#     Initial Coordination Meeting

**Purpose:** This form is to document communication between the SSCC and CPS during the Initial Coordination Meeting (ICM). The ICM is convened by CPS and held within 7 days of referral to the SSCC for placement and/or services to a child/youth (Stage I-III) and/or family (Stages II-III). The ICM is to review child/youth/family history and identify service needs to be included on the child/youth and/or family plan(s) of service.

**Directions:** Prior to the ICM, the removal worker completes beginning sections of the form and stops at the “Discussion Points” section. The removal worker brings this form to the ICM along with the Child Caregiver Resources Form (Form 2625), Affidavit for Removal and Temporary Visitation Schedule (if complete). After the ICM, the worker will file the completed form under the *Family Services* tab of the conservatorship case file and email a copy to the SSCC. (Please Note: process is subject to change. Please refer to specific SSCC’s Operations Manual for additional guidance.)

| STAFFING INFORMATION  |
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| Date: Click here to enter a date. |
| Case Name:       | Case ID:       |
| Removal Worker:       | Unit:       | Removal Supervisor:       | Unit:       |
| Court/County:       | Date of Next Hearing: Click here to enter a date. |
| Removal Date: Click here to enter a date. | Emergency [ ]  Non-Emergency [ ]  |
| Cause Number:       | Date due to CVS: Click here to enter a date. |

| STAFFING PARTICIPANTS |
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| Name: | Relationship to Child: |
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| CHILD’S INFORMATION  |
| **Name:** | **Age:** | **Current Placement:****-Caregiver Name (foster or kinship)****-Agency name** **(if appropriate)** | **Placement Type:** | **Placement Date:** | **Current Photo in IMPACT:** | **Day Care Requested:** |
|       |       |       | Choose an item. | Click here to enter a date. | Yes[ ]  No[ ]   | Yes[ ]  No[ ]   |
| Child’s Recommended Service Package:Choose an item. |
| Child’s Selected Service Package:Choose an item. |
| Selected Add-On Services (select all that apply):[ ]  Transition Support Services for Youth & Young Adults[ ]  Kinship Caregiver Support Services[ ]  Pregnant & Parenting Youth or Young Adults Support Services |
| **Name:** | **Age:** | **Current Placement:****-Caregiver Name (foster or kinship)****-Agency name** **(if appropriate)** | **Placement Type:** | **Placement Date:** | **Current Photo in IMPACT:** | **Day Care Requested:** |
|       |       |       | Choose an item. | Click here to enter a date. | Yes[ ]  No[ ]   | Yes[ ]  No[ ]   |
| Child’s Recommended Service Package:Choose an item. |
| Child’s Selected Service Package:Choose an item. |
| Selected Add-On Services (select all that apply):[ ]  Transition Support Services for Youth & Young Adults[ ]  Kinship Caregiver Support Services[ ]  Pregnant & Parenting Youth or Young Adults Support Services |
| **Name:** | **Age:** | **Current Placement:****-Caregiver Name (foster or kinship)****-Agency name** **(if appropriate)** | **Placement Type:** | **Placement Date:** | **Current Photo in IMPACT:** | **Day Care Requested:** |
|       |       |       | Choose an item. | Click here to enter a date. | Yes[ ]  No[ ]   | Yes[ ]  No[ ]   |
| Child’s Recommended Service Package:Choose an item. |
| Child’s Selected Service Package:Choose an item. |
| Selected Add-On Services (select all that apply):[ ]  Transition Support Services for Youth & Young Adults[ ]  Kinship Caregiver Support Services[ ]  Pregnant & Parenting Youth or Young Adults Support Services |
| **Name:** | **Age:** | **Current Placement:****-Caregiver Name (foster or kinship)****-Agency name** **(if appropriate)** | **Placement Type:** | **Placement Date:** | **Current Photo in IMPACT:** | **Day Care Requested:** |
|       |       |       | Choose an item. | Click here to enter a date. | Yes[ ]  No[ ]   | Yes[ ]  No[ ]   |
| Child’s Recommended Service Package:Choose an item. |
| Child’s Selected Service Package:Choose an item. |
| Selected Add-On Services (select all that apply):[ ]  Transition Support Services for Youth & Young Adults[ ]  Kinship Caregiver Support Services[ ]  Pregnant & Parenting Youth or Young Adults Support Services |
| **Name:** | **Age:** | **Current Placement:****-Caregiver Name (foster or kinship)****-Agency name** **(if appropriate)** | **Placement Type:** | **Placement Date:** | **Current Photo in IMPACT:** | **Day Care Requested:** |
|       |       |       | Choose an item. | Click here to enter a date. | Yes[ ]  No[ ]   | Yes[ ]  No[ ]   |
| Child’s Recommended Service Package:Choose an item. |
| Child’s Selected Service Package:Choose an item. |
| Selected Add-On Services (select all that apply):[ ]  Transition Support Services for Youth & Young Adults[ ]  Kinship Caregiver Support Services[ ]  Pregnant & Parenting Youth or Young Adults Support Services |

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| PARENT or GUARDIAN INFORMATION |

