

Monthly Child Report

Child Name: _____ Date: _____

Date of Birth _____ CWCMP Case Manager: _____

Date Placed: _____ Facility: _____ Case Coordinator: _____

CWCMP Agency: ☐ Saint Francis ☐ KVC ☐ Cornerstones of Care ☐ TFI ☐ EmberHope Connections

Section 1: Child/Youth Safety

Critical Incidents, Significant Incidents, Unusual Incidents that occurred during this reporting period:

Date of Incident:	Incident Type:	Action Taken:

SECTION 2: Child/Youth Well-Being – Support/Services

2.1 Interactions between Child/Youth and their Network:

Name and relationship to child/youth (parent, sibling, relative, kin, worker etc.)	Date and Type of Contact	Location of Contact

SECTION 3: Child/Youth Well-Being – Physical and Mental Health

Section 3.1: Medications (include Over the Counter Medications):

Medication	Dose	Frequency	*Route	Purpose	Side Effects

*Oral, topical, patch, inhalation etc.

Medication errors that occurred within the past month (refusal, ran out of prescriptions, refill needed, etc.) Include how medication error was resolved.

Has child/youth experienced any adverse reactions to a medication? ☐Yes ☐No

If yes, describe reactions and include follow up steps taken:

3.2 Current Health Providers:

Mental Health:

Does the Child/Youth have a documented Mental Health Diagnosis on the referral? ☐Yes ☐No

If yes, explain_____.

Does the child/youth have a new mental health diagnosis obtained during current placement? ☐Yes ☐No If yes, explain_____.

Is child/youth receiving Mental Health Services? ☐Yes ☐No

If yes:

Date:	
Type of services:	
Name of Service Provider:	
Name of person delivering service:	
Comments	

Physical Health:

Date of last KBH: _____Next KBH due: _____

Are immunizations current? ☐Yes ☐No

Date:	
Type of service:	
Name of Service Provider:	
Name of person delivering service:	
Comments	

Dental Health:

Date:	
Type of Service:	
Name of Service Provider:	
Name of person delivering service:	
Comments:	

Vision Health:

Date:	
Type of Service:	
Name of Service Provider:	
Name of person delivering service:	
Comments	

Other (additional) Provider(s):

Date:	
Type of Service:	
Name of Service Provider:	
Name of person delivering service:	
Comments	

Does the child file include:

☐ Medical Consent ☐ Journal Entry ☐ Medical Card ☐ Initial Referral

☐ Authorization for Release of Confidential Information

If not present, date of request to case management team: _____

SECTION 4: Child/Youth Well-Being – Education

School Name: _____ Phone Number: _____

Grade Enrolled: _____ Date Enrolled: _____

Comments: _____

Is child attending school regularly? ☐ Yes ☐ No

Is there a current IEP? ☐ Yes ☐ No ☐ NA Date of IEP: _____

Describe child's progress in school (academically & behaviorally):

Describe Education Concerns:

Updates to IEP:

SECTION 5: Child/Youth Development:

5.1 Life Skills

Describe any additions to life book this month:

Describe life skills child/youth worked on this month (4 and older):

Describe normal childhood activities participated in this month (i.e. recreational activities, hobbies):

5.2 Adjustment:

Child/Youth's adjustment to the facility this month: ☐Very Well ☐Satisfactorily ☐Poorly

Explanation:

Child/Youths Voice (Child/Youth wishes to share the following):

Child/Youth's Milestones:

Additional Comments (include if child is nonverbal, please assess well-being by worker's observation):

Is child/youth employed? ☐Yes ☐No

Is child/youth currently on probation? ☐Yes ☐No

If YES, explain change and progress toward completion of probation requirements:

SECTION 6: Discharge

*Discharge Summary (include continued care, service recommendations, and discharge placement, if known):

**This report will serve as the discharge summary*

Date of discharge: _____

SECTION 7:

Report Prepared By: _____ Date: _____

Report Reviewed By: _____ Date: _____

SECTION 8: Attachments:

PLEASE INCLUDE ATTACHMENTS separately in the same email if the following areas were updated during the reporting month:

1. Safety plan with the placement regarding the Child/Youth
2. Medication Log
2. Corrective Action Plans/Partnership Development Plans with the foster/kinship parent regarding the compliance of the home to DCF regulations
3. School IEP
4. School Reports/Grade Cards
5. KBH
6. Immunizations
7. Dental Exam
8. Vision Exam
9. Other Medical appointments

Please send completed report to the appropriate case management provider:

Saint Francis: MonthlyProgressReports@st-francis.org

KVC: KVCMonthlyReports@kvc.org

TFI: MonthlyReports@TFIFamily.org

Cornerstones of Care: KSmnthlyprogressreports@cornerstonesofcare.org

EmberHope Connections: Connectthroughreports@emberhope.org