

Improving the Quality of Family Life in Erie County

Service Coordination Mechanism

**Family & Children
First Council**

Erie County



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Erie County Family & Children First Council
Service Coordination Mechanism
Executive Summary

Since its inception in the early nineties, the Ohio Family & Children First Initiative has been a catalyst for bringing community agencies together to coordinate and streamline services for those families and children needing or seeking assistance. Erie Counties first Service Coordination Mechanism was written in 2006. In 2010 a committee comprised of members of the FCF, the County Board of Developmental Disabilities, Juvenile Court and Job's & Family Services reviewed the plan and updated it. This updated plan was presented to the FCF Funding Priorities Committee and then the full Council and approved for submission to the State in June 2010. (See attached Resolution)

This Coordination Mechanism shall serve as a guiding document for coordination of services when a child is referred to the council for assistance. With adopting this mechanism the Council will strive to ensure that:

- Services are delivered using a family-centered, community based approach.
- Services are responsive to the cultural, racial and ethnic differences of the population being served.
- Service outcomes are evaluated.
- Available funding resources are fully utilized or integrated.
- Wraparound services and community supports are utilized.
- Specialized treatment for difficult-to-serve populations and evidence-based treatment services are encouraged.
- Most importantly, families are given a voice in decision-making for their children.

The Family & Children First Council in Erie County has focused on multi-need youth as its target population for Service Coordination. In order for any agency or family seeking service coordination they must contact Cindy Franketti at Erie County Juvenile Court (419)627-7782. An initial assessment of a family's needs will be made by the Wraparound Service Supervisor. This assessment will determine the eligibility and Level of Service Coordination needed and a referral will be made to the appropriate agency/community resource.

1. **Level One:** A **Service Coordination** referral is those parents who are not involved in multiple agencies, yet are seeking services that they are having difficulty accessing through one agency. Level One Service Coordination families will be referred to an appropriate agency for assistance prior to Wraparound being considered as an option.
2. **Level Two:** A Level Two referral is those children who are already multisystem involved. A wraparound referral form will be filled out and processed for initiation of **Wraparound** services.
3. **Level Three:** If the needs of the family cannot be met through already existing collaborative efforts, the need to form a Family Team for Wraparound will be evaluated and initiated if appropriate. The referral will then be assigned a Wraparound Team Facilitator and Team Support Specialist. Our County utilizes

the four Phases of High Fidelity Wraparound to meet the needs of those families who need a high level of Service Coordination.

When eligible for High Fidelity Wraparound Services, the Wraparound Supervisor will assign a Team Facilitator. The Team Facilitator will work with the family on determining the team membership, setting up meetings and doing a family strengths, needs and cultural discovery assessment. The Facilitator will also initiate all Releases of Information to protect the family's confidentiality. The Team will work with the family on formulating an Individualized Family Service Coordination Plan to be initiated within the county.

The FCF Service Coordinator will be responsible for tracking all Service Coordination Plans initiated in the county and will regularly report to the Wraparound Management Response Team on progress and statistics for evaluation.

When a child & families Individualized Family Service Coordination Plan, which has been developed by their team, has identified needs in which cannot be funded through any other community funding options, the request for funding will be presented to the FCF Director for review of appropriateness and final approval.

Erie County will utilize out-of-home placement only after families are provided the range of community-based therapeutic/supportive services and those services are deemed inadequate by the Family Team to provide a reasonable level of safety and well being for the child and family, or when an emergency exists, which requires immediate intervention. With the implementation of Service Coordination, Wraparound and the formation of Family Teams, it is envisioned that any recommendation for a non-emergency out-of-home placement of a child would originate from the Family Team of that child.

The Wraparound Management Response Team will review the cases of children who have been placed out-of-home and are involved in Wraparound. This team will monitor each child's progress and the implementation of the plan for reintegration back into the community as developed by the Family Team.

The FCF Council shall inform parents and/or custodians of their rights to use the dispute resolution process as described in the Service Coordination Mechanism. Parents or custodian shall use existing local agency grievance procedures to address disputes involving an agency not involved with the service coordination plan. The dispute resolution process shall address conflicts that arise in three distinct situations: the family is in disagreement with one agency; the family is in disagreement with the service plan; or one agency is in disagreement with another agency or the service plan.

FCFC of Erie County shall assure that there is a process, through the Ohio Department of Health (ODH), for complaint resolution that includes mediation and civil hearing procedures for parents of children birth to three who have a developmental delay or diagnosed disability. Parents of children birth to three determined to be eligible for HMG services shall be informed of their rights annually, at a minimum, throughout the time the

child is receiving HMG services. Parents of children enrolled in HMG who are involved with the Home Visiting component of HMG shall follow the dispute resolution process as outlined in the Service Coordination Mechanism.

Through the Family Team process and the Wraparound Management Response Team, outcomes for Service Coordination will be measured and evaluated. Evaluation procedures will include Consumer satisfaction surveys. There will be ongoing input from families during the planning, implementation and evaluation process developed to measure results and key indicators of progress through informal and formal meetings.

In the above outlined procedures there are areas, which will need continued strengthening and attention. These include:

- Community-wide access to the Family Team process.
- Extensive internal systems information and education regarding the process and procedures; this would include cross system training.
- Community information and education regarding the process and procedures, which assures access to non-system involved children and families.

Ongoing and aggressive efforts at community education will be needed in order to assure awareness and access to the process, particularly for those children and families who may not be currently involved in any of the systems, but are in need of support. Our county will provide agencies with ongoing training opportunities on Service Coordination and Wraparound.

Continuous feedback of service gaps will be forwarded to the Administrative Level for review, attention and program/services development.

This plan will be reviewed annually for needed revisions as it is viewed by our Council as a "work in progress". The Family & Children First Council will be provided with monthly updates on the process and its progress.

ERIE COUNTY SERVICE COORDINATION MECHANISM

Overview and Goals

This **Service Coordination Mechanism** O.R.C. 121.37 (C) is based on the accomplishments of the youth serving systems in Erie County and relies significantly on procedures and patterns developed collaboratively over time with those systems. It attempts to build on the strong foundation already developed in the county, as well as move forward in those areas, which remain challenging. We have attempted to frame the Service Coordination Mechanism within the existing structures and relationships established, so as to assure continuity and consistency in the system of care for our youth and their families. This Coordination Mechanism shall serve as a guiding document for coordination of services for families and children in our county. For children who also receive services under the Help Me Grow program (HMG), the service coordination mechanism shall be consistent with rules adopted by the Department of Health under section 3701.61 of the Revised Code. This mechanism was developed and approved with the participation of the agencies involved in the Family & Children First Council of Erie County.

The Family & Children First Council (FCFC) is comprised of several levels of group activities all of which are directed toward providing Erie County families and children with a high quality of well-integrated services.

- The Administrative Level consists of the top executives of all the systems who participate in the Family & Children First Council, along with parent representation. The membership includes the Director of the Erie County Health Department, Director of Erie County Job & Family Services, Director of the Children's Service Unit of Job & Family Services, Judge of the Erie County Common Pleas Court Juvenile Division, the Director of Juvenile Court Probation, The Director of the Erie/Ottawa MHR Board, Superintendent of Erie County Board of DD, Superintendent of Sandusky City Schools, Superintendent Representing Other Local School Districts, Regional Director of The Ohio Department of Youth Services, Chairperson/Designee of the Help Me Grow Early Childhood County Collaborative, Chair/Designee of the County Commissioners, a Headstart representative, a representative of the City of Sandusky, the United Way of Erie County, the Director of Kinship House and three Parent Representatives.
- The Finance/Funding Priorities Committee (FFPC) of the Council. This subcommittee reviews finances of the FCC and discusses funding priorities to make recommendations to the Administrative Level of the Council. This Committee membership also serves as the Dispute Resolution Subcommittee (DRS).
- The Early Childhood Community Collaborative (ECCC). This subcommittee of the council addresses information, issues and concerns regarding the Help Me Grow program and programs dealing with the 0-3 population.
- The Wraparound Management Response Team (WMRT). This level consists of the middle level managers of the participating systems. The WRMT reviews referrals to the Wraparound initiative, is a resource for teams, monitors treatment for Council youngsters, and identifies service gaps to report the Administrative Level.

- The “Family Team” Level of the Council is the direct service level. The Family Team is a multiple system team, which provides strengths based assessment and treatment planning for children and their families. Any case manager in any system may request a team meeting to develop the most creative and flexible service package for a child and family.

It is the presumption and experience that the key participants in the Family & Children First Council are on the whole addressing the needs of children and families with whom they come in contact, given their current resources. The focus of this Service Coordination Mechanism is on those multi-system/multi-challenged children and families who are not being served effectively due to inadequate services and supports, and on facilitating greater overall systems integration for all children and families served by the systems.

Principles and Values

Vision

For any organization, and certainly for any collaborative effort to succeed, there must be a consensus on the foundation on which that collaboration rests. The Family & Children First Council of Erie County’s vision is that we are ***“Improving the Quality of Family Life in Erie County”***. We do this with a commitment to the following beliefs:

- ⤴ Families are our most important human resource, and their children our most vulnerable class of citizens. Children with multiple needs are at an even higher risk of failure in becoming self-reliant adults. We believe that our forum can create ideas and influence policy.
- ⤴ We will positively influence an array of systems, which already exist to support families, and with these systems form a safety net of support.
- ⤴ The child serving systems will one day coalesce at all levels, so that children and families will be offered comprehensive services which will support them and form an unbreakable chain.
- ⤴ Children and families will be nurtured and protected by an all-encompassing system, which will wrap around them according to their unique needs.
- ⤴ That one day, in Erie County, every family will be afforded the opportunity to secure supportive and educational services to fully enhance the lives of our families and children.

Mission

In tandem with that vision is the following:

The Family & Children First Council shall assure that services to families and children are delivered in a timely, effective, and coordinated manner and in the least restrictive environment. It is our intent to achieve local collaborative decision making to create partnerships within the community to ensure that families and children of Erie County will have the nutrition and health care needed to have healthy minds and bodies; families will understand and address the developmental needs of their children; and family members will

be literate and possess the knowledge and skills necessary to be productive and responsible citizens.

Guiding Principles:

Our Family & Children First Council is geared to improve services to multi-need children and families. With that in mind our Family & Children First Council supports the following:

- ❖ *The system of care shall include a comprehensive array of effective services.*
- ❖ *Services shall be individualized to meet the unique needs of the child and family and will address the eight life domain areas.*
- ❖ *The array of services shall be the least restrictive and most appropriate.*
- ❖ *Families and surrogate families shall be full participants in the planning and delivery of services.*
- ❖ *Children shall receive services that are integrated and coordinated across agencies.*
- ❖ *Early intervention and prevention programs shall be promoted in order to enhance the opportunities for success.*
- ❖ *The rights of children and families shall be protected.*
- ❖ *Services shall reflect the cultural and ethnic diversity of the community and its residents.*

Our Council also supports Ohio's Commitments to Child Well-being:

- ♥ *Expectant parents and newborns thrive*
- ♥ *Infants and toddlers thrive*
- ♥ *Children are ready for school*
- ♥ *Children and youth succeed in school*
- ♥ *Youth choose healthy behaviors*
- ♥ *Youth successfully transition into adulthood*

Our County will utilize these commitments as a framework to assist us in organizing local programs and resources, aligning local activities and measuring our performance in ***“Improving the Quality of Family Life in Erie County”***.

Process for Accessing the Family & Children First Council (FCFC)

Service Coordination Mechanism (SCM)

To Develop an Individualized Family Service Coordination Plan (IFSCP)

O.R.C. 121.37 (C)(1) A procedure for referring a child and family to the County Council for Service Coordination (Wraparound Phase 1.1)

The Family & Children First Council in Erie County has focused on multi-need youth ages 0-21 as its target population. An Erie County Council child needs many systems for support; is involved in multiple systems; is at risk for institutionalization; presents as a systems' failure; and usually has multiple failures across multiple systems. Included in this population are those children whose families are voluntarily seeking services and those children involved with the Help Me Grow (HMG) System.

The **Erie County Service Coordination Mechanism (ECSCM)** makes the presumption that the needs of many youth and families who come into contact with the juvenile justice system, child welfare, mental health, drug/alcohol services and others, are being adequately met by those systems. It recognizes that each system has areas of responsibility and that this collaborative approach is not intended to replace or usurp the primary role of any one of these systems. This mechanism is an option when the resources of one system are not adequate to address the needs of the youth and family. This mechanism strives to ensure that the need for other interventions can be identified prior to court involvement, and that services are put in place to meet those needs, building on family strengths.

In order for any agency or family seeking service coordination they must contact the Wraparound Supervising Coordinator at Erie County Juvenile Court 419-627-7623. An initial assessment of a family's need for Service Coordination or enrollment in Wraparound is made by the Wraparound Coordinator. Referral dates and follow-up notes are recorded by the Wraparound Coordinator. (See Wraparound Brochure)

This initial assessment will determine the eligibility and Level of Service Coordination or Wraparound needed.

1. **Level One:** A **Service Coordination** referral is those parents who are not involved in multiple agencies, yet are seeking services that they are having difficulty accessing through one agency. Level One Service Coordination families will be referred to an appropriate agency for assistance prior to Wraparound being considered as an option.
2. **Level Two:** A Level Two referral is those children who are already multisystem involved. A wraparound referral form will be filled out and processed for initiation of **Wraparound** services. (See Addendum A -Referral Form)
3. **Level Three:** If the needs of the family cannot be met through already existing collaborative efforts, the need to form a Family Team for Wraparound will be evaluated and initiated if appropriate. The referral will then be assigned a Wraparound Team Facilitator and Team Support Specialist. Our County utilizes the four Phases of High Fidelity Wraparound to meet the needs of those families who need a high level of Service Coordination.(See pages 21-28)

Family choice is emphasized in the selection and/or provision of services. Except in those cases where child or public safety is the predominant concern, families should be offered the opportunity for assistance and the opportunity to reject part or all of that assistance. It will be incumbent upon the Family & Children First Council to address these needs in ways, which are timely, culturally relevant, community-based and collaborative.

O.R.C. 121.37 (C)(2) A procedure for notification of all comprehensive family service coordination plan meetings. (Wraparound Phase 1.2, 1.3 .1.4)

When it is decided that the family would benefit from the formation of a Family Team and the wraparound process initiated, the family will be given the opportunity to design their own family team. All families will sign a FCFC Release of Information prior to contacting potential team members. (See Addendum B)

The Coordinator will assign a Team Facilitator or become the Team Facilitator for the referred family. The Parent will have the opportunity to meet the assigned Team Facilitator and decide if they will be the appropriate match for the family, if not they may choose another facilitator that they are able to relate to. The parent and the Team Facilitator will determine who should be present at a Family Team meeting. The parents/family and child are integral and essential partners on convening the team. The parents decide whom they would like to have invited to their Family Team Meeting. The facilitator will encourage them to invite informal supports such as:

- Family members
- Friends
- Church members
- And others from their neighborhood and community that they can count on for support.

The Team Facilitator will suggest that they may want to invite formal supports such as:

- Family Support Workers
- Counselors
- Teachers from the child's local school district or their representative
- Jobs & Family Service Personnel
- Juvenile Court
- MR/DD
- Or others involved with their family as service providers

The Team Facilitator may also help them to consider people that don't work with their family now but may be able to provide them with information, services, resources, or additional supports. They will also inform them that there may be people who *must be invited* because of legal reasons and are necessary to have input from if they are involved with them, (JFS or JC staff).

The Team Facilitator will record all contacts with team members and compile a team roster for the family. The Team Facilitator or Team Support Specialist will contact all team members prior to the first scheduled team meeting for the family. Team members are also informed of the next scheduled meeting date prior to leaving each meeting. The team members are reminded of the next scheduled team meeting by e-mail via our established communication process. (See Additional Materials Section)

O.R.C. 121.37 (C)(3) A procedure permitting a family to initiate a meeting and invite support persons (Wraparound Phase 1.4-1.5)

All families involved in Wraparound will be given the information on their team sign in sheet. Meetings will be regularly scheduled by the team, if however, parents feel a need to have additional meetings scheduled, they can contact their Team Facilitator for assistance in setting up the meeting. The parent will be provided with information on Parent Advocates available in the area for support on their team.

O.R.C. 121.37 (C)(4) A procedure ensuring a comprehensive family service coordination plan meeting occurs before an out-of home placement is made, or within ten days after placement in the case of an emergency (Wraparound Phase 1.2, 2.2)

It is the intent of the Erie County Service Coordination Mechanism that services for children with serious emotional disturbance should be planned and implemented to maximize the support of the family and the community to provide adequately for the safety and well-being of the child at home. The team will develop a crisis/safety plan in the first initial meetings. Services shall be individually planned to meet the unique needs of each child and family. The continuum of services shall include, but not be limited to, individual and family counseling, crisis intervention services, respite care, foster care, therapeutic foster care, intensive home-based family support services, residential treatment, and inpatient services. All efforts will be made to provide services without requiring the parents to relinquish custody of the child. Relinquishment of custody will be considered as an avenue of last resort in order to maximize funding streams available for the needed services. Erie County will utilize out-of-home placement only after families are provided the range of community-based therapeutic/supportive services and those services are inadequate to provide a reasonable level of safety and well being for the child and family, or when an emergency exists, which requires immediate intervention.

With the implementation of Service Coordination/Wraparound and the formation of Family Teams, it is envisioned that any recommendation for a non-emergency out-of-home placement of a child would originate from the Family Team of that child. When an emergency out-of-home placement occurs, the Department of Jobs and Family Services schedules a Team Decision Making (TDM) meeting with the family within 2 days of the emergency placement. At this meeting a plan will be completed for the family to resolve issues or to make further referrals for Service Coordination. Cases in Erie County, which are part of the Service Coordination/Wraparound process, will be reviewed and updated on a regular basis at the Wraparound Management Response Team meetings held monthly. With this regular review and update of cases the Wraparound Management Response Team should be aware of any case that has the future potential to become a recommendation for residential placement.

Access to services for children with serious emotional disturbance and their families shall be voluntary whenever informed consent can be obtained. All potential and available resources for funding will be considered when calculating the financial obligation of the family. When a child is in a voluntary placement, which is funded in whole or in part by local, state or federal funds, the Erie County Management Response Team will review the placement every 30 days.