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| Name: | Relation: | Address/Phone: | Native American or Alaska Native: | Parent Served: | Referral for Paternity Test Completed? |
|       |       |       | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  N/A[ ]  |
|       |       |       | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  N/A[ ]  |
|       |       |       | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  N/A[ ]  |
|       |       |       | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  N/A[ ]  |
|       |       |       | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  | Yes[ ]  No[ ]  N/A[ ]  |

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| RELATIVES and SIGNIFICANT OTHERS (INCLUDING SIBLINGS NOT IN CARE) |
| Name: | Relationship: | Address: | Phone: |
|       |       |       |       |
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| LEGAL PARTIES |
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| Legal Party: | Name: | Phone: | Email: |
| Attorney for CPS: |       |       |       |
| Attorney for Mother: |       |       |       |
| Attorney for Father: |       |       |       |
| Attorney Ad Litem: |       |       |       |
| Guardian Ad Litem/CASA: |       |       |       |
| Other:       |       |       |       |
| Other:       |       |       |       |
| Other:       |       |       |       |

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| FAMILY INFORMATION |
| Primary language of the children and family:      Will any translation service(s) be needed? Yes[ ]  No[ ] If yes, what service(s) will be needed?       who will receive the service?        |
| Has a home assessment been requested: Yes[ ]  No[ ]  N/A[ ]  If yes, on whom?       |
| Has an ICPC home assessment been requested: Yes[ ]  No[ ]  N/A[ ]  If yes, on whom?       |
| Does a home assessment need to be requested: Yes[ ]  No[ ]  N/A[ ] If yes, provide information on family to be assessed:       |
| Has a kinship referral been made: Yes[ ]  No[ ]  N/A[ ]  |
| Has a Permanency Plan Meeting been scheduled: Yes[ ]  No[ ]  If yes, date scheduled: Click here to enter a date. If no, who will schedule:      Type of meeting: Family Group Conference[ ]  Family Team Meeting[ ]  Circle of Support[ ]  Single Child Plan of Service Meeting[ ]  Other:       |
| Has a CANS Referral been made? Yes[ ]  No[ ]  N/A[ ]  If yes, date of referral?       |
| Have all the caregivers been notified of the 3 in 30 requirements: Yes[ ]  No[ ]  If no, who will:       |
| Was any child born outside of the United States: Yes[ ]  No[ ]  if yes, Who/Where:      If yes, has the case been assigned as secondary to the Immigration Specialist: Yes[ ]  No[ ]   |
| Does any child have any medical or complex behavioral healthcare needs: Yes[ ]  No[ ]  If yes, has a consultation been held with the Well-Being Specialist: Yes[ ]  No[ ]   |
| Does the case need additional referral(s): Yes[ ]  No[ ]  If yes, what type: subject matter experts[ ]  local permanency specialist[ ]  courtesy worker for child[ ]  Courtesy worker parent[ ]  Other[ ]       If any checked: Person the referral is for:       Who is responsible for the referral(s)?       |

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| DISCUSSION POINTS |
| Facilitator will ensure discussion is held regarding each of the sections below at the time of the ICM staffing and all information is documented on this form. |
| Reason(s) for Removal. What SDM danger indicator(s) is present: |
| Parent:       | Danger Indicator(s):       |
| Parent:       | Danger Indicator(s):       |
| What parental behavior changes are necessary to achieve reunification: |
| Parent:       | Behavior Change(s) Needed:       |
| Parent:       | Behavior Change(s) Needed:       |
| Prior CPS history: |
| Name/Relation:       | CPS History:       |
| Name/Relation:       | CPS History:       |
| Criminal history of family members: |
| Name/Relation:       | Criminal History: [ ]  Yes [ ]  No |
| Name/Relation:       | Criminal History: [ ]  Yes [ ]  No |
| Visitation Schedule:(parents, relatives, siblings, significant others) |
| Visitor Name/Relationship: | Child/ren to Visit: | Days/Time of Visit: (E.g., Mon, Wed/5p-7p) | Location of Visit: | Type of Visitation: |
|       |       |       |       | Choose an item. |
|       |       |       |       | Choose an item. |
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|       |       |       |       | Choose an item. |
| Services for Parent: |
| Name/Relationship:      Recommended Services:       |
| Name/Relationship):      Recommended Services:       |
| Permanency Plan:      |
| Family Service Plan Complete: Yes[ ]  No[ ] Date Approved in IMPACT: Click here to enter a date.Date to be Filed with Court: Click here to enter a date. |
| Legal Issues for Case:       |
| Notes/Other:       |

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| CHILD’S NEEDS |
| Child’s Name: | Needs/Concerns:-E.g., TB test, educational, medical, mental, behavioral, therapeutic, developmental, dental, vision, hearing needs | Services Received or Needed:-E.g., ARD, ECI, therapy, medical/dental, vision, hearing, extra-curricular, medications to address identified needs, include progress/barriers | Child Sexual Aggressive Sexual Behavior Problem: |
|       |        |       | Yes[ ]  No[ ]  |
|       |       |       | Yes[ ]  No[ ]  |
|       |       |       | Yes[ ]  No[ ]  |
|       |       |       | Yes[ ]  No[ ]  |
|       |       |       | Yes[ ]  No[ ]  |

