# **DISPOSITION SUMMARY/AFTERCARE PLAN**

#### **RESIDENTIAL CINS/FINS**

CDS Family & Behavioral Health Services, Inc.

## Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Participant #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Program Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program Disposition Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Disposition (Check one)

**Planned:**  \_\_\_\_ 1. Services Completed, Aftercare Planned

\_\_\_\_ 2. Services Completed, Referral Made

**Unplanned**: \_\_\_\_ 3. Family Voluntarily Withdrew \*

\_\_\_\_ 4. Services Incomplete, Youth Expelled \*

\_\_\_\_ 5. Service Incomplete, Youth Ran Away

\_\_\_\_ 6. Services Completed, Youth Removed By Protective Agency

\_\_\_\_ 7. Service Incomplete, Adjudicated Delinquent \*

\_\_\_\_ 8. Other \*

**(\* Consult with a supervisor prior to using these responses.)**

**Living Arrangement at Disposition:** (Check one) \_\_\_\_ Appropriate\_\_\_\_ Inappropriate\_\_\_\_ On-the-Run

**Comments:** *(*Location or living arrangements of youth at Disposition. If the youth is not with the family at Disposition, describe the reasons for the alternative placement, plans for the youth living arrangements and interim objectives set that will accomplish an eventual return, if possible and appropriate.)

**Services Provided:** (check all that apply)

\_\_\_\_ Emergency Response/On-Call \_\_\_\_Centralized Intake \_\_\_\_ Non-Residential

\_\_\_\_ Case Staffing Committee \_\_\_\_ Residential

(Give a brief recapitulation of events in the case, including findings and recommendations for future services.)

**Referrals/Appointments Made During Disposition Process:**

Agency: Contact Person:

Phone Number: Location(s):

Appointment Made: (If so time and day)

Hours and Days of Services of the Referral Agency:

Agency: Contact Person:

Phone Number: Location(s):

Appointment Made: (If so time and day)

Hours and Days of Services of the Referral Agency:

Agency: Contact Person:

Phone Number: Location(s):

Appointment Made: (If so time and day)

Hours and Days of Services of the Referral Agency:

Address continuing medication needs if applicable:

Physicians Name Phone #

Physicians Name Phone #

**Aftercare Plan:** The following is recommended to support continued maintenance of goals and objectives, and to continue to increase adjustment and well-being or community integration. If applicable include: counseling and/or other supports, education status and goals, employment preparation and career planning, housing plans, and transition into independent adult. Include input from resource individuals in his/her school and community.

**Options if Problems Recur:**

**CDS Personnel Responsible for Follow-Up for Disposition/Aftercare Plan from Services:**

**Signatures**:

Parent(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

*(Check all that apply)*

­\_\_\_\_\_ Copies provided to Participant and/or Parent/Guardian(s)

\_\_\_\_\_ Copies offered to Participant and/or Parent/Guardian(s) and declined

­­­­\_\_\_\_\_ Copies mailed to Participant and/or Parent/Guardian(s)

\_\_\_\_\_ Copies provided to individuals who participated in the development of the plan

\_\_\_\_\_ Copies sent to referral source