When a child & families Individualized Family Service Coordination Plan, which has been developed by their team, has identified services in which funding is needed, the request for funding will be presented to the Council Director for review of appropriateness. The FCF Director will assist in determining the appropriate resources for the funding of services and supports. Resources of funding may include: FCSS funding streams, Help Me Grow, or Agency Shared Funding. The Agency Director providing shared funding must sign off on the Funding Request Form when agreeing to share funding. (See Additional Materials-Funding Section)

O.R.C. 121.37 (C)(5) A procedure for monitoring progress and tracking outcomes of each comprehensive family service coordination plan. (Wraparound Phase 3.1, 3.2)

The Wraparound Management Response Team of the Family & Children First Council will be updated and review each case involved in the Wraparound process on a monthly basis. Any case that is an out-of-home placement will be tracked and monitored by the Wraparound Management Response Team. The Wraparound Management Response Team, when appropriate, will monitor the progress and track the outcomes of each service coordination plan requested in the county to assure continued progress toward stated goals, appropriateness of placement, and continuity of care after discharge from placement with appropriate arrangements for housing, treatment, and education.

O.R.C. 121.37 (C)(6) A procedure for protecting the confidentiality of families. (Wraparound Phase 1.1)

All Family & Children First Council participants have entered into a confidentiality agreement which assures the timely access to appropriate information while respecting the right to privacy of children and parents. All families involved in Service Coordination/Wraparound, Family Team Meetings and HMG sign a Release of Information Form initiated prior to formation of the Family Team or the sharing of family/agency information. The Family & Children First Authorization for Information Sharing will be signed by the parents for a period not to exceed 180 days. Parents are informed of their right to revoke the release in writing at any time. Parents within the Help Me Grow system are given their Parents Rights Brochure. The Release of Information for the HMG system shall follow the ODH guidelines as applicable. At each team meeting an agreement of confidentiality is also signed by all the team participants. (See Addendum B and C)

O.R.C. 121.37 (C)(7) A procedure for assessing the needs, strengths and culture of any child or family referred. (Wraparound Phase 1.2, 1.3, 1.4)

The Wraparound Supervisor will have an initial intake meeting with the family. At this initial meeting or soon after, the Team Facilitator will then have a conversation with the family as part of a needs, strengths and cultural discovery/assessment. (See Addendum D, Family Development Matrix, and Additional Materials) During the early assessment process, the primary focus will be the safety, permanency and well being of the children in the family. The purpose of this early stage is to engage and develop a relationship with all household members, including the children as well as the parents & caretakers. In addition, during this phase of information gathering from the family, the facilitator begins to develop the Family Team with the parents. The importance of an inclusive assessment cannot be stressed enough. Without a thorough assessment, the facilitator will not have a clear view of family interaction and family dynamics. This information will be shared as part of the first team meeting. Our county uses several different tools to assess the needs and strengths of the families it works with. When a Family Team is formed, assessments/screenings which have already been done will be incorporated into this assessment process and be shared with the team.

For each family participating in Service Coordination, the team will utilize the Family Development Matrix as part of the strengths and needs assessment. This Family Develop Matrix will help to establish baseline data for each family in 13 general outcome areas. This matrix provides information on areas a family is successful and those areas that need immediate assistance. The Families progress is tracked over time in each of the outcome areas as they receive services. This allows the team to identify the family's successes as well as areas in need of further

attention and assistance; consequently, allowing service coordination to be more targeted giving the family accurate assistance. (See Addendum D, Family Development Matrix, and Additional Materials Section)

Central to the above process is the role of the parents and family and a focus on the strengths present in the child's life. The ultimate completion of this process represents the Team's "official assessment" of the child and family's needs. It is inclusive of other more detailed or formal assessments made at various points but represents the global and comprehensive information base from which the system will work.

O.R.C.121.37 (C)(8) Developing an Individualized Family Service Coordination Plan (IFSCP)
(Wraparound Phase 2.1, 2.2)

Family Team (Wraparound) meetings are community support/assistance planning meetings. They are guided by strength-based, family assessment model. The family most often will be referred to Service Coordination/Wraparound for development of a family team by the system that currently holds the lead case management responsibility. The parents/family and child are integral and essential partners on the convening team.

Parents and families, including the child if appropriate, are full and equal participants in the development of the strengths-based assessment and individualized service plan. Such planning meetings are to be scheduled at times and places which are convenient to families.

A Family Team may be convened for any child involved in any of the mandated or other participating systems/agencies when there are such conditions as: difficulty in creating an appropriate service plan; intersystem barriers inhibiting the execution of a plan; financial barriers limiting the planning; difficulty in identifying the full array of services needed or other factors which appear to be impacting the smooth flow of the system in meeting the stated needs of the child and family.

The purpose of these Family Team meetings is to creatively examine what might work for the child and family, and to develop individualized goals. It develops strategies which cover the range of needed services including where the child lives and what direction all of the involved systems are headed. The purpose of the meeting is to develop an array of treatment, education, recreation, and living arrangements written into a plan, which will work for the child and family. (See Addendum E)

- ♥ All Family & Children First Council participants have entered into a confidentiality agreement that assures the timely access to appropriate information while respecting the right to privacy by children and parents.

Since the majority of children for which a Family Team meeting is called, are already involved at some level in one or more of the key systems, it is likely that relevant background material, including assessments and evaluations exists. The Team does not duplicate evaluations or assessments; however, the Team may request additional information to properly assess the full range of needs.

The needs identified through the assessment process will be synthesized into a unified, coordinated, family service plan which is inclusive of all appropriate services and supports and unifies all existing plans.

As a part of the individualized planning process any current plan by any agency or system is reviewed and can be modified, revised and/ or included in the Individualized Family Service Coordination Plan (IFSCP) as needed. At times the Family Team process can be used to augment any current service plan, with a broader or more specific and individualized array of services and supports. If the child is involved in various systems or agencies which require services plans, the Child & Family plan will either become a part of the record(s) or in some cases may replace it, depending on the circumstance.

The plans, which are developed, should be driven by the needs, goals and choices of the child and family. They should not be limited by what is currently available, or the origin of the resources. This is a way to ensure that treatment planning is in the best interests of the child and family and not driven by resources.

- ♥ Every effort will be made during the planning process to identify a range of services and supports, which are acceptable, accessible and relevant to the parents, child and family culture. It is quite possible that current services may need to be modified and individualized to meet the unique needs of the child and family. It is also possible that through the wraparound process, services and supports, which do not currently exist, will be brought on line.

O.R.C. 121.37 (C)(9) Erie County FCFC dispute resolution process.

The purpose of service coordination is to provide a venue for families needing services where their needs may not have been adequately addressed in traditional agency systems. Each agency system has areas of responsibility and the collaborative approach is not intended to replace or usurp the primary role of any one of these systems. Dispute resolution is an important component of any services delivery system. Although agencies and professionals are committed to meeting the needs of the child and/or family there are times when one or more members of the team may question decisions or the process. In all instances families are encouraged to ask questions and become informed as to what is available, what their child might need, and what rights and responsibilities they have as parents. Conflicts may arise in three distinct types of situations:

- ✓ The family is in disagreement with one agency;
- ✓ The family is in disagreement with the service plan; or
- ✓ One agency is in disagreement with another agency or the service plan.

If the dispute does not pertain to service coordination, parents or custodians shall use existing local agency grievance procedures to address disputes. This process is in addition to and does not replace other rights or procedures that parents or custodians may have under other sections of the Ohio Revised Code. Each agency represented on a county Family and Children First Council (FCFC) that is providing services or funding for services that are the subject of the dispute initiated by a parent shall continue to provide those services and the

funding for those services during the dispute process. These rights shall not be interpreted as overriding or affecting decisions of a juvenile court regarding an out-of-home placement, long-term placement, or emergency out-of-home placement.

The FCF Council shall inform parents and/or custodians of their rights to use the dispute resolution process. Parents or custodian shall use existing local agency grievance procedures to address disputes not involving Service Coordination. FCFC of Erie County shall assure that there is a process, through the Ohio Department of Health (ODH), for complaint resolution that includes mediation and civil hearing procedures for parents of children birth to three who have a developmental delay or diagnosed disability. Parents of children birth to three determined to be eligible for HMG services shall be informed of their rights annually, at a minimum, throughout the time the child is receiving HMG services. Parents of children enrolled in HMG who are at-risk shall follow the dispute resolution process as outlined in this Service Coordination Mechanism.

Family Team Disputes

The process for handling each of the above situations is dependent on the premise that individuals and agencies will, in all instances, seek clarification and resolution at the Family Team level prior to initiating the formal conflict resolution process. The Family Team serves to utilize the recommendation of all parties, including that of the parent or guardian, that promotes the well being of the child(ren) in regards to services for the child(ren). If there is significant and unresolved conflict regarding any aspect of the Comprehensive Service Plan by any participant (including parents) in the Wraparound process, every attempt is made to resolve that conflict with the participating members of the Family Team. If the Family Team cannot resolve the dispute, the dispute resolution process can be initiated. Each family will be notified of their right to utilize the dispute resolution process and provided information regarding the process at the first Family Team meeting. Parents who choose to utilize an advocate or mentor are encouraged to include those representatives in the process. If difficulties in resolution at this level occur, the Council Director can be asked to sit on the team as a mediator for conflict resolution. At no time during the dispute resolution process will services to the family be disrupted. This keeps the conflict mediation and dispute resolution as close to the direct level of care as possible.

The process itself is a mediating process and is based on a “stay at the table” approach, which is understood and accepted by the participants. The final Family Team plan, which emerges, is the negotiated document and contains “team” solutions.

Disputes Between Agencies

When disagreements arise between agencies as to the services or funding of services a child and/or family is to receive, any agency represented on the council may initiate the local dispute resolution process established in the county service coordination mechanism applicable to the council. If a dispute is initiated between agencies, the following timeline will be utilized:

1) Within 7 calendar days of the disagreement/dispute the disputing agency must submit a Dispute Resolution Request Form (See Additional Materials- Handout Section) to the FCFC Director communicating the desire to utilize the dispute resolution process. Supporting evidence or documentation concerning the dispute should be submitted with this request. This request should be submitted to:

ATTN: FCFC Director

Erie County Family and Children First
414 Superior Street
Sandusky, Ohio 44870

2) Upon receipt of the agency request to utilize dispute resolution, a meeting between the Wraparound Management Response Team (WMRT) and the disputing agency will be convened within 15 calendar days. This meeting will be scheduled at a mutually convenient time for the majority members of the disputing agency and the WMRT. The disputing agency will prepare a presentation for the WMRT regarding the nature of the dispute, the specific issues that are requested to be resolved, and a proposed solution. This presentation can be made by the director of the agency or an approved representative of that agency. Each WMRT member must vote on the proposed solution. A majority vote will determine resolution of the dispute. The FCF Director will act as facilitator in the process, but will not have a deciding vote. The WMRT will be responsible for preparing the responses to the disputing agency and the FCF Director will issue a written response in regards to the decision to that agency within 3 calendar days.

3) If a resolution cannot be found at the Wraparound Management Response Team of the Council, then a referral is made by the Council Director to the Council's designated Dispute Resolution Subcommittee. This Subcommittee may require any additional information or ask any participants for further details regarding the conflict. Any additional information requested will also be provided to all Family Team Members. The Subcommittee will issue a majority recommendation within 10 working days. The recommendation is then conveyed to the Family Team. This decision is considered to be locally binding.

4) If the disputing agency disagrees with the decision of the Dispute Resolution Subcommittee (DRS), the disputing agency has the right to request that the dispute be reviewed by the final arbitrator, the presiding Juvenile Court Judge. The disputing agency must submit in writing a request to move to the final stage of the dispute resolution process within 7 calendar days of receiving the DRS decision. Upon receipt of this request, the Program Coordinator for FCF will submit within 5 calendar days all documentation regarding the dispute, (including, but not limited to) the request for dispute resolution and supporting documentation, the responses made by the FFPC, treatment information, and other relevant information to the presiding Juvenile Court Judge. The Juvenile Court Judge will decide which presiding Judge will be assigned to the dispute. The court shall hold a hearing as soon as possible, but no later than ninety days after the motion or complaint is filed. At least five days before the date on which the court hearing is to be held, the court shall send each agency subject to the determination written notice by first class mail of the date, time, place, and purpose of the court hearing. This decision will direct one or more agencies represented on the council to provide services or funding for services to the child. The determination shall include a plan of care governing the manner in which the services or funding are to be provided. The presiding Juvenile Court Judge shall utilize the plan or care on the family service coordination plan developed as part of the county's service coordination mechanism and evidence presented during the local dispute resolution process in making the determination. The presiding Juvenile Court Judge may require an agency to provide services or funding only if the child's condition or needs qualify the child for services under the laws governing the agency. While the local dispute resolution process or court proceedings are pending, each agency shall provide services and funding with no interruption until a final decision is rendered. If an agency

that provides services or funds during the local dispute resolution process or court proceedings is determined through the process or proceedings not to be responsible for providing them, it shall be reimbursed for the costs of providing the services or funding by the agencies determined to be responsible for providing them.

Non-Emergent Disputes Between Parent/Guardian and FCFC

A non-emergent dispute will be defined as a dispute that does not require an immediate response due to the safety or well-being of the child(ren). If a non-emergent dispute is initiated by a parent or guardian, the following timeline will be utilized:

1) Within 7 calendar days of the disagreement/dispute the family will submit a Dispute Resolution Request form to the FCF Director communicating the desire to utilize the dispute resolution process. Supporting evidence or documentation concerning the dispute should be submitted with this request. This request should be submitted to:

ATTN: FCFC Director
Erie County Family and Children First
414 Superior Street
Sandusky, Ohio 44870

2) Upon receipt of the family request to utilize dispute resolution, a meeting with the Wraparound Management Response Team will be convened within 15 calendar days. This meeting will be scheduled at a mutually convenient time for the majority members of the family and the Wraparound Management Response Team. The family will prepare a presentation for the Wraparound Management Response Team regarding the nature of the dispute and the specific issues that are requested to be resolved. This presentation can be made by the family, an advocate, or the Child and Family Team lead case manager.

3) At the meeting with the Wraparound Management Response Team, the family will present information regarding the nature of the dispute and identify specific issues that are requested to be resolved. All pertinent Wraparound Case information will be completed by the Family Team and the family to provide historical and current information relevant to the dispute and to specifically identify the issues sought to be resolved. The Wraparound Management Response Team will meet in closed session after the family's presentation to draft written responses to the Family Team regarding the issues identified in the dispute.

4) The Dispute Resolution Subcommittee will meet within 7 days of Wraparound Management Response Team meeting to review the responses drafted to the family. The DRS will either approve or reject the responses in writing. In the event that the DRS approves the responses of the Wraparound Management Response Team, a letter will be immediately issued to the family by mail addressing the disputes. In the event that the DRS rejects the responses of the Wraparound Management Response Team the DRS becomes responsible for preparing the responses to the family. These responses will be written the day of the DRS meeting and mailed immediately to the family. The FCF Director will be used as a neutral facilitator in this meeting and will be responsible for the written responses to the family.

5) When the provision of services cannot be resolved through the designated dispute resolution process, the final arbitrator will be a Juvenile Court Judge. The Juvenile Court Judge will determine which Judge will hear the dispute. The family must submit in writing within 7 calendar days of receipt of the responses a request to have the dispute to be decided upon by the final arbitrator. Upon receipt of this request, the Director for FCF will submit within 5 calendar days all documentation regarding the dispute, (including, but not limited to) the request for dispute resolution and supporting documentation, responses made by the Wraparound Management Response Team and the Dispute Resolution Subcommittee, treatment information, and other relevant information to the presiding Juvenile Court Judge. The presiding Judge will issue a written decision based upon the dispute within 14 calendar days. **The entire process shall be completed in no more than 60 days.**

Emergent Disputes Between Parent/Guardian and FCFC

An emergent dispute will be defined as a dispute that requires an immediate response due to the safety or well-being of the child(ren). In these instances, the immediate decision is made collaboratively with the parents or guardians and any immediate accessible staff available. FCF will work to address the emergency in as timely and effective means possible. If an emergent dispute is initiated by a parent or guardian, the following timeline will be utilized:

1) Within 3 calendar days of the disagreement/dispute the family will submit a Dispute Resolution Request form to the FCF Director communicating the desire to utilize the dispute resolution process. Supporting evidence or documentation concerning the dispute should be submitted with this request. This request should be submitted to:

ATTN: FCFC Director
Erie County Family and Children First
414 Superior Street
Sandusky, Ohio 44870

2) Upon receipt of the family request to utilize dispute resolution, a meeting with the Wraparound Management Response Team will be convened within 5 calendar days. This meeting will be scheduled at a mutually convenient time for the majority members of the family and the Wraparound Management Response Team. The family will prepare a presentation for the Wraparound Management Response Team regarding the nature of the dispute and the specific issues that are requested to be resolved. This presentation can be made by the family, an advocate, or the Family Team lead case manager.

3) At the meeting with the Wraparound Management Response Team, the family will present information regarding the nature of the dispute and identify specific issues that are requested to be resolved. All Wraparound case information will be completed by the Family Team and the family to provide historical and current information relevant to the dispute and to specifically identify the issues sought to be resolved. The Wraparound Management Response Team will meet in closed session after the family's presentation to draft written responses to the Family Team regarding the issues identified in the dispute.

4) The Dispute Resolution Subcommittee (DRS) will meet within 3 days of Wraparound Management Response Team meeting to review the responses drafted to the family. The DRS will either approve or reject the responses in writing. In the event that the DRS approves the responses of the Wraparound Management Response Team, a letter will be immediately issued to the family by mail addressing the disputes. In the event that the DRS rejects the responses of the Wraparound Management Response Team the DRS becomes responsible for preparing the responses to the family. These responses will be written the day of the DRS meeting and mailed immediately to the family. The FCF Director will be used as a neutral facilitator in this meeting and will be responsible for the written responses to the family.

5) When the provision of services cannot be resolved through the designated dispute resolution process, the final arbitrator will be the presiding Juvenile Court Judge. The Juvenile Court Judge will determine which Judge will hear the dispute. The family must submit in writing within 7 calendar days of receipt of the responses a request to have the dispute to be decided upon by the final arbitrator. Upon receipt of this request, the Director for FCF will submit within 2 calendar days all documentation regarding the dispute, (including, but not limited to) the request for dispute resolution and supporting documentation, responses made by the Wraparound Management Response Team and the Dispute Resolution Subcommittee, treatment information, and other relevant information to the presiding Juvenile Court Judge. The judge will issue a written decision based upon the dispute within 10 calendar days. **The entire process shall be completed in no more than 30 days.**

Please note, that when requested, the Ohio Family and Children First (OFCF) Cabinet Council (CC) will provide an administrative review of unresolved local disputes regarding conflicts among parents, agencies, and/or councils pertaining to the county council service coordination process or decisions made during the individual family service coordination process. The dispute must be concerning a decision made or a process proposed or implement during a phase of the county service coordination process regarding a family or child who is formally involved in the county Family and Children First service coordination. This includes a disagreement regarding the denial of acceptance of a family into the county service coordination process. Agencies, providers, or parent/legal guardians who have participated on a family service coordination plan team may request a dispute resolution review. The OFCF Service Coordination Committee will review such requests and make recommendations to the CC for its review and approval. With CC approval, the OFCF will respond, in writing to the county council requests for dispute resolution review within 30 days of the receipt of the request by the State Service Coordination Committee.

