**Mental Health & Disabilities Plan of Action Meeting**

 \_\_\_\_ **Entered in ChildPlus?**

|  |  |
| --- | --- |
| Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Center/Site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POA Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Items being discussed (check all that apply):**

**If what you are using for the POA is not listed below, you may be using the wrong form. Check the Education ICOPA form or contact MH/Disabilities team for assistance.**

STOP

□ Articulation □ ASQ:SE □ Behavior Observation Forms □ Parent Concerns □ Teacher Concerns

□ Concerns on Physical/Dental Exam (ex: speech, motor) □ M-CHAT (**EHS only)** □ Denver II (**EHS only)**

**Concerns/ Discussion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Plan of Action:**

□Rescreen within 2 weeks (Articulation, ASQ:SE, M-CHAT, or Denver II)-- Deadline to rescreen: \_\_\_\_\_\_\_\_\_\_

□Immediate Referral within 5 days. **Select who referral will be made to**:

□ Mental Health/Disabilities (use Referral section below), and/or □ Head Start Dietitian (via email)

□Parent declined referral and related services. **(Declined Services Form must be attached)**

□Child is already in treatment process with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (list agency or provider)

**Signatures (Everyone Present Must Sign):**

Parent/Legal Guardian Head Start Staff Signature and Position

Other Other

 \_\_\_\_ **Entered in ChildPlus?**

**Referral (If applicable)**

**Complete the following if Plan of Action is to refer or if child does not pass rescreen.**

Referral Date: \_\_\_\_\_\_\_\_\_\_\_ Staff Making Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Attach copies of: □ Hearing □ Vision □ Relevant screenings □ Behavior observations (if applicable)\*\*

***Place a copy of this form in the Brown Folder before sending to Mental Health/Disabilities.***

**Rest of form to be completed by Mental Health/Disabilities staff only. ~~-~~**

Recommendations:

Date:

 Mental Health & Disabilities Staff Signature