Embrace Families

Next court date: ______________
Next staffing date: ____________

To Do/Share:
1____________________
2____________________
3____________________
4____________________
5____________________

HOME VISIT SUMMARY – OUT OF HOME

Case Name:________________________________Date/Time:__________________Announced or Unannounced (Circle one)

Address:____

Condition/Description of the Home: ____

Caregiver's Name:_________________________Relationship to Child(ren) ______________________________

Household Member/Visitor	Seen		Interviewed Privately (required age 1+)	
Child:	Y	N	Y	N
Child:	Y	N	Y	N
Child:	Y	N	Y	N
Child:	Y	N	Y	N
Adult:	Y	N	Y	N
Adult:	Y	N	Y	N
Other:	Y	N	Y	N

CHILD(REN)

What child(ren) said during individual interview/demeanor: ____

____

____

____

____

If child is visiting parents/siblings separated by placement, what does the child say about the visits? ________________

____

Child (ren)'s physical appearance, interaction observations, concerns & needs: ______________________________

____

Discussions regarding case plan goal/permanency plan? ____

____

Viewed child's bedroom - any concerns noted? ____

School updates/issues? Y / N   Records obtained? Y / N Current School_____________Grade Level _____   IEP? Y/N

Life skills addressed? Y / N   Life skill form received (at least monthly)? Y / N

The caregiver has a current Client Resource Record (CRR/MJV) Y / N If no, plan to create? _______

CRR/MJV was reviewed during this home visit? Y / N; If No, reason:____________________________________

The CRR/MJV contains updated Medical, Dental & Vision information: Y / N

If no, what is missing/who will obtain? ____

Have there been any medical, dental and/or vision appointments since the last home visit? Y / N

Records obtained? Y / N

Are there any medical, dental and/or vision appointments scheduled? Y / N If so, when? _______________________

Child's current Primary Care Physician:_______________________Current Dentist: ____________________________

CAREGIVER

What did Caregiver say & what was observed? ______________________________

____

____

Updates on services for child (ren): ______________________________

____

Sufficiency of the safety plan to manage danger threat?

____

____

Names/Agency/Contact Info of current therapeutic providers & dates services provided: ______________________________

____

Parent visitation dates, location, frequency: ______________________________

Have parents been included/participated in medical/dental/mental health decisions/appointments/involving child?

Describe: ______________________________

Sibling visitation dates, frequency, location: ______________________________

Caregiver's report regarding visitation: ______________________________

____

Behavioral Management Plan

Is the child on a Behavior Management Plan? Yes / No (If yes, review the plan.) Are all the requirements being followed?

____

Are they still necessary? Yes/No (If no, consult with supervisor): ______________________________

____

Is the placement stable? Yes/No (If no, why not? May want to consider a Placement Support Staffing): ____________

____

ADDITIONAL NOTES

____

____

Case Manager: ______________________________ **Date:** ______________________________

Caregiver: ______________________________ **Date:** ______________________________

Date scanned into FSFN: ______________________________

30 Day Home Visit Psychotropic Medication Review

(Must be completed for all children in OHC prescribed Psychotropic Medications)

Child:_______________________________________**Placement Type:** _____________________________________

Psychotropic Medication(s) and Dosage(s):

Medication Name	Dosage	Time To Administer	Frequency/ How often	Purpose
1.				
2.				
3.				
4.				
5.				

Treating Psychiatrist: ____

Last Medication Management Appointment: ____

Next Medication Management Appointment: ____

1. **Is the child taking the medication(s) as prescribed?** ____**Yes** _____**No If No, describe reasons and follow up action to be taken:** ____

2. **Has the Medication Log been reviewed?** ______**Yes** _______**No** **If No, explain why and the follow up action to be taken:** ____

3. **Has the child or caregiver reported any side effects from the medication(s)?**_____**Yes** _______**No**
   If Yes, describe reaction and follow up actions taken or to be taken: ___________________________

   ____

4. **Has the caregiver noticed that the medication(s) have had a positive impact on the child's functioning/behavior?**
   ______ **Yes** _______**No** **If No, describe impact and follow up actions taken or to be taken:** ____________

   ____

5. **Does the child feel that the medication is helpful?**______**Yes** _______**No** **If No, explain reasons and follow up action to be taken:** ____

   ____

6. **Does the child have any questions or concerns about the medication?**_____**Yes** _______**No**
   Has the psychiatrist discussed the questions/concerns with the child?_____**Yes** _______**No**
   If the child had questions/concerns identify the questions/concerns and what action will be taken: _________

   ____

Case Manager Signature: ____________________________ **Date:**__________

Case Manager Supervisor Signature _____________________ **Date:** _________