

**DIVISION OF DEVELOPMENTAL
DISABILITIES SERVICES
Individual/Family-Centered Assessment
and Case Management Plan for Adults and Children**

_____ Initial
_____ Annual

Date: _____

Individual: _____

SSN # _____

Medicaid # _____

Name & Address of Residence/Home/GH/SCLH/Other:

Name & Address of Employment / Day Service/School, etc:

Case Manager: _____

TCM Code: _____

Section 1: Assessment

Life areas to be addressed, as appropriate: 1) Housing; 2) Safety, Supervision, Communication, Mobility; 3) Family/Friends; 4) Recreation/Leisure; 5) Health/Medical; 6) Transportation; 7) Education/Training, Employment/Day Activity; 8) Daily Living (e.g. food, clothing, daily living skills); 9) Financial/Money Management; 10) Emotional/Behavior.

Wants/Needs	Resources/Supports Currently Available**	Resources/Supports Needed**

**address resources in the following order: natural, generic, specialized resources

Case Manager should initial each review date.

Date Reviewed:

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Initial:

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*This plan format applies to adults age 18 & over and children ages 3-17

**Individual/Family-Centered Assessment and Case
Management Plan for Adults and Children**

Individual: _____

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Section 1: Assessment (continued)

Wants/Needs	Resources/Supports Currently Available**	Resources/Supports Needed**

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**Individual/Family-Centered Assessment and Case
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Section 1: Assessment (continued)

Wants/Needs	Resources/Supports Currently Available**	Resources/Supports Needed**

****address resources in the following order: natural, generic, specialized resources**

Completed by: _____
Date

Approved by: _____
Date

**Individual/Family-Centered Assessment and
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Individual: _____ **Date** _____

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Section II: Case Management Plan

Case Management Objectives	Projected Contact / Activity Frequency	Expected Date of Accomplishment

**Case Management Plan
PARTICIPANTS**

Individual: _____

Date _____

Page _____

Name / Signature	Relationship / Position	Check Appropriate Column for Plan Meeting	
		Attended Meeting	Provided Input But Did Not Attend Meeting