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| ASSESSMENT SERVICES TO BE OBTAINED |
| Child1:       | 3-Day Exam:  | CANS: | Texas Health Steps Medical Checkup: | Psychological Evaluation: | Psychiatric Evaluation: |
| Instruction/Time Frame: | Within 3 Business Days of Removal | Ages 3-17Within 30 Days of Removal | Within 30 Days of Removal | If Needed | If Needed |
| Provider: |       |       |       |       |       |
| Date Scheduled: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Date Completed: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Responsible for Completion: |       |       |       |       |       |
| Child2:       | 3-Day Exam:  | CANS: | Texas Health Steps Medical Checkup: | Psychological Evaluation: | Psychiatric Evaluation: |
| Instruction/Time Frame: | Within 3 Business Days of Removal | Ages 3-17Within 30 Days of Removal | Within 30 Days of Removal | If Needed | If Needed |
| Provider: |       |       |       |       |       |
| Date Scheduled: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Date Completed: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Responsible for Completion: |       |       |       |       |       |
| Child3:       | 3-Day Exam:  | CANS: | Texas Health Steps Medical Checkup: | Psychological Evaluation: | Psychiatric Evaluation: |
| Instruction/Time Frame: | Within 3 Business Days of Removal | Ages 3-17Within 30 Days of Removal | Within 30 Days of Removal | If Needed | If Needed |
| Provider: |       |       |       |       |       |
| Date Scheduled: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Date Completed: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Responsible for Completion: |       |       |       |       |       |
| Child4:       | 3-Day Exam:  | CANS: | Texas Health Steps Medical Checkup: | Psychological Evaluation: | Psychiatric Evaluation: |
| Instruction/Time Frame: | Within 3 Business Days of Removal | Ages 3-17Within 30 Days of Removal | Within 30 Days of Removal | If Needed | If Needed |
| Provider: |       |       |       |       |       |
| Date Scheduled: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Date Completed: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Responsible for Completion: |       |       |       |       |       |
| Child5:       | 3-Day Exam:  | CANS: | Texas Health Steps Medical Checkup: | Psychological Evaluation: | Psychiatric Evaluation: |
| Instruction/Time Frame: | Within 3 Business Days of Removal | Ages 3-17Within 30 Days of Removal | Within 30 Days of Removal | If Needed | If Needed |
| Provider: |       |       |       |       |       |
| Date Scheduled: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Date Completed: | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Responsible for Completion: |       |       |       |       |       |

| NEXT STEPS |
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| Date of Initial Service Planning Meeting: Click here to enter a date. |
| Next Steps: | Who is Responsible: | Date to Complete: |
| Other:       |       | Click here to enter a date. |
| Other:       |       | Click here to enter a date. |
| Other:       |       | Click here to enter a date. |
| Other:       |       | Click here to enter a date. |
| Other:       |       | Click here to enter a date. |

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| DOCUMENT VERIFICATION |
| Documents To Be Completed: | Completed: | Party Responsible: | Comments: |
| Placement Authorization (Form 2085)  | Yes[ ]  No[ ]  | Choose an item. |       |
| Designation of Medical Consenter & Education Decision-Maker Forms Completed with Signatures. (Form 2085b) | Yes[ ]  No[ ]  | Choose an item. |       |
| Copies of Signed Designation of Education Decision-Maker Form (K-908-2085-E) Provided to the:E.g., School, Caregiver/Facility, Parents, Managing Conservator, attorneys, any other person named by the court to have an interest in the child’s welfare | Yes[ ]  No[ ]  | Choose an item. |       |
| Education Portfolio Started and Provided | Yes[ ]  No[ ]  | Choose an item. |       |
| Copy of Rights of Children (form K-908-2530)given to child, caregiver, and parent. | Yes[ ]  No[ ]  | Choose an item. |       |
| Signature of Child/youth age 5 and older on CPS Rights of Children (form 2350) | Yes[ ]  No[ ]  | Choose an item. |       |
| Temporary Visitation Schedule (form K-908-2640) developed with parents | Yes[ ]  No[ ]  | Choose an item. |       |
| While Your Child Is In Care Pamphlet Given | Yes[ ]  No[ ]  | Choose an item. |       |
| Recommended and Selected Service Package entered | Yes[ ]  No[ ]  | Choose an item. |       |
| Placements Entered & Approved | Yes[ ]  No[ ]  | Choose an item. |       |
| Medical Consenter Entered | Yes[ ]  No[ ]  | Choose an item. |       |
| Foster Care Application Completed | Yes[ ]  No[ ]  | Choose an item. |       |
| Birth Certificate | Yes[ ]  No[ ]  | Choose an item. |       |
| Birth Verification from DHS | Yes[ ]  No[ ]  | Choose an item. |       |
| Social Security Card | Yes[ ]  No[ ]  | Choose an item. |       |
| Shot Records | Yes[ ]  No[ ]  | Choose an item. |       |
| Common Application (Form 2087) completed within 30 days of paid placement referral | Yes[ ]  No[ ]  | Choose an item. |       |