

EMERGENCY & SHELTER SERVICES FOCUS PLAN

NAME: _____ **Client ID #** _____ **A New Leaf** **Today's Date/Time:** _____
Autumn House

IDENTIFIED TREATMENT TEAM:

CLIENT FAMILY VISION: would like to remain in safe shelter while increasing her knowledge and understanding of domestic violence.

- attend groups
- have her basic needs met
-

PERSON'S STRENGTHS:

Type of Meeting: Initial Two Week Review Other

| IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs) | INTERVENTIONS to MEET OBJECTIVES | | Desired Out come | Date Achieved | Out Come Met |
|---|----------------------------------|----------------|------------------|---------------|---|
| | Specific Services and Frequency | Strengths Used | | | |
| 1 | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

FOCUS Minutes:

Provide a summary below of the progress the person has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

This was _____ initial service plan meeting. The service plan was created.

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Discharge Plan:

Team Members Present at FOCUS Meeting:

Date of Next Scheduled FOCUS meeting:

| | | | |
|-----------------------------|-------------|-------------|-------------|
| Family Member _____ | Date: _____ | | |
| Treatment Coordinator _____ | Date: _____ | Other _____ | Date: _____ |
| Children's Specialist _____ | Date: _____ | Other _____ | Date: _____ |
| Case Manager _____ | Date: _____ | Other _____ | Date: _____ |
| Program Manager _____ | Date: _____ | Other _____ | Date: _____ |
| BHPP/SP _____ | Date: _____ | Other _____ | Date: _____ |
| BHPP/PS _____ | Date: _____ | Other _____ | Date: _____ |

My signature indicates I was included in the development of the Focus Plan. I agree with this Focus Plan and authorize the interventions, services and/or treatment methods.