St. Clair County Community Mental Health Services Authority

Program Placement/Transfer Meeting for Children in Specialized Residential

Date:_____

Individual:_____ Case #:_____

Start Time:_____Stop Time:_____

I. IDENTIFYING INFORMATION:

DOB: _____ Sex:_____ Race:_____ Religious Preference: _____

Height: _____ Weight:_____ Hair Color:_____ Eye Color: _____

Identifying Marks (Please include scars, tattoos, moles, birthmarks, freckles, other distinguishing marks and ***location on body***; if none, please write "none"):

II. PURPOSE OF MEETING (Include name of receiving transfer program[s]):

Proposed Residential Placement: _____

Address: _____

III. GROUP DISCUSSION:

Placement Preparation (Appropriate to the child's age, individual needs, the circumstances leading to placement, special problems; address consumer's strengths, abilities and preferences):

IV. PARENTS:

Parent's Name: _____ Marital Status: _____

Address: _____ Phone #: _____

V. LEGAL CIRCUMSTANCES (custody, court involvement, court wardships, etc.):

Legal Guardian: _____

Address: _____ Phone #: _____

Custody, who: _____ Type: _____ Court Wardship: _____

Individual court involvement: ☐ Yes ☐ No ☐ N/A ☐ Pending

☐ Delinquency ☐ Abuse/Neglect

Family involvement in civil, criminal or probate court procedures:

☐ Yes ☐ No ☐ Pending, who: _____

VI. MEDICAL HISTORY OF CHILD:

Immediate and Significant Health Needs: _____

_____

Current Medical Diagnosis, if known: _____

Accidents: _____

Hospitalizations: _____

Allergies: ☐ Unknown ☐ Other: _____

Medications: _____

Child's Physical and Emotional State at Time of Placement: _____

_____

_____

VII. SCHOOL INFORMATION:

School Program: _____

Grade: _____ Special Education (if so, state type): _____

Date of written notification of placement sent to school program: _____

VIII. DISPOSITION:

A. Placement Disposition:

☐ TRANSFER/PLACEMENT – Home Placement Date: _____ ☐ N/A;

☐ Program/School Start Date: _____ ☐ N/A;

☐ Visitation Scheduled: ☐ Yes – Date/Time: _____

☐ No – Explain: _____

☐ RESPITE TRANSFER – Timeframe: _____

☐ DISCHARGE FROM GROUP HOME (must completed section D)

☐ NO PLACEMENT/TRANSFER

☐ DEFERRED – Explain details of deferral: _____

B. Placement Plan: Notification/Consent:

Parents informed of the plan: ☐ Yes ☐ No

Are parents in agreement: ☐ Yes ☐ No

Persons assuming custody

Informed of the plan ☐ Yes ☐ No ☐ N/A

Child informed of the plan ☐ Yes ☐ No

If any of the above answered "No", explain:

C. Placement Needs/Record Follow-Up:

Immediate Needs; Refer to attached interim goals

Immunization Record: ☐ Yes ☐ No

Physical (within 12 months): ☐ Yes ☐ No

Dental Record: ☐ Yes ☐ No

Medical History: ☐ Yes ☐ No

D. Discharge for Group Home:

Group Home: _____ Date of Discharge: _____

Time of Discharge: _____

Child Discharged to (Name/Title): _____

Destination (Address): _____

Rationale for Discharge:

Follow-up services/supports recommended or in place at time of discharge:

IX. **THIS SECTION FOR RE-PLACEMENT ONLY** (Replacement is any placement out of the home other than the original out-of-home placement):

A. Reason for Re-Placement:

_____

_____

B. Evaluation of Appropriateness for Continued Foster Care:

_____

_____

_____

C. Mental Health & Substance Abuse Services History of Individual:

☐ Yes, update form #023A

X. TRANSFER CHECKLIST: This checklist may be completed and affixed by the current and new primary caseholders.

_____ _____ _____

Case Holder Signature/Credentials | Print | Date

_____ _____ _____

Psychiatrist Signature/Credentials (Optional) | Print | Date

Other Signatures:

_____ _____

_____ _____

_____ _____

☐ Individual/Guardian/Parent Received Copy

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EHR: Services, Placement/Transfers