The following requirements must be met BEFORE the county dispute case can be reviewed:

- 1. The involved family must sign a release to have its information shared with the OFCF Service Coordination Committee and the Cabinet Council.*
- 2. The family must have been referred to and accepted into some level of the county council service coordination process. Two exceptions to this requirement are:
 - a) When a family was referred to the county FCFC service coordination, either by itself or by another party, and was not accepted into the county service coordination. In this circumstance, an administrative review will be granted, if**

the fact of not being accepted into service coordination is the matter being disputed.

b) If the dispute is regarding service being provided through Help Me Grow for a Part C eligible child.

3. The county council must verify that the county council dispute resolution process has been completed without satisfactory resolution as determined by the concerned parties.

4. The county council must request the Cabinet Council review and submit requested documents pertaining to the dispute.

5. The county juvenile court judge may be the county's final arbiter of the county service coordination disputes. The CC will not review cases for which the complainants have sought a juvenile court ruling. The CC administrative review must be requested and completed PRIOR to seeking resolution through the county juvenile court as final arbiter of the dispute.

***O.R.C. 121.37 (D) Implementation of an Individualized Family Service Coordination Plan (IFSCP)
High Fidelity Wraparound-Phase 3***

***O.R.C. 121.37 (D)(1) Designates service responsibilities among the various agencies.
(Wraparound Phase 3.1)***

The Individualized Family Service Coordination Plan (IFSCP) developed by the Family Team will clearly identify and define the responsibilities for provision of services by all parties involved including timelines to be followed. If the identified services and supports are not presently available, the plan will outline what efforts will be undertaken to address the service gaps. The Team Facilitator and/or parent will be responsible for monitoring the implementation of the Individualized Family Service Coordination Plan and will reconvene the group as needed to update or modify the plan. The Team Facilitator works collaboratively with other systems case managers who may be assigned to the case. (See Addendum E)

From time to time, the Family Team may concur that an out-of-home placement is needed. The Family Team will cooperate to locate a placement, which will meet the identified treatment needs of the youth. Prior to the placement the team should complete a placement plan, which details expected outcomes and benchmarks for discharge. During placement, the Family Team should continue to meet to review the placement and the youth's progress toward discharge. The team, prior to the youth's discharge, should formulate an aftercare plan. All cases of out-of-home placement will be tracked and monitored by the Wraparound Management Response Team.
(See above procedures)

O.R.C.121.37 (D)(2) Designates an individual to track progress, schedule reviews and facilitate meetings. (Wraparound Phase 3.1, 2,3)

The Team Facilitator or person responsible for implementing the agreed upon plan will work with the parents in arranging for the needed services and supports. The Team Facilitator will assist the parents in navigating the system and acting as an advocate for their stated needs. Responsibilities, authority, and funding for coordinated assessment, service plan development and implementation; transition services, service activity tracking and service satisfaction will be assigned among all responsible agencies and organizations. The Team Facilitator will track the progress made toward stated goals along with the family & team members and will ensure that team members are following through with assigned responsibilities. All individual reviews will be scheduled by the team to meet the family's needs.

If for whatever reason there is significant disagreement regarding development or implementation of the plan (e.g., financial issues, gaps in the service system, disagreement over the plan by any participant), the dispute resolution process should be initiated. While the conflict resolution process is active, the child and family are to be served under a temporary plan developed by the Team process.

O.R.C.121.37 (D)(3) Ensures services are responsive to the strengths, needs, family culture, race and ethnic group, and are provided in the least restrictive environment. (Wraparound Phase 1.3, 2.1)

The Team Facilitator will explore issues of family vision, values, traditions and beliefs during the strengths assessment. We can expect that many of our natural and community supports will be culturally responsive in the provision of supports to the family. The Team Facilitator will address this in the team meeting. If it should occur that culturally appropriate services are not available to meet the needs of the plan of care, then we will work to match the family to services as best we can and continue to work with our agencies on culturally competent practice.

The team will research all possible options for the family in designing a plan that is in the least restrictive, least intrusive, and most clinically appropriate environment that takes into consideration the safety of the child, the family, and the community. The system will provide access to a comprehensive array of services that addresses the child's physical, emotional, social and educational needs within the identified least restrictive, most normative environment. Services considered for each individual youth will range along a continuum of care-least restrictive being care provided in the natural family home; to kinship care; to foster care; to therapeutic foster care; to group home; to hospitalization; to residential care; to secure residential care; to placement in the Department of Youth Services. The system will ensure that multiple services are delivered in a coordinated and therapeutic manner, and that children can move through the system of services in accordance with their changing needs.

O.R.C.121.37 (D)(4) Includes a process for dealing with a child who is alleged to be an unruly child. O.R.C. 121.37(E) (Wraparound Phase 1.2, 2.2)

With the formation of a Family Team and the formulation of an Individualized Family Service Coordination Plan (IFSCP) a youth, if identified prior to unruly charges being filed, should successfully be diverted from Juvenile Court involvement. If the preparation of a complaint under section 2151..022- (Unruly Child) of the Revised Code has been filed, the youth and parents of the

youth will be encouraged to become involved in the teaming process to divert the youth from Juvenile Court.

Erie County service providers with programs that provide respite, mentoring, short-term crisis stabilization, parenting and a variety of other prevention activities may be used as resources to help in the diversion of unruly youth from additional involvement in the Juvenile Court system. When appropriate the youth and family will be referred to such programs as Big Brothers/Big Sisters, the Boys and Girls Club, the YMCA, or for specialized mentoring services. They may be referred to The Village Foster Care Network or JFS for temporary Respite Care and short-term crisis management. The Erie County Department of Job & Family Services Children's Services Unit will assess the need for supportive services to families with youth at risk for being unruly when neglect and/or abuse are the core issues. The Erie County Department of Job & Family Service has created the ASAP program. The ASAP program provides services to youth during pre, post and during residential treatment. ASAP initials, the easily recognizable representation of "As Soon As Possible" clarifies the mission of the program - To obtain and expedite effective treatment, returning the child as quickly as possible to a less restrictive environment using evidence-based practice by skilled practitioners. The program is designed to attempt to balance the possible removal of a child from all that is familiar with the need for intensive therapeutic intervention. The focus of the direct caseworker involvement with the family unit is to address the concerns while preserving the family unit and empowering the parents. The direct case management involvement allows the agency to maximize the resources available for the family throughout the community to be successful as an alternative to out- of- home placement whenever possible. Involvement of families in all aspects of the placement is maintained. Parents are empowered to make decisions for their children. To insure family involvement would continue through placement and to assist with community reintegration, the Erie County Family and Children First Council and Erie County's Wraparound services engage the family early in the placement. Supportive services are maintained for a period following the child's return to the family to ensure the child and family's continued success in the home. The agency also utilizes the Casey Foundations Team Decision Making Model which empowers family to utilize both informal and formal support to develop plans that will be effective for their family to come up with solutions to assist make their family both safe and healthy for their children.

The Erie County Family Court offers a wide array of diversionary services to youth and their families. Juvenile Court has a program that is initiated for children at risk of unruly but for whom a complaint has not been filed. The Court and the school systems of Erie County have a program in place where the school can make a referral to the Court on issues relating to attendance or minor behavior problems for children in K through 12th grade. An informal hearing is held with the focus on overcoming barriers the family might face in achieving school success

If a complaint is filed, the Court can hold the case in abeyance pending the child and family completing a diversion contract and remaining trouble free for a period of time. The Court currently offers a counseling program, a drug and alcohol education program, skill classes, restitution, mediation and family conferencing. Court staff offers some of the programs and others are offered by partnering with community providers.

The Court recognizes that even though the complaint is heard formally in the courtroom, there is a need to offer services to reduce recidivism and prevent the child from being removed from home. In addition to traditional services provided by juvenile courts the Court has partnered with the

community to develop program such as the following: alternative school programs; girls groups, specialized programming for African American youth, parenting programs; an electronic monitoring program in lieu of detention; in-home counseling; IFAST In Home Therapy; and Juvenile Drug Court.

O.R.C.121.37 (D)(5) Includes timelines for family service coordination plan goals. (Wraparound Phase 1.5, 3.1)

All Individualized Family Service Coordination Plan (IFSCP) will include timelines for completion of goals specified in the IFSCP plan with regular reviews scheduled to monitor progress toward those goals.

O.R.C.121.37 (D)(6) Includes a plan for short-term crisis and safety. (Wraparound Phase 1.2, 2.2)

Anticipated crises for the youth and family will be defined and clarified in the Family Team meeting with input from all members. A Safety and Crisis plan will be developed with the child and family in the Family Team meeting. The Safety and Crisis plans will be both proactive and reactive. Each member of the team will be asked to put his or her concerns on the table regarding what could go wrong. There is a review of history because most crises have happened before. The team should identify where its plans seem most vulnerable and what the possible consequences would be if the plan does not function. Alternative strategies will need to be thought through as plan "B". Proactive plans include tangible or intangible supports that are expected to prevent a targeted crisis from happening. Reactive plans are developed by the team to prepare for what action they will take if the crisis actually occurs.

After each crisis occurs, the team should convene within 48-72 hours to review whether or not the plan worked: if it was effective, and if it needs modification. All changes to a plan need to be team-driven, and all members who are not present must be informed immediately so that everyone is on the same page. (See Addendum F)

Funding of Individualized Family Service Coordination Plans

Our Council continues to explore the maximizing of available local, state, and federal funds. With shared funding agreements utilized for specific children, we are moving away from discussions of "whose kid is this?" and moving more toward a planning and utilization of resources based on the needs and requests of the child and family. Whenever a family/child is eligible to receive funds for services, the appropriate forms will be completed by the Family Team. The Request for funding will be reviewed by the Wraparound Supervisor, and submitted to the Council Director to be reviewed for final approval for funding if applicable/available. When a request for funding is made by the team, all available funding resource options are considered.

A shared funding agreement may also be utilized to help in the funding of plans for a youth. The team will request the use of a shared funding agreement with the assistance of the Council Director. The Fiscal/Funding Priorities Committee of the Council may be involved in the negotiation and approval the shared funding agreement between the funding agencies. This shared funding agreement will utilize all funding sources available to the youth and family and must be agreed upon and signed off on by all systems that will be providing funding. The funding partners must

also designate a fiscal agent when utilizing a shared funding agreement. (See Additional Materials-Funding Section)

Quality Assurance of the County SC Plan

Through the Family Team process and the Wraparound Management Response Team of the Council, the above outcomes are measured and evaluated. Evaluation procedures will include Consumer satisfaction surveys that will be distributed and evaluated by the Council. There will be ongoing input from families during the planning, implementation and evaluation process developed to measure results and key indicators of progress through informal and formal meetings. The FCFC Council will submit all requested Service Coordination Data to the state for review. (See Additional Materials-Data Collection)

Other Considerations

Service gaps

In the above outlined procedures there are areas, which will need continued strengthening and attention. These include:

- Community-wide access to the Family Team process.
- Extensive internal systems information and education regarding the process and procedures; this would include cross system training.
- Community information and education regarding the process and procedures, which assures access to non-system involved children and families.
- Standardized identification number for clients

Ongoing and aggressive efforts at community education will be needed in order to assure awareness and access to the process, particularly for those children and families who may not be currently involved in any of the systems, but are in need of support. Our county will provide agencies with annual training opportunities on Service Coordination, High Fidelity Wraparound, and accessing resources for families by utilizing the 211 Information & Referral System.

Continuous feedback of service gaps will be forwarded to the Administrative Level for review, attention and program/services development.

Waivers

The Council will review and identify any rules and regulations, which may impede services to families and children and submit a request for a waiver for modification of the rules identified.

This plan will be reviewed annually for needed revisions as it is viewed by our Council as a “work in progress”.

**Phases of High Fidelity Wraparound
Phase 1**

MAJOR TASKS/Goals	Strategies
<p>PHASE 1: Engagement and team preparation</p> <p>During this phase, the groundwork for trust and shared vision among the family and Wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the Wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.</p>	
<p>1.1. Orient the family and youth GOAL: To orient the family and youth to the Wraparound process.</p>	<p>1.1 a. Orient the family and youth to Wraparound In face-to-face conversations, the facilitator explains the Wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to Wraparound and asks family and youth if they choose to participate in Wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).</p> <p>1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.</p>
<p>1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the Wraparound process.</p>	<p>1.2 a. Ask family and youth about immediate crisis concerns Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).</p> <p>1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.</p> <p>1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require</p>

	<p>immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.</p>
<p>1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.</p>	<p>1.3 a. Explore strengths, needs, culture, and vision with child/youth and family. Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).</p> <p>1.3 b. Facilitator prepares a summary document Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.</p>
<p>1.4. Engage other team members GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the Wraparound principles</p>	<p>1.4 a. Solicit participation/orient team members Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the Wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.</p>
<p>1.5. Make necessary meeting arrangements GOAL: To ensure that the necessary procedures are undertaken for the team is prepared to begin an effective Wraparound process.</p>	<p>1.5 a. Arrange meeting logistics Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members</p>

Phase 2

MAJOR TASKS/Goals	ACTIVITIES
<p>PHASE 2: Initial plan development</p> <p>During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the Wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks; a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.</p>	
<p>2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the Wraparound principles</p>	<p>2.1 a. Determine ground rules Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.</p> <p>2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.</p> <p>2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal Wraparound.</p> <p>2.1 d. Describe and prioritize needs/goals Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.</p> <p>2.1 e. Determine goals and associated outcomes and indicators for each goal Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.</p> <p>2.1 f. Select strategies Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple</p>

	<p>options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.</p>
	<p>2.1 g. Assign action steps Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.</p>
<p>2.2. Develop crisis/safety plan GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the Wraparound principles. A more proactive safety plan may also be created.</p>	<p>2.2 a. Determine potential serious risks Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.</p>
	<p>2.2 b. Create crisis/safety plan In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the Wraparound plan addresses potential safety issues.</p>
<p>2.3. Complete necessary documentation and logistics</p>	<p>2.3 a. Complete documentation and logistics Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members</p>

Phase 3

MAJOR TASKS/Goals	ACTIVITIES
<p>PHASE 3: Implementation</p> <p>During this phase, the initial Wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal Wraparound is no longer needed.</p>	
<p>3.1. Implement the Wraparound plan GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the Wraparound principles.</p>	<p>3.1 a. Implement action steps for each strategy For each strategy in the Wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about Wraparound as needed; and identifying and obtaining necessary resources.</p> <p>3.1 b. Track progress on action steps Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.</p> <p>3.1 c. Evaluate success of strategies Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.</p> <p>3.1. d. Celebrate successes The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.</p>
<p>3.2. Revisit and update the plan GOAL: To use a high quality team process to ensure that the Wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.</p>	<p>3.2. a. Consider new strategies as necessary When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.</p>

<p>3.3. Maintain/build team cohesiveness and trust GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.</p>	<p>3.3 a. Maintain awareness of team members' satisfaction and "buy-in" Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.</p>
	<p>3.3 b. Address issues of team cohesiveness and trust Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about Wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).</p>
<p>3.4. Complete necessary documentation and logistics</p>	<p>3.4 a. Complete documentation and logistics Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.</p>

Phase 4

MAJOR TASKS/Goals	ACTIVITIES
<p>PHASE 4: Transition</p> <p>During this phase, plans are made for a purposeful transition out of formal Wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the Wraparound process, and the preparation for transition is apparent even during the initial engagement activities.</p>	
<p>4.1. Plan for cessation of formal Wraparound</p> <p>GOAL: To plan a purposeful transition out of formal Wraparound in a way that is consistent with the Wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the Wraparound process.</p>	<p>4.1 a. Create a transition plan Facilitator guides the team in focusing on the transition from Wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal Wraparound.</p> <p>4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-Wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-Wraparound crisis resources.</p> <p>4.1 c. Modify Wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-Wraparound participation with the team/family. Formal Wraparound team meetings reduce frequency and ultimately cease.</p>
<p>4.2. Create a "commencement"</p> <p>GOAL: To ensure that the cessation of formal Wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.</p>	<p>4.2 a. Document the team's work Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)</p> <p>4.2 b. Celebrate success Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.</p>
<p>4.3. Follow-up with the family</p> <p>GOAL: To ensure that the family is continuing to</p>	<p>4.3 a. Check in with family Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly</p>

experience success after Wraparound and to provide support if necessary.	including a reconvening of the Wraparound team.
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Improving the Quality of Family Life in Erie County

**Service Coordination
Mechanism
Addendum
A-F**

**Family & Children
First Council
Erie County**



**Francine Bergmoser, LPC, LSW,
Director**

**4405 Galloway Road
Sandusky, Ohio 44870
(419) 621-3962 Ext. 141 FAX (419) 625-3448
fbergmoser@kscope.esu.k12.oh.us**

WRAPAROUND REFERRAL FORM

Date of Referral: ____/____/____

Date of Contact: ____/____/____

Family Name:	Mother: DOB: ____/____/____	Father: DOB: ____/____/____
Address:	Phone: Cell#:	
Referring Person:	Phone #:	

Please check each box after you have completed each:

- The family has been told about Wraparound
- The family is aware a Wraparound referral is being made and that a coordinator will be contacting them
- If there are Safety Concerns (for child/family, providers, no contact orders, etc...) explain :

FAMILY CHARACTERISTICS

Family Characteristics Indicated by Referring Person or Family: Check all that apply

- Children age 5 and under in the family Child Medically Involved MR/DD Provider: _____
- History of Alcohol or Drug Abuse (Current, Recent, or Past) Youth Parent Provider: _____
- Involved in Juvenile Drug Court Involved in Family Drug Court
- Mental Health Issues Child Caregiver Provider _____
- Family/Child(ren) Involved in Counseling Provider _____
- Physical/Sexual/Emotional Abuse Issues Provider _____
- Domestic Violence Issues Provider _____
- Placement Concern Foster/Relative Care Provider _____
- Housing Concern _____
- Child has Ed. Concerns Truancy SED On IEP Expulsion School System: _____
- Child has Behavioral Concerns: Explain _____ Provider _____
- Child Protective Involvement Name of Caseworker: _____
- Juvenile Court Involvement Name of Probation Counselor: _____ Case # _____
- List all individuals living in household on back of form:

Child(ren) being discussed at meeting or living in household:

Last Name _____	First Name _____	Middle Name _____
DOB: ____/____/____	Sex: ____	Race: ____ Social Security # ____/____/____ School: _____
Last Name _____	First Name _____	Middle Name _____
DOB: ____/____/____	Sex: ____	Race: ____ Social Security # ____/____/____ School: _____
Last Name _____	First Name _____	Middle Name _____
DOB: ____/____/____	Sex: ____	Race: ____ Social Security # ____/____/____ School: _____

Narrative: Reason for referral (Include any information for a facilitator to be aware of when engaging Family)

Fax to Cindy Franketti at 419-627-6600 or call (419) 627-7782 for information



**FAMILY & CHILDREN FIRST COUNCIL OF ERIE COUNTY
CLIENT AUTHORIZATION FOR INFORMATION SHARING**

I hereby authorize the Member agencies of the Family & Children First Council of Erie County, named on the reverse side of this Authorization, to exchange, give, receive, share, or redisclose information in their records, from whatever source derived, related to my participation and that of my minor child:

Name of Child: _____ Date of Birth: _____ Social Security # _____

in the services provided by one or more of these agencies.

