Crisis Treatment Plan

Plan Date		**Expiration Date**	
Client Name		**Age**	**DOB**
Group Home		**Phone**	
Address		**Emergency Phone**	
Group Home Case Manager			
Mother Name		**Father Name**	
Address		**Address**	
City, State, Zip		**City, State, Zip**	
Phone		**Phone**	
Legal Guardian		**Phone**	
Address		**Relationship**	
City, State, Zip			
School		**Phone**	
Contact		**Grade**	**Spec Ed Serv**
CCF Coord		**Phone**	
DHS Soc Worker		**Phone**	
		Emergency Phone	255-6067
Therapist		**Phone**	
Psychiatrist		**Phone**	
MD		**Phone**	
Primary Insurance		**Policy #**	
Secondary Insurance		**Policy #**	
Diagnosis			
Medications			

PERTINENT FAMILY INFORMATION (Identify family members, natural supports; individual and family strengths; religious/cultural beliefs; and detail child's and family's history of mental health tx, AODA, and suicide/homicide risk.):

RESPITE OPTIONS (emphasis on natural supports):

CRISIS SUPPORT PLAN (Include: 1. Daily schedule of youth and an intervention plan for potential difficulties in each environment; 2. Strategies for de-escalation to avoid hospitalization or a more restrictive placement; 3. Identify the individuals who may be able to assist the person in the event of a mental health crisis.):

Home:

School:

Community:

RESPONSE PLAN (May be provided by group home, staff, community resources, mental health providers, family, Youth Crisis/ESU.):

1) Utilize internal resources and supports.
2) Utilize child/youth mental health providers.
3) Parent/guardian involvement.
4) Utilize child/youth community supports.
5) Arrange for risk assessment.
6) Refer to hospital plan.
7) Youth Crisis or ESU consultation.
8) Involve law enforcement.

AFTER HOURS/EMERGENCY PLAN FOR MENTAL HEALTH CRISIS (Outline a calling and resource tree with protocols and phone numbers.):

HOSPITAL PLAN (Include who will assess for hospitalization, who will admit child if necessary, and which ER the child/family should utilize.):

Parent or Legal Guardian: ______________________________ **Date** ________________

Group Home Supervisor: ______________________________ **Date** ________________

YCS Coordinator: ______________________________ **Date** ________________

Youth Crisis Manager: ______________________________ **Date** ________________

Consulting Psychiatrist: ______________________________ **Date** ________________

cc: Youth Crisis