Initial Plan Development
WRAPAROUND PLAN OF CARE
INTERAGENCY SCREENING COMMITTEE REVIEW

Child's _____ Referring Worker _____
Child's ID#: _____ D.O.B.: _____ DCFS Social Worker: _____
Program Activation Date: _____ MH Worker: _____
Facilitator _____ Probation Officer: _____

Monthly estimate of service _____ to _____ (*Not to exceed 6 months*).
If modification date modified: ____/__/____

For ISC use only:

Date Reviewed: _____

Approved ☐ Denied ☐

Explanation: _____

_____

_____

_____

_____ _____
DCFS LIAISON Date PROBATION LIAISON Date

_____ _____
MENTAL HEALTH LIAISON Date OTHER MEMBER Date

WRAPAROUND PLAN OF CARE

Child's Name: _____ Service dates from ____/ /____ to ____/ /____

Major goal: _____

STRENGTHS	DOMAIN	NEED	STRATEGY	RESOURCE

WRAPAROUND PLAN OF CARE

Child's Name: _____ Service dates from ____/ /____ to ____/ /____

STRENGTHS	DOMAIN	NEED	STRATEGY	RESOURCE

WRAPAROUND PLAN OF CARE

Child's Name: _____ Service dates from ____/ / ____ to ____/ / ____

STRENGTHS	DOMAIN	NEED	STRATEGY	RESOURCE

Child/Family Team Member Date

Child/Family Team Member Date

Child/Family Team Member Date

Child/Family Team Member Date

Child/Family Team Member Date

Child/Family Team Member Date

Child/Family Team Member Date

Child/Family Team Member Date