I understand the following:

1. The purpose of this information sharing is to improve the communication about services to me and my family.
2. Each of the member agencies has agreed:
 - a) to share this information only with other member agencies:
 - b) not to share information with non-member agencies without my written consent unless otherwise required or authorized by law; and
 - c) Information exchanged due to this authorization will not be used against me or my children for purposes of criminal investigation, prosecution, or sentencing, unless otherwise required by law or judicial order.
3. Any and all rights to confidentiality, which I may have under state or federal law, will continue, except for information covered by this form
4. I may revoke this Authorization at any time except for information that has been previously exchanged.
5. This Authorization shall automatically expire 180 days from the date below unless I revoke it sooner.
6. This Authorization shall not restrict information sharing otherwise authorized by law.

I authorize sharing of the following information: (Circle and initial, if yes, and sign below)

- Yes _____ Case Information: Identifying information, plus medical and social history, treatment/service history, Psychological evaluations, IEP's, IFSP's, transition plans, vocational assessments, grades and attendance, financial information and other personal information held by any of the member agencies regarding me or my minor children.
- Yes _____ HIV and AIDS- related diagnosis and treatment
- Yes _____ Substance abuse diagnosis and treatment
- Yes _____ Social Security Number

If yes: This Authorization for information sharing has been explained to me. I have read the disclosures below. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to the sharing of information as described above.

Signature of Client

Date Signed

Signature of parent/guardian (if applicable)

Staff Person Facilitating this Authorization

Relationship of Person Signing to Client

If applicable, date of revocation. (Revocation must be submitted in writing)

I am also authorizing the exchange of information with the following specific persons/agencies:

Signature of Client (or parent/guardian if applicable) _____ Date Signed _____

MEMBER AGENCIES: (PLEASE CHECK EACH FOR AUTHORIZATION)

- | | | | |
|--------------------------|---|--------------------------|---------------------------------|
| <input type="checkbox"/> | Erie/Huron/Ottawa County Board of Education (Erie County Schools) | <input type="checkbox"/> | Regional/Local Family Advocates |
| <input type="checkbox"/> | Sandusky City Schools | <input type="checkbox"/> | ODADAS |
| <input type="checkbox"/> | Erie County Board of MR/DD | <input type="checkbox"/> | OSU Research/Evaluation |
| <input type="checkbox"/> | Mental Health & Recovery Board of Erie/Ottawa Counties | | |
| <input type="checkbox"/> | Bayshore Counseling | | |
| <input type="checkbox"/> | Erie County Department of Job & Family Services | | |
| <input type="checkbox"/> | Erie County Family/Juvenile Court | | |
| <input type="checkbox"/> | Ohio Department of Youth Services | | |
| <input type="checkbox"/> | Firelands Counseling & Recovery Services | | |
| <input type="checkbox"/> | Erie County Early Intervention Collaborative/Help Me Grow | | |
| <input type="checkbox"/> | Erie County Health Department | | |
| <input type="checkbox"/> | Erie/Huron Counties Community Action Commission, Inc. | | |
| <input type="checkbox"/> | Boys Village | | |
| <input type="checkbox"/> | Family & Children First Council Director/Council | | |

Definition of "Case Information":

If this release authorizes the disclosure of Case Information, consent to such disclosure may include the following types of information, if it is in files of the agency disclosing this information:

- a. Identifying information: names, birth dates, sex, race, address, telephone number, social security number, type of services being received and name of agency providing services to me or my minor children. Medical records, including but not limited to results of physical and mental examinations, diagnoses of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment services received, summary of treatment plans and treatment needs.
- b. Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional or mental status. and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, and other test results.
- c. All records of services provided by the Erie County Department of Human Services except child abuse investigation reports.
- d. Juvenile court and detention records.
- e. School records: This information is subject to the Family Educational Rights and Privacy Act of 1974, 20 USC 1232g, and the Ohio Student Records Privacy Act RC 3319.321.

To all Agencies receiving information disclosed pursuant to this consent:

If the records released pursuant to this consent include records of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly pertained by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If the records released include information of HIV-related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnosis.



Family & Children First Council
Wraparound
Parent Strength Assessment

Date of Visit ___ / ___ / ___

Date of Referral ___ / ___ / ___

IDENTIFYING DATA

Family Name _____ Phone (____) _____

Child's Name _____ Birthdate _____

Residence Address _____ City _____

State _____ Zip _____

School _____ Grade Level _____

Father's occupation _____ Mother's occupation _____

Mother's education _____ Father's education _____

Number of moves in last 5 years _____ Birth order of child _____

PARTICIPANTS TO ASSESSMENT

Name of respondent _____ Birthdate ___ / ___ / ___ Relationship _____

Name of other participants _____

1. The things I like most about my child(ren) are:

2. My life would really be better in six months from now if:

3. My family's life would really be better six months from now if:

4. The most important thing I have ever done is:

5. I am happiest when:

6. The best times we have had as a family are:

7. Name some special rules that your family has:

8. Who are the people you call when you need help and/or want to talk? Who has helped you in the past when you needed help? Who do you feel you can trust to be there when you need them?

9. What activities do you and your family enjoy together? What do you enjoy most about yourself?

10. What are your family traditions? In which cultural events does your family participate?

11. Are there any special values or beliefs taught to you by your parents or other people who are important to you?

12. Does your family belong to any part of a faith community? In what way? Do you belong to any social clubs?

Notes/additions:

Interviewer's signature: _____ Date: ___ / ___ / ___

Parent's signature: _____ Date: ___ / ___ / ___



Erie County
Family & Children First Council
Wraparound
Child Strength Assessment
Form

Name: _____

Age: _____

Date: _____

1. The things I like to do after school are _____

2. If I had ten dollars I'd _____

3. My favorite TV programs are _____

4. My favorite game at school is _____

5. My best friends are _____

6. My favorite time of day is _____

7. My favorite toy is _____

8. My favorite CD/music is _____

9. My favorite subject at school is _____

10. I like to read books about _____

11. The places I'd like to go in town are _____

12. My favorite foods are _____

13. My favorite inside activities are _____

14. My favorite outside activities are _____

15. My hobbies are _____

16. My favorite animals are _____

17. The three things I like to do most are _____



Family Team Meeting Notes

Name: Siblings:	Facilitator:	Date: Location:
----------------------------------	---------------------	----------------------------------

Team Members Present:		Team Members Absent:
------------------------------	--	-----------------------------

Discussion of Ground Rules used through the Wraparound process:

- ❖ _____
- ❖ _____
- ❖ _____

Family Vision:

--

Team Mission:

--

Family Strengths:

- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____

Family Accomplishments since the last meeting:

- ❖ _____
- ❖ _____
- ❖ _____

List of Family Needs:

- ❖ _____
- ❖ _____
- ❖ _____

Review of Plan:

- ❖ _____
- ❖ _____
- ❖ _____

Actions/Tasks to complete	By Whom	By When

Next Meeting Date: _____ **Time:** _____ **Location:** _____

<p>Actions taken, including punishments?</p> <p>Rewards, what did the person get out of the crisis (unmet need)</p> <p>Emotions or responses by <u>others</u>?</p>
<p>What have you tried in the past to avoid the crisis? How well did it work?</p>
<p>Why do you think the crisis continues to happen? What is this individual getting from the crisis:</p>
<p>When triggers start what can you take to prevent the crisis from happening?</p>
<p>What can the youth do instead of the crisis behavior?</p>
<p>If the crisis occurs what do I do: (detailed, sequential action steps to be followed by the team). Include who (natural & formal supports) will do what, when and how often:</p>

Improving the Quality of Family Life in Erie County

**Service Coordination
Mechanism
ADDITIONAL
MATERIALS**

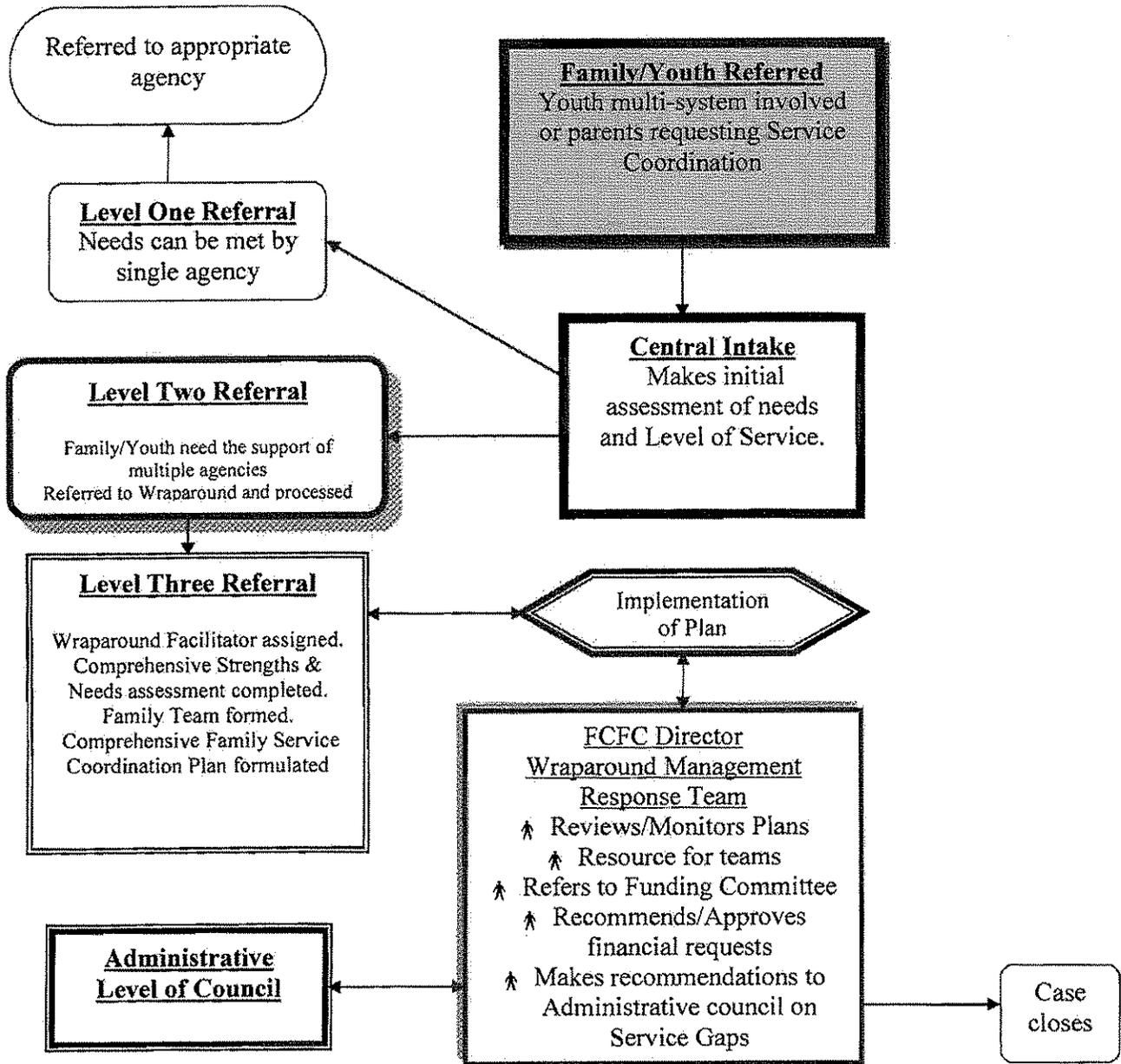
**Family & Children
First Council
Erie County**



**Francine Bergmoser, LPC, LSW,
Director**

**4405 Galloway Road
Sandusky, Ohio 44870
(419) 621-3962 Ext. 141 FAX (419) 625-3448
fbergmoser@kscope.esu.k12.oh.us**

Erie County Service Coordination Flow Chart





Family Name _____

FAMILY TEAM MEETING PARTICIPANTS

Date _____

List Dates

	Planned/Possible participants (Persons to be invited to the FTM)	Relationship/Role	Address	Phone#/E-Mail	Left Message	Sent Letter	Spoke with
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							



Provider Evaluation Form - Family Team Meeting
Please complete before you leave

Your Name: _____ Date: _____

Please circle/answer the following questions about the Family Unity Meeting:

1. The Family Team Meeting's purpose was explained to me clearly

~~5~~ ~~4~~ ~~3~~ ~~2~~ ~~1~~
Excellent Very good Good Fair Poor

Comments: _____

2. I felt the Family Team Meeting was _____ for the family

~~5~~ ~~4~~ ~~3~~ ~~2~~ ~~1~~
Excellent Very good Good Fair Poor

Comments: _____

3. I believe that participating in the Family Team Meeting strengthened the family

~~5~~ ~~4~~ ~~3~~ ~~2~~ ~~1~~
Excellent Very good Good Fair Poor

Comments: _____

4. Quality Safety/Crisis plans were made by the family and the children

~~5~~ ~~4~~ ~~3~~ ~~2~~ ~~1~~
Excellent Very good Good Fair Poor

Comments: _____

5. The Family Plan that was developed by the family was supported by the providers invited to the meeting

~~5~~ ~~4~~ ~~3~~ ~~2~~ ~~1~~
Excellent Very good Good Fair Poor

Comments: _____

Revised 2/19/2010

Cover page-

Transition Packet
“Youth Name”

List family members/Persons living in home

Youth Name

Family Member

Family Member

Individuals living in Home

Date of Transition

First Page:

Summary

Second Page:

- Family Vision
- Team Mission
- List of all strengths

Third Page:

- List out the Needs statements – (after each need statement make a list of services or supports in the community to help maintain this need)
- List out all of the accomplishments

Fourth Page:

- Natural Supports – (list what they do for the family)
- Informal Supports
- Formal Supports

Last Page:

Community Services and Supports

Services:

New Parent Services

OSU Extension Office-419-627-7631

Heartbeat-419-625-9511

Toni Deluca, Parenting Classes-419-627-6940

Parents as Teachers-419-602-0150

Firelands Regional Medical Center, Community Outreach-419-557-7410

Erie County Health Department (WIC) - 419-626-5623

Housing

HUD housing-WT Realty-419-626-1979

Erie Metropolitan Housing Authority-419-625-0262

VOA - Crossroads Homeless Shelter-419-626-6505

Food/Clothing

Care and Share, Inc.-419-624-1411

Salvation Army-419-627-2491

Second Harvest Food Bank-800-848-9431

Thrift Shop at Grace Episcopal Church-419-625-5453

Victory Kitchen-419-627-8732

Habitat for Humanity-thrift store with appliances and furniture-419-433-2609

Angel Food Ministries – 419-626-8730 (Emergency Hotline – 877-366-3646) – Sandusky Alliance Church, 1135 Wayne Street, Sandusky, Ohio 44870

Daycare/Nursery School

Child Care Resource Center-800-526-5268

Kiddie Korral - 419-626-9082

Playland Day Cares LTD.-419-625-8200

Sandusky Central Catholic School Early Childhood-419-626-3075

Tammy Sue's Daycare-419-624-8404

YMCA-419-621-9622

Head Start/CAC-419-625-2214

Kaleidoscope Center (toddler classes)-419-626-0208

Adult Education

Sandusky Career Center-419-625-9294

Ehove Career Center-419-627-9665

Ohio Business College-419-627-8345

Sandusky ABLE-419-621-2778

Northern Oh SERRC-440-967-8355

Center for Cultural Awareness -419-621-1117

Respite Providers:

Village Network – Jeff Vulpio – 216-313-6155

Respite Care – Care giving is a demanding task and caregivers need time off from their responsibilities to relieve stress and prevent burnout. The Village Network is able to provide Respite this service provides short-term care to support the needs of youth, treatment foster care and primary families.

Home Health Providers:

First Choice Home Health of Ohio – Karol Spicer – 419-626-9740

Maxim Pediatric Services – Douglas Maybaum – 440-617-9634

Heritage Health Care Services, Inc. – Samantha Diffenbacher – 419-609-0945 or 800-811-0320

Agency Information:

ARC of Erie County: – 419-625-9677

Provides individuals and families affected by developmental disabilities by promoting an enhanced quality of life through social integration, advocacy and education, Aid to Individuals and Family Directed Resources.

Erie County Board of DD: – 419-626-0208

“Our mission is to promote choice, independence, and to support people with disabilities in exercising their rights to be respected, responsible members of their community.” Providing case management, assist in communication, referrals to other supports & services and appointments with Psychologist Jason Dura, assists with funding sources for equipment needed, advocates at school meetings, and assists in transitioning from school age to adulthood. Continuing to provide services to adults in need.

Easter Seals Northern Ohio: - 419 626-8447

2215 Cleveland Road, Suite 106, Sandusky, OH 44870

Easter Seals Northern Ohio's commitment to help children and adults with disabilities live with equality, dignity and independence is carried out through programs in four service areas: Medical Services, Home and Community Based Services, Educational Services and Recreational Services.

Help Me Grow: – 419-621-3962

A program for Ohio's expectant parents, newborns, infants, and toddlers to age 3, that provides health and developmental services so that children start school healthy and ready to learn. Services are designed with the family's concerns and goals in mind.

Success for Youth: – 419-624-6419

Assists with employment services, resumes', job coaching, job shadowing, interviewing techniques and socialization that is appropriate for youth seeking employment.

TDH Enterprises: – 419-732-1420

A comprehensive program designed to create a competitive advantage for today's job market. Provides; Job Seeking Skills Training, Work Experience / On-the-Job Training, Job Development and Placement, Supportive Services, Training and Educational Services.

Family and Children First Council: – 419-624-6355

Mission: to assure that services to families and children are delivered in a timely, effective and coordinated manner and in the least restrictive environment.

Big Brothers/Big Sisters: – 419-626-8694

Big Brothers Big Sisters of America is a non-profit organization whose mission is to help children reach their potential through professionally supported, one-to-one relationships with mentors that try to have a measurable impact on youth.

