FLORIDA DEPARTMENT OF HEALTH

FAMILY SUPPORT PLAN FOR SINGLE AGENCY CARE COORDINATION

Date	GOALS - DREAMS	NEXT STEPS – ACTION PLAN	Date	HOW DID IT WORK?

Name: _____
ID No: _____
Date of Birth: _____

Participant Consent: I helped make this plan and agree to it. _____
Family Consent: I helped make this plan and agree to it. _____
Relationship(s) to Participant: _____
Care Coordinator: _____ Date: _____

DH 3151, 8/99 Stock Number: 5744-000-3151-4 (White copy to Record - Yellow copy to Participant/Family)

INSTRUCTIONS for FAMILY SUPPORT PLAN for SINGLE AGENCY CARE COORDINATION

This plan should be used for Healthy Start participants receiving ongoing care coordination when the participant does not have complex concerns and priorities involving multiple providers in the Family Support Plan process. Principles of family support planning are the same whether this form or the standard Family Support Plan form is used. There should be only one Family Support Plan for each participant. Additional copies of the form may be used if more space is needed. (Only at the family's request will there be more than one Family Support Plan for different individuals in the same family.)

PURPOSE: The purpose of the Family Support Plan is to involve participants/families in activities that will reduce their identified risk factors and therefore improve birth outcomes and their child's health.

WHAT: The Family Support Plan is part of the care plan developed by the participant and the care coordinator. The Family Support Plan does not take the place of progress notes, SOAP notes or problem lists, but supplements these tools. The Family Support Plan is key to involving the family in their plan of care. The Family Support Plan is the family's plan. The white copy should be kept in the record and the yellow copy should be given to the family.

WHY: The Family Support Plan will provide the family with documentation of their plan and updates as well as enable anyone working with the participant to easily see how identified concerns, priorities, and resources are being addressed.

WHEN: The Family Support Plan is part of the care coordination process that begins after initial assessment.

HOW: Use the information concerning the participant's risk factors and resources obtained from the Healthy Start screen, initial contact, and initial assessment to develop with the participant a plan of care that includes a Family Support Plan. When this form is used, it is assumed that the participant's or family's concerns, priorities, strengths, and resources have been identified in conjunction with the family. The Family Support Plan builds on the identification of these concerns, priorities, strengths, and resources.

DREAMS - GOALS: Record the date and the dream or goal the plan is being written to achieve. The dream or goal is a statement of what participants or families want to see happen in their lives. At this point, encourage clients to have big dreams/goals; examples might be to have their own apartment, to stop smoking, to work in a job that they like.

NEXT STEPS - ACTION PLAN: Decide together the small steps needed to reach their larger goals/dreams. Write the plan of action for the identified goals/dreams. For example, an action plan might be obtaining information concerning subsidized housing; attending a smoking cessation class; and taking the GED exam. Discuss WHO will do WHAT by WHEN. Include family, individuals, and agencies responsible for each step or available as resources. Identify and record family and individual resources that will be used to achieve each step. The location, start date, frequency, and duration of services should be addressed in this section. Identify funding sources, as appropriate.

HOW DID IT WORK?: Evaluate steps taken or not taken at each visit. Date and document the follow-up status of each step each time assessment of progress is made. For instance, the participant is on a waiting list for subsidized housing, continues to smoke but has signed up for the smoking cessation class, and has obtained information concerning preparing for the GED exam.

Encourage and support steps accomplished, decide together what needs to happen next … more small steps or if a goal is reached, a new goal. Date and identify whether goals are still active (as in the examples), inactive, or have been resolved.

The participant, family member of the child, or guardian must sign the plan indicating their participation in the development of and understanding of the plan. Also, indicate their relationship to the child. The care coordinator must sign and date the plan.

Give the yellow copy to the family and place the white copy in the record.