



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+)	
	Y	N	Y	N
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 (Caregiver Portal) Y / N If no, plan to create? \_\_\_\_\_

Caregiver Portal was reviewed during this home visit? Y / N; If No, reason: \_\_\_\_\_

The Caregiver Portal 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: \_\_\_\_\_  
\_\_\_\_\_

Are there any new household members? Yes\_\_ No\_\_ *Note: If yes is selected, follow up activities are needed.*

**BEHAVIORAL MANAGEMENT PLAN**

Is the child on a Behavior Management Plan? Yes / No (If yes, review the plan.) Are all 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: \_\_\_\_\_

- Is the child taking the medication(s) as prescribed? \_\_\_ Yes \_\_\_ No If No, describe reasons and follow up action to be taken: \_\_\_\_\_
- Has the Medication Log been reviewed? \_\_\_ Yes \_\_\_ No If No, explain why and the follow up action to be taken: \_\_\_\_\_
- 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: \_\_\_\_\_
- 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: \_\_\_\_\_
- Does the child feel that the medication is helpful? \_\_\_ Yes \_\_\_ No If No, explain reasons and follow up action to be taken: \_\_\_\_\_
- 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: \_\_\_\_\_