Erie Shores Network: – 419-626-2006

Erie Shore Network, Inc. is a Mental Health Agency, funded by the Mental Health & Recovery Board of Erie & Ottawa Counties, and is Ohio Department of Mental Health certified. Erie Shore Network, Inc. is also affiliated with Firelands Regional Medical Center and Firelands Counseling and Recovery

Services. They are able to provide informal supports through social and educational community activities.

Vicki Deel-Lezon: – 419-684-5385

Erie County Parent Mentor who provides advocacy with IEP meetings and IDEA guidelines. Vicki advocates for the needs of the child while assisting with the desires of the parent.

Firelands Counseling and Recovery Services: – 419-557-5177

Emergency Hotline – 1-800-826-1306

Provides Mental Health counseling, Child Psychiatrist with medication management, case management and linking families to needed Mental Health services. FCRS also provides Mental Health assessments and adolescent Chemical Dependency assessments and counseling.

Bayshore Counseling Services: – 419-626-9156

1218 Cleveland Rd. – 1-800-686-0088

Bayshore provides Education, individual, family, and marital counseling, psychiatric consultations, Adult Chemical Dependency counseling and assessments. Bayshore also provides parenting education.

Department of Job and Family Services: – 419-626-6781

The staff of the Erie County Department of Job and Family Services, are dedicated to serving the community by providing services that enhance the quality of family life. Agency Departments: Child Support, Children's Services, Family and Work force development, Job Search (Your Job Store), and Unemployment.

Boys and Girls Clubs: – 419- 624-9250

The Boys & Girls Club of Erie County is a youth serving organization with its main location in the downstairs area of the First Congregational United Church of Christ in Sandusky, Ohio. Our mission is to provide youth between the ages of 6 and 18 with a safe and nurturing environment during non-school hours and in the summer. Research shows that the hours from after school to 8:00 p.m. are critical for many school-aged youth.

Ohio Rehabilitation Services Commission: – 419-625-8819

The Ohio Rehabilitation Services Commission (RSC) is a state agency serving Ohioans with disabilities and employment needs. The Bureau of Vocational Rehabilitation (BVR) and Bureau of Services for the Visually Impaired (BSVI) help people with disabilities get or keep a job. For those unable to work, the Bureau of Disability Determination (BDD) determines eligibility for Social Security disability benefits or Supplemental Security Income.

Erie County Health Department: - 419-626-5623

Works to protect and improve the health of the community, by preventative medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards. Services provide; Birth & Death records, Environmental health services, Health education and outreach, Nursing and clinical services, Public health preparedness, and WIC.

Job Corps: – 216-541-2500

Job Corps is a no-cost education and career technical training program that helps young people ages 16 through 24 improve the quality of their lives through career technical and academic training. Youth

live in and are paid while in the program, gaining independence in both daily living and employment skills, while completing their education. There are locations located in Cleveland, Cincinnati and Dayton, Ohio and across the nation – (800) 733-5627.

Activities & Mailing Lists

Ex: 211

Sandusky Library – 419-625-3834

Erie Metro Parks – 419-625-7783

Sandusky Parks and Recreation – 419-627-5886

Salvation Army – 419-626-3862

Erie County Health Department (WIC) – 419-626-5623

Erie County Board of Developmental Disabilities – 419-626-0208

Help Me Grow – 419-621-3962

WSOS/CAC-419-626-4320

Care and Share Inc.-419-624-1411

Victory Kitchen-419-627-8732

Erie County Metro. Housing-419-625-0262

Sandusky Transit-419-627-0740

Erie County Care-A-Van-419-366-7892

Crisis/Safety Plan

Transition Question:

1. **What services will continue after Wraparound is no longer involved?**
2. **How will the services be paid for after Wraparound transition's out?**
3. **Do you want to keep the current helpful people in your life?**
4. **Updated Safety/Crisis Plan**
5. **What would you do if JFS becomes involved in your life after Wraparound is done?**

Family & Team Signatures:

_____ Signature	_____ Date	_____ Signature	_____ Date
_____ Signature	_____ Date	_____ Signature	_____ Date
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Improving the Quality of Family Life in Erie County

**Service Coordination
Mechanism
FAMILY DEVELOPMENT
MATRIX**

Family & Children

First Council

Erie County



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The Erie County Family Council

Family Development Matrix

How The Matrix Works. . .

- The Family Development Matrix (i.e., the Matrix) is based on 13 **Outcome Areas**:
 - Shelter
 - Food & Clothing
 - Transportation & Mobility
 - Health & Safety
 - Social & Emotional Health
 - Finances
 - Family Relations
 - Community Relations
 - Adult Education & Employment
 - Children's Education & Development
 - Children's Care & Safety
 - Youth Services
 - Immigration & Resettlement.

- The **Outcome Areas** are based on life domains and consist of five **Status Levels**.

- Each **Status Level** corresponds with the various stages of life a family may be experiencing. While some areas may be in need of immediate assistance (i.e., **Risk Levels**) other parts of the family's life may be flourishing (i.e., **Growth Levels**).

- The Matrix provides a basis for a relationship between families and service providers. It also contributes to consistency in quality service delivery.

- The family is assessed in each **Outcome Area** as applicable to their self-identified needs.

- A family's progress is tracked over time in each of the applicable **Outcome Areas** as they receive services.

- The Matrix quantifies a family's development. Creating a visual image of the family's growth over time.

- This allows the family and service coordinator to identify the family's successes as well as areas in need of further attention and assistance; consequently, allowing service coordination to be more targeted giving the family accurate assistance.

The Erie County Family Council

Family Development Matrix

Establishing a Baseline with the Family. . .

- After an initial relationship with the family is established (i.e., second or third visit/meeting), the service coordinator should explain the **Map** to the family.
- The **Map** is the one-page diagram of all the **Outcome Areas** and their corresponding **General Indicators**.
- Then, the family and the service coordinator should work together to identify the **Outcome Areas** the family wishes to work on based on their need(s) and goals.
- When discussing an **Outcome Area**, be sure to thoroughly explain the **General Indicators** before delving into the **Status Levels**.
- The first time the Family Development Matrix is used, the family's **Baseline Scores** (i.e., their **Status Levels**) are established in the various **Outcome Areas**.
- IMPORTANT: It is not necessary to complete the entire Matrix assessment during the initial meeting/visit between the service coordinator and family.
- IMPORTANT: Nor is it necessary to complete the entire Matrix assessment during one visit/meeting.
- However, it is important to record the date of each **Baseline Assessment** once it is established with a family.
- The **Baseline Assessment** is the initial **Status Level** that corresponds with the family's life or current condition in an **Outcome Area**.
- When determining a **Status Level**, use the **Best-Fit Rule**. The **Best-Fit Rule** refers to selecting a status level that best fits the family's current condition. Every aspect of the status level may not exactly correspond to the family's current condition; but rather, they generally can identify with the majority of indicators within the status level.
- IMPORTANT: When determining **Status Levels**, the service coordinator should be working in conjunction with the family.
- IMPORTANT: Be careful not to inflate or underscore a family's status level.
- The Matrix is not an assessment tool used to issue judgment against the family; it is designed to help the family during their time of need.

The Erie County Family Council Family Development Matrix

What Each Status Level Means. . .

- The family is assessed in each **Outcome Area** as applicable to their self-identified needs.
- TIP: If a family feels their entire life is in total crisis, it is often useful to use the entire Matrix. By using each of the **Outcome Areas** rather than merely looking at their risk areas, the service coordinator can demonstrate areas of strength as well as areas in need of assistance.
- Every **Outcome Area** consists of a 5-point scale that assesses a family's **Status Level**.
- The **Status Levels** corresponds with the various stages of life a family may be experiencing. While some areas may be in need of immediate assistance (i.e., **Risk Levels**) other parts of the family's life may be flourishing (i.e., **Growth Levels**).

Growth Levels	Thriving: Score 5 Prevention, early intervention & sustain family system.
	Self-Sufficient: Score 4 Monitoring to maintain family.
	Stable: Score 3 Family establishes functional level with consistent recurring support.
Risk Levels	At-Risk/Vulnerable: Score 2 Intervention required preventing further deterioration.
	In-Crisis: Score 1 Requires immediate intervention to protect the individual or family

The Erie County Family Council Family Development Matrix

More on the Status Levels. . .

Thriving

The family systems are strong, healthy and fully functional in this outcome area. The family is achieving its goals. ***Growth Level – Score 5***

Safe/Self Sufficient

The family is strong and had made significant progress in improving its circumstances. It is generally secure as a result of its own efforts. The family has a clear vision of its ultimate goals. Intervention is resource-oriented and motivation is from within. ***Growth Level. - Score 4***

Stable

The Family no longer is in danger, and the family is ready and willing to change. Planning occurs for its future. Supportive services are provided to assist the family in implementing their plans. ***Growth Level – Score 3***

At-Risk/Vulnerable

The Family is secure from immediate threats to health and safety, but has not yet developed or committed to strategies/plans for long-term growth and change. Continuing safety-net intervention provides a platform on which the family can build its plans from improving circumstances. ***Risk Level – Score 2***

In-Crisis

The Family cannot meet its needs. They are unwilling or unable to work toward positive change. The Family systems have collapsed or are in immediate danger of collapse. Strong outside intervention required to move family to “At-Risk” level. ***Risk Level – Score 1***

The Erie County Family Council

Family Development Matrix

Updating the Matrix with the Family. . .

- Update the Matrix on a *monthly* basis.
- Only update the outcome areas that the family has identified as areas they wished to work on. Leave all other **Outcome Areas** blank.
- Do not assess the family's status level in outcome areas they have not identified need. Leave those **Outcome Areas** blank.
- Preferably, update the Matrix in a face-to-face meeting with the family.
- IMPORTANT: If the service coordinator does not have a scheduled face-to-face meeting with the family or the family is not available to meet during any given month, the service coordinator should do one of the following:
 - Update the family's **Status Level** based on their progress to date, *or*
 - If the service coordinator is not aware of the family's progress to date, carry over the number from the previous month.

Adding New Outcome Areas with the Family. . .

- Keep in mind, new **Outcome Area(s)** can be added as needed by the family to work on in addition to the initial **Outcome Areas**.
- If the family identifies a new **Outcome Area(s)**, proceed through the assessment, note the date of the **Baseline Assessment**, and record the corresponding **Status Level**.
- The following month, update the new **Outcome Area(s)** with the rest of the **Outcome Areas** accordingly in the corresponding month.

The Erie County Family Council Family Development Matrix

IFSP Reminders to Keep in Mind when Working with the Matrix. . .

- The family is in control of the IFSP - the family needs to commit to the plan in order to have it be successful.
- The family and the service coordinator should work together to identify the Outcome Areas the family wishes to work on based on their need(s) and goals. When determining Status Levels, the service coordinator should be working in conjunction with the family.
- The intensity of service coordination can vary in intensity depending on the family's needs.
- Do not walk in with a preconceived notion of what a family needs.
- The Matrix is not an assessment tool used to issue judgment against the family; it is designed to help the family during their time of need.
- Work to enhance the capacity of families to meet their own needs.
- By giving families the skills to cope with their problems enables them to gain effective control over their lives.
- Remember to put together the family's *Dream Team* - those people who will assist the family's support system.
- If you interview a family rather than have a conversation, he/she will feel you are doing a job. If you have a conversation, they will know & feel you actually care.



The Erie County Family Development Matrix Map

Shelter	Food/Clothing	Transportation/Mobility	Health/Safety
<ul style="list-style-type: none"> Stability of housing over time Living Conditions Structural safety of housing Resources for housing 	<ul style="list-style-type: none"> Resources for food and clothing Quality of diet; adequacy of clothing Nutritional value of meals Conditions of food preparation resources (utensils, space, appliances, sanitation) 	<ul style="list-style-type: none"> Access to transportation based on level of need Safety, condition of transportation Legal status of driver, vehicle 	<ul style="list-style-type: none"> Health habits Ability to afford health care Status of physical health Environmental conditions Access to health resources
Social/Emotional Health	Finances	Family Relations	Community Relations
<ul style="list-style-type: none"> Ability and willingness to identify needs and access resources Sense of personal responsibility Presence, degree of substance abuse Quality of mental health Quality of social support system 	<ul style="list-style-type: none"> Income level in context of local cost of living Long & short-term financial goals Budgeting skills & financial discipline Access to financial institutions and resources Savings 	<ul style="list-style-type: none"> Family structure Family functioning Intra-family communication skills, ability to resolve conflict Parenting skills 	<ul style="list-style-type: none"> Relationships with friends and neighbors Knowledge of /access to community resources Participation in community life (school, church, clubs)
Adult Education	Children's Education/Development	Children's Care & Safety	Immigration/Resettlement
<ul style="list-style-type: none"> Employment Presence or absence of career goals, appropriateness of goals Job preparedness; job skills or work history 	<ul style="list-style-type: none"> Age-appropriate development and behavior Verbal communication Parent/child interaction School behavior; attendance and readiness to learn 	<ul style="list-style-type: none"> Access to quality childcare, after school programs Ability to afford childcare, after school programs Assure safe environment 	<ul style="list-style-type: none"> Immigration status Language skills based on needs Cultural identity and knowledge of dominant culture
Youth Assets/Social Skills	Adult Employment		
<ul style="list-style-type: none"> Relationships with friends and adults Sense of fair play/cooperation Leadership skills Teamwork Ability to follow directions Makes wise decisions Study skills 	<ul style="list-style-type: none"> Employable educational skills Presence or absence of educational goals, appropriateness of goals Level of education 		



The Erie County Family Development Matrix Map



Adult Education

General Indicators:

- Employable educational skills
- Presence or absence of educational goals, appropriateness of goals
- Level of education

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Has obtained sufficient education to maintain a job paying higher than minimum wage ■ Constant development of new transferable educational skills ■ Pursues educational goals without additional resources
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Can pursue career goals because of sufficient education or vocational training ■ Has attained marketable educational job skills beyond high school ■ Has education beyond high school or training
	3 - Stable <ul style="list-style-type: none"> ■ Has high school diploma or GED or is skill trained for a job ■ Actively looking into ways to reach educational goals ■ Has an updated resume or skills to complete job applications ■ Adequate education to maintain job
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Interest in obtaining an education, but no clear job goals ■ Pursuing GED or Vocational Training ■ Inadequate educational preparation but has interest in pursuing education
	1- In-Crisis <ul style="list-style-type: none"> ■ No educational skill which would assist with job obtainment ■ No High School Diploma or GED ■ No interest or inadequate education



Adult Employment

General Indicators:

- Employment
- Presence or absence of career goals, appropriateness of goals
- Job preparedness; job skills or work history
- Level of education

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Employed by secure business offering comprehensive benefit package ■ Has made steady advancement in career of choice ■ Constant development of new transferable skills
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Has employment with benefits and potential for advancement ■ Can pursue career goals with assistance ■ Has attained marketable skills
	3 - Stable <ul style="list-style-type: none"> ■ Present employment has limited advancement ■ Actively looking into ways to obtain goals ■ Has understanding of job skills, can search for job with assistance ■ Adequate education to maintain job
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Has seasonal/temporary employment with inadequate hours or benefits ■ Interest in working but no clear job goals ■ Minimal job skills and work history ■ Inadequate educational preparation but has interest in pursuing education to maintain job
	1- In-Crisis <ul style="list-style-type: none"> ■ Unemployed, no leads for next job ■ No interest in working ■ No positive work history or job skills ■ Inadequate education to obtain a job



Children's Care and Safety

General Indicators:

- Access to quality child care and after-school programming
- Ability to afford child care and after-school programming
- Assure safe environment in child care setting

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Recognizes and has access to high quality structured childcare and/or after-school programming. ■ Resources allow for choice of and variety of opportunities when securing childcare and/or after-school programming. ■ Child and parent determine options for engagement/involvement.
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Choice of dependable childcare and/or after-school programming. ■ Sufficient resources to allow choice of childcare and/or after-school programming. ■ Parent engaged in child's activities.
	3 - Stable <ul style="list-style-type: none"> ■ Has dependable childcare and/or after-school programming for at least six months. ■ Sufficient resources for childcare and/or after-school programming. ■ Consistent supervision and ability to respond to emergency situation.
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Has inconsistent childcare and/or after-school programming. ■ Insufficient resources for childcare and/or after-school programming. ■ Inconsistent supervision of children.
	1 - In-Crisis <ul style="list-style-type: none"> ■ Has no knowledge of, or access to, quality childcare and /or after-school programming. ■ Children unsupervised. ■ Children exposed to frequent household visitors.



Children's Education & Development

General Indicators:

- Age-appropriate development and communication
- School behavior
- School/family interactions
- Attendance and readiness to learn

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Child meets all age appropriate, developmental benchmarks, exceeding some. ■ Child uses adults as resources, mentor others. ■ Family excels in interaction with school. ■ Child seeks out opportunities to promote enrichment, participates in extra-curricular activities.
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Child meets developmental benchmarks in all areas. ■ Requires age appropriate supervision and displays self-discipline. ■ Family has open communication with school. ■ Regular attendance and occasionally participates in extra-curricular activities.
	3 - Stable <ul style="list-style-type: none"> ■ Meets developmental benchmarks in most areas. ■ Requires some intervention to moderate behavior; child responds to intervention plan. ■ Family sufficiently meets school interaction plan (i.e. parent/teacher conferences). ■ Regular attendance.
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Child is not meeting appropriate developmental benchmarks. ■ Inappropriate behaviors requiring significant in-school intervention. ■ Family has minimal interaction with school. ■ High absenteeism.
	1 - In-Crisis <ul style="list-style-type: none"> ■ Serious developmental delays or deficiencies. ■ Child is hurting other children; displays disruptive behavior resulting in suspension or expulsion. ■ Family is not responsive to school. ■ Excessive absenteeism.



