DCBS - Individual Health Plan

General Info	Date
Name (child)	Region
DOB ☐ Male ☐ Female	County of Origin
TWIST Case Name	DCBS FSW
TWIST Case Number	FSOS
Date of Placement	Medically Fragile Liaison
	Foster parent
Birth Mother Name	Foster parent Region
Participated in IHP ☐ Yes ☐ No ☐ N/A	Foster Parent County
	Type of Placement
Birth Father Name	☐ Bio home/Relative placement ☐ Medically Fragile (DCBS)
Participated in IHP ☐ Yes ☐ No ☐ N/A	☐ Foster care (DCBS) ☐ Basic
Permanency Plan	☐ Foster care (PCC) ☐ Advanced
	☐ PCC - placement ☐ Degreed
	☐ Other

Medical Passport Issued? ☐ Yes ☐ No

Current medical diagnosis (list all)	

Current medications	Drug Allergies
	Hospitalizations

Current health care providers

Name	Specialty	Location/Address	Invited to conference	Input received
			☐ Yes	
			☐ Yes	
			☐ Yes	
			☐ Yes	
			☐ Yes	

Treatment/rehabilitative services

		Provider	Invited to conference	Input received
Speech therapy	☐ Receiving ☐ Needed ☐ N/A		☐ Yes	
Occupational therapy	☐ Receiving ☐ Needed ☐ N/A		☐ Yes	
Physical therapy	☐ Receiving ☐ Needed ☐ N/A		☐ Yes	
Home health	☐ Receiving ☐ Needed ☐ N/A		☐ Yes	
Durable medical equipment	☐ Receiving ☐ Needed ☐ N/A			
First Steps	☐ Receiving ☐ Needed ☐ N/A		☐ Yes	
Dev. Interventionist	☐ Receiving ☐ Needed ☐ N/A		☐ Yes	

Individual Health Care Plan

Child: _____ **DOB:** _____ **Date:** _____

Present Status	Current Treatment in Place	Further Actions Needed	Person Responsible	Follow up Plan
Problem #1				
Problem #2				
Problem #3				
Problem #4				

Child name: _____ Date: _____

Vision **Hearing** **Immunizations** **Nutritional** **Dental Health** Date of Dental Exam **Mental Heath** **Developemental Assessment**				
Comments:				

Child name: _____ Date: _____

Health Planning Conference Participants

As a member of the Health Management planning conference, I understand that information presented at this conference is confidential and not for public dissemination.

_____	_____	_____
Parent	**Parent**	**DCBS -FSW**
_____	_____	_____
Foster Parent	**Foster Parent**	**DBS - FSOS**
_____	_____	_____
Health Care Provider	**Mental Health Provider**	**DCBS – Medically Fragile Liaison**
_____	_____	_____

Health Care plans distributed date_____ **by** _____