**Wraparound Facilitation**

**Individualized Support Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Youth Name (First, MI, Last):** | **Client #:** | **TAN #:** | **Date:** |
| **Guardian Name:** | **DOB:** | **Phone:** | **Address:** |
|     | **Start Date:** | **Target Completion Date**: |
| **Vision/Mission/Strengths** |
| **Family Vision/Preference Statement:** |
| **Team Mission:** |
| **Strengths/Abilities: Youth, Family Members, & Team** |  |    |
| **Client Name Case #** |
| **Crisis Plan** |
| **Diagnosis:** |
| **Medications:** |
| **Brief History:** |
| **Triggers:** |
| **Potential Crisis:** |
| **Action Steps for home and school to meet Identified Needs re: Potential Crisis:** |
| **Persons Responsible and phone numbers:**  |
| **Crisis Debriefing after Resolution:****Client Name Case #** |
| **Needs Statements/Strategies** |
| **Needs Statement****1** |  | Start Date: |
| End Date/Duration: |
| **Outcome:** |  |
| **Life Domain Area of need**:[ ] Family [ ] Residence [ ] Social [ ] Education/Vocation [ ] Medical/Physical Health [ ] Community [ ] Psychological/Emotional/Behavioral [ ] Safety [ ] Basic Physical Needs [ ] Financial [ ] Leisure/Recreation |
| **Youth** **Strategies** |  |
| **Parent/Guardian/Community Strategies:** |
| **Strategy Completion Date:** | **Strategy Discontinue Date:** | **Reason for Discontinuation:** |
| **Client Name Client #** |
| **Needs Statement****2** |  | Start Date: |
| End Date/Duration: |
| **Outcome:** |  |
| **Life Domain Area of need**:[ ] Family [ ] Residence [ ] Social [ ] Education/Vocation [ ] Medical/Physical Health [ ] Community [ ] Psychological/Emotional/Behavioral [ ] Safety [ ] Basic Physical Needs [ ] Financial [ ] Leisure/Recreation  |
| **Youth Strategies** |   |
| **Parent/Guardian/Community Strategies:** |
| **Strategy Completion Date:** | **Strategy Discontinue Date:** | **Reason for Discontinuation:** |
| **Client Name Client #** |
| **Needs Statement****3** |  | **Start Date:** |
| **End Date/Duration:** |
| **Outcome:** |  |
| **Life Domain Area of need**:[ ] Family [ ] Residence [ ] Social [ ] Education/Vocation [ ] Medical/Physical Health [ ] Community [ ] Psychological/Emotional/Behavioral [ ] Safety [ ] Basic Physical Needs [ ] Financial [ ] Leisure/Recreation |
| **Youth** **Strategies** |  |
| **Parent/Guardian/Community Strategies:** |
| **Strategy Completion Date:** | **Strategy Discontinue Date:** | **Reason for Discontinuation:** |
| **Client Name Client #** |
| **Needs Statement****4** |  | **Start Date:** |
| **End Date/Duration:** |
| **Outcome:** |  |
| **Life Domain Area of need**:[ ] Family [ ] Residence [ ] Social [ ] Education/Vocation [ ] Medical/Physical Health [ ] Community [ ] Psychological/Emotional/Behavioral [ ] Safety [ ] Basic Physical Needs [ ] Financial [ ] Leisure/Recreation |
| **Youth** **Strategies** |  |
| **Parent/Guardian/Community Strategies:** |
| **Strategy Completion Date:** | **Strategy Discontinue Date:** | **Reason for Discontinuation:** |
| **Client Name Client #** |
| **Team Contacts/Resources** |
| **Support Name/Signature** | **Contact and Organization** | **Role** |
|  |  |  |
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|  |  |  |
| **Discharge** |
| **Support Summary:** |
| **Further Recommendations:** |
| Youth Signature: | Date: |
| Parent/Guardian Signature: | Date: |
| Wraparound Facilitator Signature: | Date: |
| Supervisor Signature: | Date: |
| Other Signature (Name/Relationship): | Date: |
| Other Signature (Name/Relationship): | Date: |

 Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Wraparound Team Meeting**

Wraparound team for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and Family

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start – End Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* I am aware that everything said in this meeting is confidential. Confidentiality means that what we discuss is private and should not be discussed outside of this meeting or with others not involved in this family’s Wraparound process. By signing, I agree to preserve the confidentiality of all information discussed. I agree that this information will be used for the purposes outlined in the Wraparound planning process only. I understand that if any abuse or neglect is disclosed in this process, mandated reports will be made.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Family Team Member\*** | **Role, Agency, or Relationship to Youth** | **Phone Number(s)** | ***To be filled out by Wrap Facilitator*: Release authorized?**  |
|  | Wrap Facilitator |  |  |
|  |  |  | Y or N |
|  |  |  | Y or N |
|  |  |  | Y or N |
|  |  |  | Y or N |
|  |  |  | Y or N |
|  |  |  | Y or N |
|  |  |  | Y or N |
|  |  |  | Y or N |
|  |  |  | Y or N |

“*Wraparound* is a family centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by helping them meet their unmet needs both within and outside of formal human services systems, while they remain in their neighborhoods and homes, whenever possible” (wraparoundsolutions.com).