Community Relations

General Indicators:

- Relationships with friends and neighbors
- Knowledge of and access to community resources
- Participation in the community (i.e. school, church, clubs, etc)

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Involved and positive relationships with friends and neighbors ■ Feels safe in neighborhood and community ■ Takes action to prevent problems ■ Contributes as a community volunteer and refers others to community resources
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Ability to work through problems with friends and neighbors ■ Knowledge of and access to resources; able to share resources with others ■ Engages in some form of community activity (e.g. ongoing involvement with child's school)
	3 - Stable <ul style="list-style-type: none"> ■ Building relationships with friends and neighbors ■ Family is aware of and accesses community resources as needed ■ Engages in occasional community/extended family helping behaviors
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Relationships with friends and neighbors creates problems ■ Accesses services with help of an agency ■ Unable/unwilling to lend help to other community members
	1 - In-Crisis <ul style="list-style-type: none"> ■ Isolated from friends and neighbors ■ No knowledge of resources; not accessing services ■ Engaged in behaviors that are threatening to self and others



Family Relations

General Indicators:

- Family structure
- Family functioning
- Intra-family communication skills, ability to resolve conflict
- Parenting skills

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Supportive family that takes action to maintain strong ties ■ Family members demonstrate nurturing behavior toward each other ■ Conflicts easily negotiated due to good communication within family ■ Parents and children have mutually agreed upon rules and expectations
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Supportive family relations, able to withstand stress ■ Family members demonstrate supportive behaviors ■ Able to manage conflict without assistance ■ Parents set realistic rules expectations that children agree
	3 - Stable <ul style="list-style-type: none"> ■ Ability to depend on immediate and extended family in times of stress ■ Family members get along ■ Able to resolve conflicts with or without assistance ■ Parents set realistic rules with minimal input from children
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Extended family members unable to depend on each other for support ■ Family members withdrawn from each other ■ Poor communication among family members characterized by conflict ■ Unrealistic or non-existent rules
	1 - In-Crisis <ul style="list-style-type: none"> ■ Immediate family members isolated from one another ■ Existence of child or spousal abuse, neglect, violence with possible intervention by criminal justice system ■ Children have been removed from the home ■ Constant conflict and/or threat of violence



Finances

General Indicators:

- Income level consistent with local cost of living
- Long-term and short-term financial goals
- Budgeting skills and financial discipline
- Access to financial institutions and resources
- Savings

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Expect income to increase with or better than cost of living ■ Sufficient income to allow family choices for non-essential purchases ■ Regularly contributes to retirement fund and able to save on a regular basis ■ Established relationship with financial institution ■ Savings are adequate to cover loss of income for three months
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Expects continued income at current level or better for at least next year ■ Sufficient income to meet family needs, recreation and emergencies ■ Plans and sticks to monthly budget, able to save on a regular basis ■ Pays bills on time, delays purchases to handle debt load
	3 - Stable <ul style="list-style-type: none"> ■ Anticipate continuation of income level for next six months ■ Adequate income to meet basic needs and emergencies ■ Plan monthly budget ■ Able to save when possible ■ Able to pay bills on time ■ Aware of and use appropriate resources for help
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Occasionally unable to meet basic needs ■ Spontaneous, inappropriate spending ■ No savings ■ Overdue bills ■ Limited knowledge of and access to resources for help
	1 - In-Crisis <ul style="list-style-type: none"> ■ No money; cannot meet basic needs ■ Overwhelming debt load ■ No knowledge of available resources for help, or unwilling to access them



Food and Clothing

General Indicators:

- Resources for food and clothing
- Quality of diet; adequacy of clothing
- Nutritional value of meals
- Conditions food preparation resources (utensils, space, appliances, sanitation)

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Has resources for diet of choice ■ Everyone in the family eats a nutritious diet ■ Has clean, durable clothing appropriate to full range of individual and family activities
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Has resources to provide sufficient and nutritious food for family members ■ Has clean, appropriate clothing for school, work or leisure
	3 - Stable <ul style="list-style-type: none"> ■ Has sufficient personal or community resources to obtain and prepare food ■ Meals have some nutritional balance ■ Clothing is clean and appropriate for school and work
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Limited resources to obtain food for family ■ No health problems but meal lacks quality and important nutrients ■ Has facility but has insufficient utensils, appliances for meal preparation ■ Clothing is ill-fitting, inadequate, or inappropriate for school or work
	1 - In-Crisis <ul style="list-style-type: none"> ■ No resources to obtain food ■ Health problems due to poor nutrition ■ No facilities for cooking, preparing meals ■ Lack of adequate clothing for different seasons, for basic needs



Health and Safety

General Indicators:

- Healthy habits
- Ability to afford health care
- Status of physical health
- Environmental conditions
- Access to health resources

Growth Levels	<p>5 - Thriving</p> <ul style="list-style-type: none"> ■ Practices preventive health behaviors ■ Has comprehensive health insurance and adequate financial resources to pay ■ Free from chronic illness and disease or condition is stabilized ■ Lives in safe and healthy environment ■ Works in safe and healthy environment ■ Has a variety of health care choices
	<p>4 - Safe/Self-Sufficient</p> <ul style="list-style-type: none"> ■ Identifies own health needs and consistently seeks treatment when needed ■ Insurance covers most of the cost of care and family arranges to cover remainder ■ Free of chronic disease or condition is stabilizing ■ Lives in a predominantly safe and healthy environment ■ Works in a predominantly safe and healthy environment ■ Can get medical care when needed and has treatment alternatives
	<p>3 - Stable</p> <ul style="list-style-type: none"> ■ Recognizes safe behaviors and begins to make them routine ■ Major medical insurance coverage and/or adequate income to pay over time ■ Receiving treatment for on-going conditions but continued impairment in some major life activities ■ Lives in an environment that is usually safe ■ Works in an environment that is usually safe ■ Able to access health care, but with difficulty (gaps in care)
Risk Levels	<p>2 - At-Risk/Vulnerable</p> <ul style="list-style-type: none"> ■ Engages in poor self-care and/or unsafe behaviors that threaten health ■ No health insurance: inadequate or inappropriate use of health care insurance ■ Not financially equipped to handle medical emergency ■ Current untreated or poorly treated health problem(s) ■ Lives in unsafe environment, may be exposed to environmental hazards ■ Works in unsafe environment, may be exposed to environmental hazards ■ Limited knowledge of or access to medical resources
	<p>1 - In-Crisis</p> <ul style="list-style-type: none"> ■ Engages in dangerous and/or self-destructive behaviors, i.e. substance abuse ■ Unable to qualify for health insurance ■ Needs immediate medical care ■ Lives in a dangerous environment that poses immediate threat to health & safety ■ Works in a dangerous environment that poses an immediate threat to health & safety ■ Has no knowledge of or access to medical resources



Shelter

General Indicators:

- Stability of housing over time
- Living conditions
- Structural safety of housing
- Resources for housing

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Owns home. ■ Has long-term tenancy. ■ Housing conditions are healthy and well maintained.
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Tenancy is secure for at least one year. ■ Housing conditions are healthy. ■ Housing is safe, structurally sound and appropriate for need.
	3 - Stable <ul style="list-style-type: none"> ■ Living in stable housing. ■ Temporary situation that will last for at least six months with a plan for the next move. ■ Living conditions are sanitary. ■ Housing is safe.
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Lives in temporary or transitional housing without a plan for next move. ■ Lives in unsanitary conditions. ■ Housing is unsafe. ■ Housing size is inadequate.
	1 - In-Crisis <ul style="list-style-type: none"> ■ Involuntary homeless. ■ Living in dangerous, unsanitary conditions. ■ Housing is hazardous. ■ No resources to cover housing costs.



Social and Emotional Health

General Indicators:

- Ability and willingness to identify needs and access resources
- Sense of personal responsibility
- Presence, degree of substance abuse
- Quality of mental health
- Quality of social support system

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Uses resources to enhance personal and community relations ■ No history of substance abuse or long-term recovery ■ Have access to social and mental health counseling if needed ■ Unconditional personal and family support system created through community resources and/or involvement
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Uses resources to prevent or overcome known challenges ■ Accepts responsibility for choices and behavior ■ Develops ways to change behavior ■ People willing to take action in support
	3 - Stable <ul style="list-style-type: none"> ■ Uses community resources to overcome challenges ■ Acknowledges substance abuse and/or behavior problems and is receives help, may already be in recovery ■ Not using substances as coping, may be successfully recovering ■ Has personal and family support
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Limited knowledge of or access to mental health resources ■ No concept of personal responsibility ■ Abuse of illegal or prescription drugs and/or alcohol, may be seeking help ■ Improper management of mental condition ■ Poor support system
	1 - In-Crisis <ul style="list-style-type: none"> ■ No knowledge of or access to mental health resources ■ Total denial of present condition, apathy, sense of hopelessness ■ Abusing drugs or alcohol and/or involved in negative relationships ■ History of mental disturbance, distorted sense of reality ■ Lack of or destructive support system



Transportation and Mobility

General Indicators:

- Access to transportation based on level of need
- Safety, condition of transportation
- Legal status of driver, vehicle (license, insurance, etc.)

Growth Levels	5 - Thriving <ul style="list-style-type: none"> ■ Owns own vehicle ■ Maintains safe, reliable vehicle ■ Has current driver's license; car insurance with comprehensive coverage
	4 - Safe/Self-Sufficient <ul style="list-style-type: none"> ■ Has reliable transportation ■ Ability to control frequency and destination ■ Has choice of transportation ■ Basic car insurance and license
	3 - Stable <ul style="list-style-type: none"> ■ Has access to transportation when needed but relies on others ■ Uses safe forms of transportation ■ Has valid license and insurance
Risk Levels	2 - At-Risk/Vulnerable <ul style="list-style-type: none"> ■ Limited access to transportation ■ Uses unsafe forms of transportation (i.e. hitchhiking, unsafe car) ■ Drives without a license, registration or insurance
	1 - In-Crisis <ul style="list-style-type: none"> ■ No access to transportation to satisfy basic needs



Youth Assets/Social Skills

General Indicators:

- Relationships with friends and adults
- Sense of fair play/cooperation
- Leadership skills
- Teamwork
- Ability to follow directions
- Makes wise decisions
- Study skills

Growth Levels	<p>5 - Thriving</p> <ul style="list-style-type: none"> ■ Consistently respects others' opinions and is able to express beliefs in a non-confrontational manner. ■ Shows compassion and concern for others. ■ Demonstrates and models good organizational skills. Serves as a positive role model for peers. ■ Consistently works well with others. ■ Consistently follows directions and listens. ■ Makes wise decisions. ■ Completes tasks in a timely and orderly fashion.
	<p>4 - Safe/Self-Sufficient</p> <ul style="list-style-type: none"> ■ Respectfully listens to others' opinions. ■ Understands and respects the rights of others. ■ Recognizes and is influenced by positive role models. ■ Works well with others in most situations. ■ Understands directions and complies. ■ Makes safe decisions. ■ Needs little direction to complete tasks in timely, orderly fashion.
	<p>3 - Stable</p> <ul style="list-style-type: none"> ■ Expresses own opinions but may have difficulty listening to opinions of others. ■ Understands their right to make choices. ■ Recognizes healthy leadership but displays no interest in taking leadership. ■ Works well with others in certain situations. ■ Cooperates but may not always understand directions. ■ Seeks others' advice in making decisions. ■ Displays interest in completing tasks.
Risk Levels	<p>2 - At-Risk/Vulnerable</p> <ul style="list-style-type: none"> ■ Shows inappropriate responses to others' opinions. ■ Shows little compassion and concern for others. ■ Strongly influenced by peers' decisions. ■ Works with others but requires supervision. ■ Exhibits attitude and requires monitoring. ■ Sometimes intimidates others. ■ Shows little pride in completed tasks.
	<p>1 - In-Crisis</p> <ul style="list-style-type: none"> ■ Shows a total disregard for others' opinions and usually resorts to physical violence. ■ Isolated and withdrawn. ■ Makes decision with total disregard for others. ■ Is unable to work with others. ■ Refuses to listen. ■ Frequently intimidates others; is viewed as a "bully." ■ Refuses to complete tasks.

The Erie County Family Development Matrix

5-Thriving 4-Safe/Self Sufficient 3-Stable 2-At-Risk 1-In Crisis	Date of Baseline	Baseline	January	February	March	April	May	June	July	August	September	October	November	December
Shelter														
Food & Clothing														
Transportation/Mobility														
Health & Safety														
Social & Emotional Health														
Finances														
Family Relations														
Community Relations														
Adult Education & Employment														
Children's Education & Development														
Children's Care & Safety														
Immigration & Resettlement														
Youth Assets/Social Skills														
Judicial System Involvement														

CLIENT/ FAMILY NAME _____
 TEAM LEADER _____
 AGENCY _____

DATE of ENTRY _____
 DATE OF TERMINATION _____

SUCCESSFUL UNSUCCESSFUL

Improving the Quality of Family Life in Erie County

Service Coordination Mechanism HANDOUTS

**Family & Children
First Council
Erie County**



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Director**

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Erie County Family Team Meeting Invitation

TO: _____

FROM: _____

DATE: _____

You are invited to participate in a Family Team Meeting being held for:

Name: _____

Family team meetings are dedicated to looking at the strengths and needs of this child and family and developing a comprehensive individualized plan. This team will provide ongoing support to this family to assist them in becoming successful. Please bring with you any information that you feel would be beneficial.

A team meeting for this family is scheduled on:

DATE: _____

TIME: _____

LOCATION: _____

If you cannot attend this meeting, please contact me at:

I look forward to working with you in the best interest of this child and family.



FAMILY TEAM MEETING AGENDA

1. **Welcome and Introductions** – *Who are we- what role do we play with the family*
2. **Ground Rules/ Confidentiality Agreement**- *Ways to manage emotions and keep the meeting focused on the outcomes/ goals*
3. **Family's Goal(s) for the Meeting**- *Family states the outcomes for the meeting and the facilitator helps to gain agreement from the team to work on these outcomes*
4. **Family's Story**- *Family's perspective of how they became involved with services/agency. The family story establishes this time as the "family's meeting" and assists the team in developing empathy for the family and understanding their perspectives and family history*
5. **Family Strengths** – *that will help the family/ child achieve the Goal(s)/ Outcomes*
6. **Family Needs – Concerns**- *What are barriers to achieving the outcomes/ goals? Asked of the family and other team members*
7. **Brainstorming Strategies- Plan of Action**- *Team creates a list of ideas that may be possibilities in addressing the needs and meeting the outcomes/ goals. Develop Agreement for who will do what, when, etc.... Ensuring that steps are small and measurable with time limits*
8. **Problem Solve ("What could go wrong?")**- *The Facilitator helps the team to explore if there is anything they can foresee that can go wrong with the plan and addressing those concerns with a "Plan B"*
9. **Agreement** – *Schedule the next meeting (Follow Up FTM) to review progress and address ongoing or new concerns. Facilitator to commit to providing a written copy of the plan to each team member within 1 week.*
10. **Thank You**- *Thank family and team members for their efforts and input.*

Survey-Lead Worker/ Family

Suggested Ground Rules:

- ◆ Confidentiality* -Exception: Mandated Reporting Criteria and the FTM Summary
- ◆ Be respectful of all participants
- ◆ One person speaks at a time
- ◆ Everyone has an opportunity to speak
- ◆ It is okay to disagree
- ◆ Be honest and open
- ◆ Everyone's contributions are valued
- ◆ Be positive and strength based
- ◆ Speak to each other, not about each other

🕒 **Additional Rules:**



Family Team Meeting Information for Service Providers and Participants

A **Family Team Meeting (FTM)** is a gathering of family members, friends, community resource representatives, and other interested people who join together to strengthen a family, brainstorm ideas to assist the family in reaching goals, and develop a protection and care plan for the children. Family Team Meetings evolve from the way that families form a natural helping system to meet needs and solve problems. The Family Team Meeting is often the forum in which the child and family team comes together to help the family craft and implement a written plan for change.

The Family Team- Families need help in times of crisis and stress, so they draw together people whom they trust and who can help in responding to the issues they face. Almost everyone can identify a time when they formed a team, sometimes involving professional helpers, to meet a specific need. Likewise, most people who have drawn a team around them are willing to become contributors to such a team or circle of friends.

A Facilitator/ Coordinator will set up the Family Team Meeting by having met with the family, speaking with invited participants and service providers. Arranging for a meeting place, inviting the participants, and sharing information with the participants as to the focus of the FTM. The facilitator/ coordinator will also provide participants with a Consent for Information Exchange signed by the family if necessary. It is also the facilitator's job to facilitate/ coordinate the actual FTM.

The Family Team Meeting will be held at a safe and neutral location. The average length of the FTM is approximately 2 hours. During the meeting the family will indicate the goal (s) that will be worked on and have a chance to tell their 'story'. Then the group will brainstorm family strengths, *needs and concerns*, and resources that may help meet the goals. (*It is important that the participants be open and honest with information relevant to the families situation and identify their concerns and needs at the meeting during the time in which needs and concerns are discussed*). A strategic plan that everyone agrees to will be devised from the information gathered and each participant will receive a copy of the plan. Within 30 to 60 Days a Follow-up FTM should be held to review progress and additional goals and needs. Any team member can contact the Facilitator/Coordinator to begin the follow up process.

To be prepared for the FTM each participant should come prepared to share family strengths, needs and concerns that they have noted, and ideas on resources to meet the needs and goals for the family. *It is imperative that while we remain strength based, we also agree to be honest and open during the Family Team Meeting.

If you have questions, the best person to contact is the facilitator/coordinator of the Family Team Meeting.



Family Team Meeting Invitation

DATE

Dear Invited Participant:

I am writing to remind you of a Family Team Meeting that has been scheduled for:

_____ on _____ at _____
(Time) (Date) (Location)

The purpose of this meeting is to discuss the case plan for _____.
(Family Name)

The family identified the following goals:

You are invited to attend this Family Team Meeting in order to develop the plan along with the family. Others invited to attend are:

Prior to the meeting, please make a note of the strengths, needs, and concerns for the _____ family that you have identified. At the meeting, services to meet the family and child's needs will be designed to draw upon the various strengths identified by the team members.

If you cannot attend this meeting at this scheduled time, date or location, please e-mail me at _____ or call me at the following :() _____.

Sincerely,

Family Team Meeting Facilitator



Rights and Responsibilities for Parent-Provider Partnerships

For Parents:

- I am an equal partner with providers on the team, working jointly to address needs and plan on behalf of my child.
- I see the provider as a person who is working with me for the well being of my child & family.
- I see my goal as reaching a mutual understanding of my child and family's needs so that as a team we can take action to meet those needs. I clearly express my own strengths and needs as well as the strengths and needs of my child & family.
- I am an active participant in the decision-making process concerning services for my child & family, and I seek ways to insure my active involvement.
- I know that wraparound does not mean that I will receive large amounts of money or new possessions, but that the focus is on needs.
- I understand that a provider often has responsibility for service coordination and communication with many children & families, including my own.
- I don't let past negative experiences or negative attitudes get in the way of establishing a good working relationship with the providers I am working with now.
- I encourage the providers involved with my child to communicate with each other and to keep me informed as well.
- When I make a commitment to a plan of action, I follow through on my responsibilities.
- I talk with other parents involved in the child serving system, sharing my experiences and knowledge.
- I commit to regarding providers with the same respect that I expect them to give to me. I help promote a culture that is supportive and friendly to providers.

