coordinators are required to base each care plan on the results of the Family Questionnaire, but are not restricted to a specific format. Please note again this is a sample, not a required format.

Recipient's Name_____
Medicaid Number_____
WIC Site_____

Initial Assessment Date_____
Date of Family Plan Development_____
Total Points from Family Questionnaire_____

Questionnaire Categories	Critical Elements	Family Plan (Including Goals and Expected Outcomes)
A. General Information Total Possible Points (235) Actual Points_____	Age of mom_____ HMO_____ MD_____ Phone_____	
B. Employment Total Possible Points (55) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	Employed Y N Childcare Y N On W-2? Y N	
C. Family Functioning Total Possible Points (320) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	English literacy Y N Demonstrates ability to care for all children Y N With safe, maintained home (rate on a scale of 0-5) + 0 1 2 3 4 5 - Out-of-home placement of children Y N Transient/homelessness Y N Transportation Y N	
D. Parenting Attitudes/Skills Total Possible Points (165) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	Demonstrates nurturing behaviors (rate on a scale of 0-5) + 0 1 2 3 4 5 - Past history of abuse/neglect of children Y N Foster home placement Y N Abuse/neglect of mother as a child Y N	

Questionnaire Categories	Critical Elements	Family Plan (Including Goals and Expected Outcomes)
F. AODTA (Alcohol and Other Drug and Tobacco Abuse) Total Possible Points (210) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	Past history of AODTA abuse? Y N Smokes Y N Household smoke Y N Alcohol use Y N Other substance abuse Y N	
G. Personal Support/Coping Skills Total Possible Points (481) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	(Rate on a scale of 0-5) Stress management + 0 1 2 3 4 5 - Family abuse + 0 1 2 3 4 5 - Personal support + 0 1 2 3 4 5 - Community support systems + 0 1 2 3 4 5 - Family support + 0 1 2 3 4 5 -	
Date of Care Plan Updates:	**Referrals/Follow-up:**	**Collateral Contacts:**

Signature of Mother_____ **Date**_____
Signature of Care Coordinator_____ **Date**_____

Family Members and/or Other Supportive Persons Involved in the Care Plan Development:

_____
_____
_____
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_____