**COUNTY ASSESSMENT**

**Goal 1:** Facilitate access to and coordinate with needed services within a single, individualized plan which is reviewed at least annually to assess the delivery, appropriateness and effectiveness of services.

**Goal 2:** Facilitate maintaining children in their home communities and with family members.

Services identified as needed are checked on the following grid; those services not checked are either Not Applicable for the age of the child or already being provided through the family's efforts:

<table>
<thead>
<tr>
<th>Access to Services</th>
<th>Coordination with Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Mental Health</td>
</tr>
<tr>
<td>□</td>
<td>Habilitation Services</td>
</tr>
<tr>
<td>□</td>
<td>Educational Services</td>
</tr>
<tr>
<td>□</td>
<td>Health Services</td>
</tr>
<tr>
<td>□</td>
<td>Vocational Services</td>
</tr>
<tr>
<td>□</td>
<td>Recreational Services</td>
</tr>
<tr>
<td>□</td>
<td>Volunteer Services</td>
</tr>
<tr>
<td>□</td>
<td>Advocacy</td>
</tr>
<tr>
<td>□</td>
<td>Transportation</td>
</tr>
<tr>
<td>□</td>
<td>Legal</td>
</tr>
<tr>
<td>□</td>
<td>Maintenance of Medical Coverage</td>
</tr>
<tr>
<td>□</td>
<td>Respite Services</td>
</tr>
<tr>
<td>□</td>
<td>Alternative Placement</td>
</tr>
<tr>
<td>□</td>
<td>Reunification</td>
</tr>
<tr>
<td>□</td>
<td>Determining services needed to reduce risk</td>
</tr>
</tbody>
</table>

Frequency of contact with child:  
- Weekly □  Monthly □  Bi-monthly □

Frequency of contact with family:  
- Weekly □  Monthly □  Bi-monthly □

Frequency of contact with providers:  
- Weekly □  Monthly □  Bi-monthly □

Primary Case Manager ______________________  Dual Case Managers ______________________

Date _______________  Primary CM Signature __________________________

Date _______________  Dual CM Signature __________________________

Date _______________  Dual CM Signature __________________________

**Updates minimum of annually maintain the same plan except as indicated by dated inserts above.**

Update ______  Primary CM Signature __________________________

Update ______  Primary CM Signature __________________________

Update ______  Primary CM Signature __________________________

Update ______  Primary CM Signature __________________________

Update ______  Primary CM Signature __________________________
ICHHS-0110 (9/28/05)

ITASCA COUNTY
CHILD WELFARE - TARGETED CASE MANAGEMENT

ITASCA COUNTY SCREENING
Child Name: ___________________________ DOB: ________________
Parent: _______________________________ PMI: ________________

DETERMINATION OF ELIGIBILITY

☐ MA or MinnesotaCare client who is under age 21 and:
   ☐ At risk of out-of-home placement or in placement as defined in MN statutes section 260C.212 sub.1
   ☐ At risk of maltreatment or experiencing maltreatment as defined in MN statutes section 626.556 sub. 10e
   ☐ In need of protection or services as defined in MN statutes section 260C.007 sub.6

FINDING ☐ Eligible ☐ Ineligible
Child is in need of protection or services as defined in MN statutes 260C.007 sub.1 due to:

This child will receive CW-TCM Services through the following provider(s):
☐ ICHHS Provider ☐ CMH/REACH Provider ☐ Tribal Provider

Plans coordinated with dual case managers ☐
If multiple providers are designated, the following outlines the division of tasks to meet the needs of the child.
In lieu of this statement, a grid of responsibilities can be attached.

Rationale for Multiple Service Providers:

Provider Tasks:

** See Plan on Back