For Youth:

- The people on my team are a part of the team because they care about me and my family. They are working with me for our well being.
- I believe that I am a partner with all team members, working together to address needs and make important decisions on behalf of me or other family members.
- I am a person just like my partners and the service providers. I have ideas, feelings, and beliefs that may or may not be different from those on the team. I deserve to have them voiced.
- I know that I am not the only voice to be heard, and that all plans/decisions are the result of the entire team. I also know that I am a child (minor) and sometimes adults in my life make decisions for me.
- I attend and participate in team meetings because the meetings are about me or other family members, and therefore, I should have my feelings, strengths, and needs voiced.
- I come to team meetings prepared. I come to meetings with ideas I want added to the agenda for discussion and questions I want answered.
- I am able to clearly express my own needs and the needs of my family to all team members. I will voice my feelings, needs, and opinions in appropriate and respectful ways.
- Adults, just like children and teenagers, make mistakes and learn things one step at a time. I treat others on the team like I would like them to treat me.
- When I make a commitment to a plan we decided on, I follow through with what I said I would do.

For Providers:

- I am an equal partner with parents and other team members, working jointly to address needs and plan on behalf of the child.
- I evaluate the child in terms of progress made, and communicate hope to the parent by doing so.
- I consistently value the comments and insights of the family and make use of their knowledge about the child's needs and activities. I will not impose my own values and how others live.
- I speak plainly, avoiding the jargon of medicine, sociology, education, psychology, or social work.
- I actively involve the parents in the establishment of a plan of action and continually review, evaluate, and revise the plan with them.
- I make appointments and provide services at times and places that are convenient for parents and other team members.
- When I make a commitment of action, I follow through on my responsibilities.
- With appropriate authorization, I obtain and share information with other providers, ensuring services are not duplicated.
- With appropriate authorization, I connect the family with other families in similar situations.
- At the request of parents, I am an active part of their information and referral network, providing them with contacts to services and to parent support networks.
- I will use the family team meeting to honestly and assertively share my concerns and fears.
- I commit to regarding parents with the same respect that I prefer they give me. I help promote an agency culture that is supportive and friendly toward parents.



What is a Family Team Meeting?

A Family Team Meeting is for people who care about you (and your family) to get together and support you with working on goals you have identified for your family. A Facilitator will meet with you to talk more about the Family Team Meeting and help you set it up.

What goals can I work on?

You get to decide which goals will be the focus of your Family Team Meeting.

Who is invited to the Family Team Meeting?

- You get to decide whom you would like to have invited to your Family Team Meeting
- We encourage you to invite family members, friends, and others from your neighborhood, community or church that you can count on for support
- You may want to invite Family Support Workers, counselors, teachers, or others involved with your family as service providers
- People you don't work with now but may be able to help you on working toward your goals or who can provide you with information, services, or resources
 - There may be people who *must be invited* because of legal reasons and are necessary to have input from if you are involved with them, (JFS or JC) staff

Also present will be a Facilitator (whom you met before, that helped you set up the meeting) who will help your Family Team Meeting flow, make sure people stay focused on your goals, and writes up what the team talks about and decides.

Who will invite these people?

- The Facilitator will contact people you have invited to be part of your team. You may also help make calls if you want to and let them know they are invited to your meeting.

What will happen at the Family Team Meeting?

- Everyone will introduce themselves to each other
- The Facilitator will go over "ground rules, such as: Be respectful of all participants, One person speaks at a time, It is okay to disagree... You may make suggestions for other rules you think the team needs to follow at your meeting
- You will be able to tell everyone the goal(s) you have chosen to work on
- You will have the chance to tell "your story" (what has been going on?- what brought you here today?) You may share as much or as little as you would like. This can be used as an opportunity for you to help others understand your situation and give them a bigger picture of what's going on with your family
- Everyone in the group will help list you and your family's strengths that you already have that will help you reach your goals
- You and the team will list the needs and concerns you and your family have in order to meet your goals
- Everyone will help list resources and steps that may help meet your goals at the same time addressing the needs and concerns you and the team listed
- Using the lists made, a Plan that everyone agrees on is written out – the Plan will show who will do what and when they will do it in order for you and your family to accomplish your goals
- Everyone you invited to be part of your team will get a copy of the Plan mailed within 10 working days of your meeting



One family One plan One focus

WHAT is WrapAround?

WrapAround is a process which develops and carries out plans for children, individuals and their families who have very complex needs. Families who have used traditional services may find WrapAround helpful in meeting the family's identified needs.

The WrapAround process is implemented with the involvement of those people important to the family.

WrapAround improves the lives of families by building on their strengths. It encourages them to make helpful, caring connections in the community. The WrapAround process ensures that services are focused on the needs of the individual and his or her family.

Key Elements of WrapAround

- Based on strengths of the individual and the family.
- Unconditional support.
- Community based.
- Community owned
- Community supports working together.
- Family voice encouraged.
- Access to flexible funding
- Outcomes measured and evaluated

WHAT can I expect?

A WrapAround facilitator works with the family to identify four to ten people who know the family best. People involved can be family members, a minister, a close friend, a coach, or others that are natural supports to the family, along with agency personnel. These people form a family team. The team works together to achieve the goals chosen by the family.

The individual! family has:

- A choice about the services they receive
- A voice in the manner in which they receive services
- Ownership of decisions that affect their lives

The facilitator, trained in the WrapAround process, is responsible for keeping the team focused on the family's goals. The family works with the facilitator to ensure the plan is right for them.

HOW is this different?

- The family directs the plan
- The plans developed are flexible and unique to each family
- Plans that do not meet the needs of the family are changed

The Family & Children First Council guides the WrapAround process in our community. This Council includes parents, service providers, business leaders, and community representatives. The Family & Children First Council is committed to developing a strong working partnership with the local community and its members.

Improving the Quality of Family Life in Erie County

Service Coordination Mechanism BROCHURES

**Family & Children
First Council
Erie County**



**Francine Bergmoser, LPC, LSW,
Director**

**4405 Galloway Road
Sandusky, Ohio 44870
(419) 621-3962 Ext. 141 FAX (419) 625-3448
fbergmoser@kscope.esu.k12.oh.us**

Ohio Family & Children First

The Ohio Family & Children First Initiative was established by Ohio Governor George Voinovich in 1992 to improve the quality of life for Ohio Families and Children while encouraging self-sufficiency and respecting the integrity and dignity of the family.

Ohio Family & Children First is a partnership of government agencies & community organizations committed to improving the well-being of children & families. The Ohio Family & Children First Initiative recognizes the family unit as the strength of a stable society and respects the family as the first and primary influence on children. A strong family is integral to the academic and social success of the child. The initiative builds on the belief that children should be raised by families, not government entities.

In 2000, Governor Robert Taft led the Initiative in a new direction by announcing that his Administration's highest priority was enabling every child to succeed.

Eric County Family & Children First is a Collaboration of:

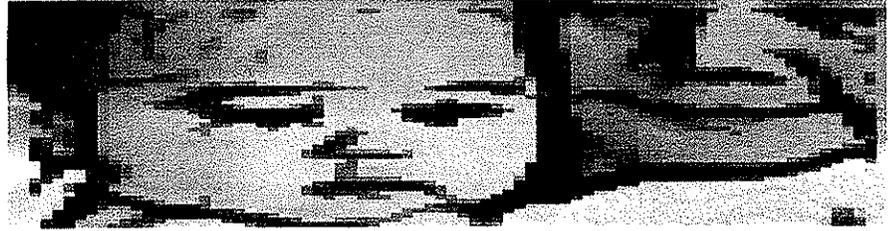
Parents of Eric County Children; Mental Health & Recovery Bd. of Erie/Ottawa Counties; Erie County Health Department; Erie County Commissioners; Erie Co. Dept. of Job & Family Services; Erie County Family Court; Erie County Board of MR/DD; Sandusky City Schools; Erie/Ottawa/Huron Educational Service Center; City of Sandusky; Ohio Dept. of Youth Services; Erie/Huron CAC; The United Way of Erie Co., and the Help Me Grow Early Intervention Collaborative.

Ohio's Commitments to Child Well-being

- Expectant parents and newborns thrive
- Infants and toddlers thrive
- Children are ready for school
- Children and youth succeed in school
- Youth choose healthy behaviors
- Youth successfully transition into adulthood



Family and Children First!



Why do Family and Children First Councils Exist?



What do Family and Children First Councils Do?



How do Family and Children First Councils Work?



Improving the Quality of Family Life in Erie County

Family & Children First Council

Erie County

Francine Bergmoser, LPC, LSW, Director

414 Superior Street Sandusky, Ohio 44870
(419) 624-6355 FAX (419) 624-6357 fbergmoser@eriecounty.oh.gov

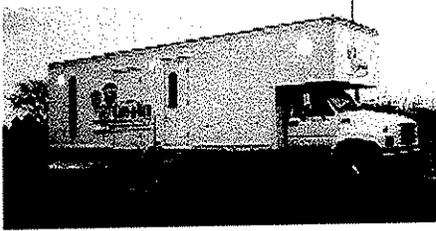


Erie County Family & Children First Projects

Care-A-Van Community Resource Center

The Erie County Care-A-Van, a 38 ft. mobile Community Resource Center, provides prevention activities to families and children in the neighborhoods in which they live. In collaboration with over 80 local agencies, the Care-A-Van provides immunizations, Car Seat Installation instruction, parenting information/skill building, health screenings and easy access to agency resources through the benefit bank. The Care-A-Van also provides "Keep Baby Safe" kits and a bicycle Helmet safety program.

For more information call:
(419) 366-8792



Provides parent education and service coordination through home visits to pregnant teenagers and families with children ages birth to three years.



For more information call (419) 621-3962 Ext 171



Service Coordination and Wraparound

Wraparound is a process which develops and carries out plans for children, individuals and their families who have very complex needs. Families who have used traditional services may find Wraparound helpful in meeting the family's identified needs.

The Wraparound process is implemented with the involvement of those people important to the family.

Wraparound improves the lives of families by building on their strengths. It encourages them to make helpful, caring connections in the community. The Wraparound process ensures that services are focused on the needs of the individual and his family.

For more information call: (419) 627-7782 (Cindy Franketti)



Wraparound

WHAT is Wraparound?

Wraparound is a process which develops and carries out plans for children, individuals and their families who have very complex needs. Families who have used traditional services may find Wraparound helpful in meeting the family's identified needs.

The Wraparound process is implemented with the involvement of those people important to the family.

Wraparound improves the lives of families by building on their strengths. It encourages them to make helpful, caring connections in the community. The Wraparound process ensures that services are focused on the needs of the individual and his or her family.

Key Elements of Wraparound

- Based on strengths of the individual and the family.
 - Unconditional support.
 - Community based.
 - Community owned
 - Community supports working together.
 - Family voice encouraged.
 - Access to flexible funding
 - Outcomes measured and evaluated
- One Family
One Focus
One Plan**



WHAT can I expect?

A Team facilitator works with the family to identify four to ten people who know the family best. People involved can be family members, a minister, a close friend, a coach, or others that are natural supports to the family, along with agency personnel. These people form a family team. The team works together to achieve the goals chosen by the family.

The individual family has:

- A choice about the services they receive
- A voice in the manner in which they receive services
- Ownership of decisions that affect their lives

The facilitator, trained in the Wraparound process, is responsible for keeping the team focused on the family's goals. The family works with the facilitator to ensure the plan is right for them.

HOW is this different?

- The family directs the plan
- The plans developed are flexible and unique to each family
- Plans that do not meet the needs of the family are changed

The Family & Children First Council guides the Service Coordinator/Wraparound process in our community. This Council includes parents, service providers, business leaders, and community representatives. The Family & Children First Council is committed to developing a strong working partnership with the local community and its members.

**Erie County
Family & Children First Council**

414 Superior Street
Sandusky, Ohio 44870
Phone: 419-624-6355
Fax: 419-624-6357
Fbergmose@eriecounty.oh.gov

**Erie County
Family & Children
First Council**

Service Coordination & Wraparound

Improving the
quality of
Family Life in
Erie County

Central Intake
419-627-7782



Developing A Family Team

What is a Family Team Meeting?

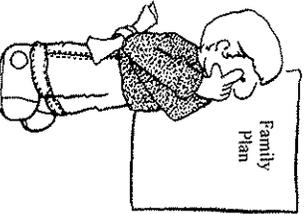
A Family Team Meeting is for people who care about you (and your family) to get together and support you with working on goals you have identified for your family. A Facilitator will meet with you to talk more about the Family Team Meeting and help you set it up.

What goals can I work on?

You get to decide which goals will be the focus of your Family Team Meeting.

Who is invited to the Family Team Meeting?

- You get to decide whom you would like to have invited to your Family Team Meeting
- We encourage you to invite family members, friends, and others from your neighborhood, community or church that you can count on for support
- You may want to invite Family Support Workers, counselors, teachers, or others involved with your family as service providers



- People you don't work with now but may be able to help you on working toward your goals or who can provide you with information, services, or resources
- There may be people who must be invited because of legal reasons and are necessary to have input from if you are involved with them, (JFS or JC)

Families have their own
Individualized Family Service
Coordination Plan

What will happen at the Family Team Meeting?

- Everyone will introduce themselves to each other
- The Facilitator will go over "ground rules, such as: Be respectful of all participants, One person speaks at a time, It is okay to disagree... You may make suggestions for other rules you think the team needs to follow at your meeting
- You will be able to tell everyone the goal(s) you have chosen to work on
- You will have the chance to tell "your story" (what has been going on? what brought you here today?) You may share as much or as little as you would like. This can be used as an opportunity for you to help others understand your situation and give them a bigger picture of what's going on with your family
- Everyone in the group will help list you and your family's strengths that you already have that will help you reach your goals
- You and the team will list the needs and concerns you and your family have in order to meet your goals
- Everyone will help list resources and steps that may help meet your goals at the same time addressing the needs and concerns you and the team listed
- Using the lists made, a Plan that everyone agrees on is written out – the Plan will show who will do what and when they will do it in order for you and your family to accomplish your goals
- Everyone you invited to be part of your team will get a copy of the Plan mailed within 10 working days of your meeting



Making a Referral

In order for any agency or family seeking service coordination they must contact Juvenile Court at 419-627-7782. An initial assessment of a family's need for service is made by the contact agency/Central Intake.

This assessment will determine the eligibility and Level of Service Coordination needed. A Level One Service Coordination referral is those parents who are not involved in multiple agencies, yet are seeking services that they are having difficulty accessing through one agency. Level One referrals will be referred to an appropriate agency for assistance prior to Service Coordination being considered as an option. Level Two is those children who are already multisystem involved.

If the needs of the family cannot be met through already existing collaborative efforts, the need to form a Family Team for Service Coordination will be evaluated and initiated if appropriate. The referral will then be given to the Family & Children First FCF Service Coordinator in the County.

To obtain a copy of the Erie County Service Coordination Mechanism or to get additional information on making a referral:

**Erie County
Family & Children First
Council**

Phone: 419-624-6355
Fax: 419-624-6357
Bergmoser@erierecounty.oh.gov



Improving the Quality of Family Life in Erie County

**Service Coordination
Mechanism
FUNDING
MATERIALS**

**Family & Children
First Council
Erie County**



**Francine Bergmoser, LPC, LSW,
Director**

**4405 Galloway Road
Sandusky, Ohio 44870
(419) 621-3962 Ext. 141 FAX (419) 625-3448
fbergmoser@kscope.esu.k12.oh.us**

Contract for Services/Materials
Erie County Family & Children First Council



TO: _____

Address: _____

The Wraparound Team for the _____ Family requests you provide the following materials or service:

Description of materials or service: _____

Dates of service to be provided: From _____ to _____

Amount of funding requested for service: \$ _____

The Family & Children First Council of Erie County agrees to pay the above amount upon completion of service or receipt of materials when a detailed invoice is submitted.

You understand that the Family & Children First Council must receive an invoice for the service/materials in order for you to be paid for the service/materials provided. If you do not have a company invoice, please request that the Service Coordinator provide you with an invoice to be filled out and submitted. Dates of service must be reflected on the invoice. The invoice total must not exceed the agreed upon total for the service stated above. Additional costs must receive prior approval or will not be reimbursed. Please be informed that we are a tax exempt government agency, therefore we cannot pay any taxes for service. If you need the tax exempt #, please request it and it will be provided to you.

All Invoices must be state that they are for: **The Family & Children First Council**

All invoices need to be submitted to:

Fran Bergmoser
Family & Children First Council
414 Superior Street
Sandusky, Ohio 44870

Please signify your approval of this agreement by completing the form below and return one copy to us for our files.

Signed _____
Service Coordinator

I agree to perform the work listed above, and I accept the terms of this agreement as stated above.

Signature _____ SSN or Federal Tax ID # _____
(Vendor) (Required by IRS)



Erie County Intersystem Services Funding Agreement

Child's Name: _____ Agreement Start Date: _____ End Date: _____

DOB: _____ Wraparound Facilitator Name: _____ # of Days:

SERVICES COVERED UNDER THIS AGREEMENT:

<input type="checkbox"/> Traditional Foster Care	<input type="checkbox"/> Respite
<input type="checkbox"/> Treatment Foster Care	<input type="checkbox"/> Transportation
<input type="checkbox"/> Residential/Group Home	<input type="checkbox"/> Other: _____

Provider Agency Name: _____

Contact Person: _____ Address: _____

Phone Number: _____

AGENCY AGREEMENT:
 The following agencies have agreed to fund the above stated services for the above named child. Their signature attests to the agreement of the designated agency staff to contribute the following amount:

Agency Information <small>(Name, Contact Person, Address, Phone)</small>	Agreement			Signature	Date
	Rate	# of Units	Total for this Contract		
				X	
				X	
				X	
				X	
				X	
				X	

Total:

FISCAL AGENCY: _____ **CONTACT PERSON:** _____

Address: _____ Phone Number: _____

By signing as fiscal agent of this shared funding agreement, said agency agrees to contract and pay the provider and bill those participating in this agreement for reimbursement.

Fiscal Agency Signature: _____ **Date:** _____

Erie County Family & Children First Council

414 Superior Street
 Sandusky, Ohio 44870
 419-624-6355



Invoice

Client Name:
 Provider Name:

Service Dates:
 Submission Date:

Day of Week	Date	Services Provided	Time In	Time Out	Total Time Unit Rate	Total Charge
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Notes:					Total Service days	
Address that reimbursement is to be submitted to:					Total Service Time	
					Service Cost	
					Total Service charges	
					Balance due	

Send all invoices to Fran Bergmoser at the above address
Payment requested will be processed and remitted with in one month of submission.

