Community Care Plan: Background Information (to be completed before meeting)
(FOR AGENCY USE ONLY)

County		**Date**	
Presenting Staff		**Agency**	

☐ Initial Meeting ☐ Review ☐ Returning to Community

Contact Information			
Youth:		**Legal Custodian:**	
Address:		Relationship:	
City, State, Zip:		Address:	
Home phone:		City, State, Zip:	
Mobile phone:		Phone:	
Date of birth/age:		Mobile Phone:	
Race :		Email:	
First Language:		First Language:	
Preferred Pronoun:		Preferred Pronoun:	
Gender Identity:		Gender Identity:	

Resources					
RSDI/SSI =	$	Child Support =	$	Adoption Assistance=	$
IV-E=	$	Other Resources:			
☐ Medicaid	☐ Foster Care	☐ Amerigroup	☐ Peach State	☐ Wellcare	#
☐ Private Insurance	Company		#		

Reason for LIPT Presentation

Education			
School		Grade	
IEP ☐Yes ☐No	If yes, area of eligibility:		
School performance:			

Youth's Name _____

Agency involvement	
DFCS involvement	
DJJ involvement	
Other agency involvement	

Physical and Mental Health Needs	
Medications (current only)	Dosage

Psychiatric/Psychological/Psychosexual/Forensic Evaluations (attach copies)					
Date	*Provider*	*Diagnoses*	*IQ*		*Recommendations*
			Full Verbal Performance		
			Full Verbal Performance		
			Full Verbal Performance		

Placement History (Attach additional pages if necessary)			
Name	Begin Date	End Date	Reason for Discharge