Improving the Quality of Family Life in Erie County

**Service Coordination
Mechanism
DATA
COLLECTION**

**Family & Children
First Council
Erie County**



**Francine Bergmoser, LPC, LSW,
Director**

**4405 Galloway Road
Sandusky, Ohio 44870
(419) 621-3962 Ext. 141 FAX (419) 625-3448
fbergmoser@kscope.esu.k12.oh.us**



Provider Evaluation Form - Family Team Meeting
Please complete before you leave

Your Name: _____ Date: _____

Please circle/answer the following questions about the Family Unity Meeting:

1. The Family Team Meeting's purpose was explained to me clearly

-----5-----4-----3-----2-----1-----
Excellent Very good Good Fair Poor
Comments: _____

2. I felt the Family Team Meeting was _____ for the family

-----5-----4-----3-----2-----1-----
Excellent Very good Good Fair Poor
Comments: _____

3. I believe that participating in the Family Team Meeting strengthened the family

-----5-----4-----3-----2-----1-----
Excellent Very good Good Fair Poor
Comments: _____

4. Quality Safety/Crisis plans were made by the family and the children

-----5-----4-----3-----2-----1-----
Excellent Very good Good Fair Poor
Comments: _____

5. The Family Plan that was developed by the family was supported by the providers invited to the meeting

-----5-----4-----3-----2-----1-----
Excellent Very good Good Fair Poor
Comments: _____

Erie County Family & Children First Council

FT Facilitator Evaluation Checklist

Facilitator Name:	Family Name:	Date:
--------------------------	---------------------	--------------

Area and Competencies	Meets FCFC Expectations			
	Yes	No	NA	See Comments
Preparation				
1. The family understands the purpose and philosophy of the family team meeting process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Family members are ready, able, safe, and eligible candidates for team participation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. The right people are invited to the meeting: <ul style="list-style-type: none"> ▪ People necessary for the major decisions to be made ▪ People invited by the family for their own support. ▪ People invited by the agency for service provision. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Participants know the purpose of the meeting and how to contribute in a positive way by: <ul style="list-style-type: none"> ▪ Coming prepared and ready for decision-making. ▪ Speaking to their concerns in constructive ways. ▪ Listening with respect to others' concerns. ▪ Recognizing and building on family strengths and needs. ▪ Sharing information, ideas, and resources. ▪ Keeping personal and confidential information private. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Participants know what to bring to be prepared as well as when and where to meet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Logistic arrangements are made, including: <ul style="list-style-type: none"> ▪ Meeting place and time that is mutually convenient for the family and other participants. ▪ Meeting place that is conducive for private and confidential conversations. ▪ The agenda includes any family rituals to begin or end meeting and address all relevant areas of the family's plan. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Facilitator is prepared to accomplish the primary purpose of the meeting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Facilitator and team participants are prepared to follow-up on decisions made and on next step plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Erie County Family & Children First Council

Area and Competencies	Yes	No	N A	See Comments
Facilitation				
9. Convenes the meeting, defines the goals, and ground rules of the meeting, introduces participants and their roles, defines decisions to be made and the possible range of actions to follow decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Uses consensus-building decision-making techniques, handles any conflict as it surfaces, selects appropriate idea-building processes, solicits all view-points, clarifies options, refocuses as necessary to stay on task and on time, monitors and manages the flow of the discussion to ensure that all are heard and no one dominates, brings discussion to closure with decisions made, and moves on to next steps, assignments and commitments. This is done by: <ul style="list-style-type: none"> ▪ Focusing on results, processes, and relationships. ▪ Designing pathways to action for realizing opportunities, building capacities, and solving problems. ▪ Seeking maximum, appropriate involvement in decisions. ▪ Facilitating the group to build agreements and meet challenges. <i>[What could go wrong with this plan?]</i> ▪ Coaching others to do their best. ▪ Confronting problems honestly and respectfully. ▪ Managing power and control issues that arise. ▪ Balancing family-centered proactive with protective authority to keep children safe and help parents succeed. ▪ Celebrating successes and accomplishments 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Builds an understanding of the family and requirements for safe case closure from assessment information, court requirements, and family team discussions, by using: <ul style="list-style-type: none"> ▪ The family's story, strengths and needs, risks, barriers to family change, and family desires to improve. ▪ Requirements for safe case closure [behavioral changes]. ▪ Changes the family must make plus their potential, motivation, and progress as it is being made [prognosis]. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Makes decisions, sets goals, secures commitments to: <ul style="list-style-type: none"> ▪ Set goals for change, selects change strategies, plans interventions and support with family and supporters. ▪ Secures commitments from participants for plans made. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Erie County Family & Children First Council

Area and Competencies	Yes	No	NA	See Comments
Service Planning and Follow-up				
13. The family team meeting provides a basis for service planning, coordination, communication, and accountability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. The family team develops, monitors, and evaluates an individualized, strengths based, needs driven service plan that fills safety and permanency requirements while meeting the unique needs of the child an family identified in the assessment. Via the planning process, the service team assists the family develop and use a network of informal supports that can help sustain the family over time. The family service plan: <ul style="list-style-type: none"> ▪ Defines agreed upon goals for the family that include measures of caregiver behavior changes that are consistent with safe case closure requirements. ▪ Focuses on achieving safety, permanency, and well-being. ▪ Addresses the child's needs for attachment, safety and security. ▪ Plans for family preservation or reunification, as indicated. ▪ Identifies alternative permanency plans, safety plans, crisis plans, and any transition plans that may be necessary. ▪ Uses supports and services that are most likely to work for the family and be a good fit for the family and situation. ▪ Specifies services and supports that are culturally competent and community based. ▪ Defines how goals are to be measured via behavior changes. ▪ States consequences of not making behavior changes. ▪ Sets time limits, clear expectations, and alternatives. ▪ Defines accountability for actions of the family and service providers and way that accountability will be ensured. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. The family team develops, monitors, and evaluates any individualized child service plans for a child with special needs. The child service plan [family's plan]: <ul style="list-style-type: none"> ▪ Addresses the special needs of the child or youth. ▪ Defines treatment goals and strategies [including an IEP.] ▪ Builds resiliency and improves the child's functioning in daily settings, including home and school. ▪ Uses collaboration as appropriate, with health care, mental health, special education, developmental disabilities, and/or juvenile justice services. ▪ Provides integration and coordination of services across settings, providers, levels of care, and funding sources. ▪ Provides for age-appropriate transitions. ▪ Prevents unnecessary disruption of the child's education. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. The effectiveness of each family team meeting is assessed by the team and with adjustments made to improve the ongoing process and results for the family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. The effectiveness of planned services is evaluated and results are achieved.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Erie County Family & Children First Council

Comments Section

Strengths
Needs and Areas for Improvement
Strategies to Address Needs

Facilitator – Ohio Fidelity Index

No, Not at all (0)
 Yes, once in a while (1)
 Yes, at least half of the time (2)
 Yes, often (3)
 Yes, A lot (4)

Youth and Family Team

	0	1	2	3	4
1. Do you as the facilitator participate in team meetings on a regular basis?					
2. Is there a representative of the school or the child's primary educational setting who actively participates on the team?					
3. Are there members of the team who participate in the wraparound process because of legal considerations (parole or probation officer, child welfare worker, etc)?					
4. Are key participants invited to the meeting such as family members, JFS worker, teacher, therapist and others significant to the family?					
5. Does the team include people that this family caregiver and child (if age appropriate) wishes to have on the team?					
6. Do team members come to meetings prepared to share information and/or update information on the family status (e.g. social history, legal information, school updates, etc)?					
7. Is it difficult to get team members to attend team meetings?					

Community-Based Services

1. Are the services and supports in the wraparound plan difficult for this family caregiver and child to access because they are offered in a location that is far away or otherwise present transportation problems?					
2. Are at least half of the services used for the child and family located in their local community or county?					
3. In the event that the team must consider a residential placement for this child, do you as the facilitator also take care to plan for transition or step-down from that placement once the child has stabilized?					
4. When a residential placement is discussed in team meetings, do you as the facilitator emphasize the use of local community placements for this child whenever possible rather than placements that are in another county or state?					
5. Do you as the facilitator work to find and use services that will present this child with opportunities to engage in the normal and typical activities for his or her age (e.g. recreational activities, employment, etc.)?					
6. Do you as the facilitator work to ensure that this child has the opportunity to attend a school in a mainstream classroom for at least part of their day?					

Cultural Competence

1. Do you as the facilitator take care to ensure that the team includes individuals who share similar race/ethnicity, spiritual orientation, lifestyle choices, and/or cultural beliefs with this child and family?					
2. Do you as the facilitator view this family's traditions, values and heritage as assets or sources of strength in the planning process?					
3. Does the team take time to incorporate this family's unique values and culture into the wraparound process (e.g. gestures, holiday observances, beliefs, etc)?					
4. Do you as the facilitator provide the family caregiver and child (if age appropriate) with opportunities to tell you and the rest of the team about their beliefs and traditions?					
5. Could you as the facilitator point to a place in the child's plan where this child and family's beliefs, traditions or spirituality have been incorporated into the planning process?					

Individualized

1. Do you as the facilitator believe that you understand the family caregiver and child well enough to effectively plan services and supports for this child and family?					
2. Do you as the facilitator actively advocate for services and resources that you and the team view as necessary for this child and family?					
3. Does the team have a written plan of care that includes life domains, goals, objectives and					

descriptions of resources to carry out the plan?					
4. Does the team come up with the creative solutions to meet the needs of the child and family caregiver when there is no clearly defined (or funded) service available in the community?					
5. Have you as the facilitator taken an active role in helping this child and family to prepare for major transitions (e.g. new school, residential placement, etc) by making plans to deal with these changes?					

Strength- Based

1. Does the team plan services and interventions that are based on the individual needs and strengths of this child and family?					
2. Does the team create a positive atmosphere around successes and accomplishments at each team meeting?					
3. Does the team seek feedback from the child and adult caregiver about what has worked in the past for his family?					
4. Does the written plan for the child include strength-based services and interventions?					
5. Does the team take the time to help this child get involved in activities that he or she likes and does well?					
6. Does the team take the time to help this child to learn how to work through problems and come to age appropriate solutions?					

Natural Supports

1. Do you as the facilitator engage significant adults in the community (such as coaches, mentors or employers) to assist in the planning and development of services for this child?					
2. Does the team help this child to seek out and develop relationships with pro-social peers?					
3. Does the team find ways to increase the support the family caregiver and child receives from friends and family?					
4. Is there a family friend or advocate for the family caregiver and child who actively participates on the wraparound team?					
5. Do you as the facilitator believe that the wraparound process is helping this family to develop or strengthen relationships that will support them when the wraparound process is finished?					

Persistence

1. Is the team able to identify barriers to service or resources/interventions and discusses possible solutions?					
2. Does the team have a written safety/crisis management plan that describes how they will meet the changing needs of the child in the case of an emergency?					
3. Do team members understand their role in the crisis management plan and could they act on the plan in the case of any emergency?					
4. Do you as the facilitator feel confident that, in the even of a major crisis, the team can keep this child in the home and community?					
5. Would you as the facilitator discontinue the wraparound process before the family is ready for it to end?					

Family Voice and Choice

1. Do you as the facilitator provide the family caregiver and child (if age appropriate) opportunities to attend orientation sessions and/or training on the wraparound process?					
2. Do you as the facilitator spend time with the family caregiver and child (if age appropriate)					
3. Do you as the facilitator take the time to inform the family caregiver and child (if age appropriate) of the range of choices that are available to their family?					
4. Do you as the facilitator ask/consult with the family caregiver and child (if age appropriate) about the types of services or resources they would prefer for their child and themselves?					
5. Do you as the facilitator believe that you are creating an atmosphere where the family caregiver and child (if age appropriate) are able to feel comfortable expressing their opinions even if they are different from the rest of the team?					
6. Do you as the facilitator take care to ensure that you are involving the family caregiver and child					

(if age appropriate) are able to feel comfortable expressing their opinions even if they are different from the rest of the team?					
7. Do you as the facilitator take care to ensure that this child (when age appropriate) has the opportunity to communicate his or her own ideas when it comes time to make decisions about their care?					
8. Do you as the facilitator believe that you and the team are in a position to overrule the wishes of this adult caregiver regarding his or her child when it is clearly in the child's best interests?					
9. Do you as the facilitator take care to ensure that this family caregiver and child have flexible and convenient arrangements to participate in team meetings (e.g. location, time, transportation and daycare)?					

Collaboration

1. Do you as the facilitator go out of your way to ensure that all team members-including friends, family, and natural support present ideas and participate in decision making?					
2. Does the team have one common written plan of care (wraparound plan) that describes how the team will meet this child's needs?					
3. Do you as the facilitator treat team members with respect and appreciation for the unique value each person brings to the team?					
4. Do you as the facilitator engage team members in brainstorming activities in order to come up with strategies that address this child's needs?					
5. Do you as the facilitator assign specific tasks to each team member at the end of meetings?					
6. Do you as the facilitator work with the team to come up with new ideas for the wraparound plan whenever the child and family's needs change?					
7. Do all the members on the team take responsibility for implementing the plan for this child?					

Flexible Resources and Funding

1. when the team has a good idea for a support or a service for this child and family, typically is there money available to fund it?					
2. Does the team use non-traditional services or even create new services for this child and family?					

Outcomes-Based

1. Are you as the facilitator able to count or measure the progress this child is making on each objective or goal of the wraparound plan?					
2. Does the team have defined criteria for success in each of the goal or objectives of the wraparound plan?					
3. Does the team utilize standardized assessments for tracking risks and strengths of this child and family?					
4. Does the team collect standardized outcome data (e.g. how well the child is functioning or the severity of problems the child is experiencing) on this individual child?					

Youth – Ohio Fidelity Index

No, Not at all (0)
 Yes, once in a while (1)
 Yes, at least half of the time (2)
 Yes, often (3)
 Yes, A lot (4)

Youth and Family Team

0 1 2 3 4

1. Do you participate as a member of the team on a regular basis?					
2. Is there a representative from your school or educational setting who actively participates on the team?					
3. Are there members of your team who participate in the Wraparound process because of legal considerations (example: you have a parole or probation officer, or case worker from JFS)?					
4. Are important of "key" participants invited to your team meetings (family, JFS worker, teacher, therapist and other individuals) who are meaningful to you and your family?					
5. Does your team consist of people you want to have on the team?					
6. Do team members come to meetings prepared to share information and/or update information on your and your family status (e.g. social history, legal information, school updates)?					
7. Do all team members regularly attend the team meetings?					

Community-Based Services

1. Are the services and supports in your wraparound plan difficult for you and your parent or caregiver to access because they are far away from where you live of because you don't have reliable transportation?					
2. Are at least half of the services you and your family uses located in your community or county?					
3. In the event that your team must consider a residential placement for you, do they also plan "up front" for your transition or step-down from that placement once you are stabilized and feeling better?					
4. During team meetings if a residential placement is discussed, does your team try to come up with placement options that are in your community rather than placements that are in another county or state?					
5. Does you team work to find services that will allow you to participate in the normal and typical activities for your age (e.g. recreational activities, sports, employment, etc.)?					
6. Do you have the opportunity to attend a school in a mainstream classroom for at least part of the day?					

Cultural Competence

1. Does you team include individuals who share similar race/ethnic backgrounds, spiritual orientation, lifestyle choices, and or cultural beliefs with you and your family?					
2. Does you team view your family's traditions, values and heritage as assets or sources of strength in the planning process?					
3. Does your team take time to incorporate the unique values and culture of you and your family into the wraparound process (e.g. gestures, holiday observations, beliefs, etc.)?					
4. Do you have opportunities to tell the team about your beliefs and traditions?					
5. Could you point to a place in your plan where your beliefs, traditions or spirituality have been included into the planning process?					

Individualized

1. Does your team understand you and your family well enough to effectively plan services and support for you?					
2. Does your facilitator advocate for services and resources the team views as necessary for you and your family?					
3. Does your team have a written plan of care that includes life domains, goals, objectives and descriptions of resources to carry out the plan?					
4. Does your team come up with creative solutions to meet your needs and your family's needs when there is no clear option or service available in the community?					
5. Has your team helped you and your family prepare for major transitions (e.g. new school, residential placement, etc.) by making plans to deal with these changes?					

Strength- Based

1. Does your team plan services and interventions that are based on the individual's needs and strengths of you and your family?						
2. Does your team create a positive atmosphere around your successes and accomplishments at each team meetings?						
3. Does your team seek feedback from you and your parent or caregiver about what has worked in the past for your family?						
4. Does your written plan include strength based services and interventions (meaning; does the team include services that highlight things you are good at or do well)?						
5. Does you team take the time to help you get involved in activities that you like or do well?						
6. Does you team take the time to help you learn how to work through problems and come to solutions?						

Natural Supports

1. Does your team engage significant adults in the community (such as coaches, mentors, or employers) to assist in the planning and development of services and treatment for you?						
2. Does your team help you seek out and develop relationships with positive or pro-social peers?						
3. Does you team find ways to increase the support you get from your friends and family?						
4. Is there a family friend or advocate who actively participates on the wraparound team?						
5. Is the wraparound process helping you and your family to develop or strengthen relationships that will support you when the wraparound process is finished?						

Persistence

1. Does your team help to identify barriers to using services or resources or interventions and discusses possible solutions?						
2. Does you team have a written safety/crisis management plan that describes how they will meet your needs in the case of an emergency?						
3. Do team members understand their role in the crisis management plan and could they act on the plan in the case of emergency?						
4. Do you feel confident that, in the event of a major crisis, your team can help keep you in your home and community?						
5. Do you think that your wraparound process could be discontinued before you or your family is ready for it to end?						

Family Voice and Choice

1. Are you and your parent or caregiver given opportunities to attend orientation sessions and/or training on the wraparound process?						
2. Does your wraparound facilitator explain or help you to better understand the different parts of the wraparound process?						
3. Does your wraparound facilitator regularly inform you about the different choices for programs and services that are available to you?						
4. Do team members ask your opinion about the types of services or resources you would prefer for yourself and your family?						
5. Do you feel comfortable expressing your opinions even if they are different from the rest of the team?						
6. Does your wraparound facilitator ensure that you are involved in designing a plan of care for yourself and your family?						
7. Do you have the opportunity to communicate your own idea when it comes time to make decisions?						
8. Do team members overrule your wishes regarding your treatment?						
9. Does you facilitator ensure convenient arrangements for you and your parent or caregiver to participate in team meetings (e.g. locations, time, transportation and daycare)?						

Collaboration

1. Does your team go out of the way to ensure that all team members-including friends, family, and natural supports – present ideas and participate in decision making?					
2. Does your team have on common written plan of care (wraparound plan) that describes how the team will meet your needs?					
3. Do team members treat one another with respect and appreciation for the unique value each person brings to the team?					
4. Does your team engage in brainstorming activities in order to come up with strategies that address your needs?					
5. Does the team assign specific tasks to each member at the end of meetings?					
6. Does your team come up with new ideas for your wraparound plan whenever your needs change?					
7. Do all of the members on the team take responsibility for implementing the plan for your care and treatment?					