

Juvenile Information			
Name of Juvenile:	County:	IJOS or County ID Number:	
Date of Request	Juvenile's Birth Date:	Type of Request: CIP <input type="checkbox"/> Re-Entry <input type="checkbox"/>	
Has the court ordered an assessment and treatment under 20-511A or 20-520(l): <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date of latest Arrest	Date of Screening Team Review:	<b>CIP Only</b> Does Juvenile meet Rule 19: <input type="checkbox"/> YES <input type="checkbox"/> NO Is Juvenile on a suspended commitment: <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Pre-Commitment Team Meeting:	<b>Re-Entry Only</b> Anticipated Release Date:

Probation Information			
Probation Officer's Name:	Email:	Phone:	Fax:
Supervisor's Name:	Email:	Phone:	Fax:

Screening Information		
YLS/CMI Score: <i>Attach copy</i>	Completed by:	YLS/CMI Completion date:

Requested Services		
<b>A. Evidence-Based Treatment (best practice):</b>		
Unit Cost:	Total Units:	Total Cost:
Requested Start Date:	Requested End Date:	Frequency:
Provider: (attach provider certification)		
<b>B. Evidence-Based Treatment (best practice):</b>		
Unit Cost:	Total Units:	Total Cost:
Requested Start Date:	Requested End Date:	Frequency:
Provider: (attach provider certification)		

# SIGNATURE PAGE

Juvenile: \_\_\_\_\_ Date \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Date \_\_\_\_\_  
(If juvenile is under 18)

Signatures certify agreement to abide by the attached Case Plan; and Authorize service providers to share information with IDJC for quality assurance.

Juvenile Probation Officer \_\_\_\_\_ Date \_\_\_\_\_

Signature certifies agreement to arrange and monitor the case plan and comply with program parameters.

Chief Juvenile Probation Officer \_\_\_\_\_ Date \_\_\_\_\_

Signature certifies agreement to comply with program parameters including reporting requirements; and Certifies requested funds will not supplant existing funding for juvenile justice purposes.

**RE-ENTRY ONLY** Juvenile Service Coordinator \_\_\_\_\_ Date \_\_\_\_\_

Clinical Supervisor \_\_\_\_\_ Date \_\_\_\_\_

IDJC District Liaison \_\_\_\_\_ Date \_\_\_\_\_

Grants Section Approval: \_\_\_ Yes \_\_\_ No (Describe special conditions below)

*If services are stopped for any reason, IDJC Grants Staff will be notified within TEN (10) business days so grant can be closed!*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Award Amount: \$ \_\_\_\_\_

Project No. \_\_\_\_\_ *(Use this number on all paperwork referring to this request.)*

Project Period: From: \_\_\_\_\_ To: \_\_\_\_\_  
*(Services will not be covered before or after these dates)*

Report Schedule:  
30-day Status Report, if no services have begun: \_\_\_\_\_

Progress Report(s): \_\_\_\_\_

6-Month Final Progress Report \_\_\_\_\_

Following approval from Grants Section –copy will be emailed to CJPO, and District Liaison

**ALLOW 10 WORKING DAYS FROM DATE RECEIVED BY IDJC GRANTS SECTION FOR REVIEW AND DECISION**

## Case Plan / Transition Plan

Name of Juvenile:	County:	IJOS or County ID Number:
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<b>Screening Team Members</b>
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Member:	Role: Parent
Member:	Role: Probation Officer
Member:	Role: JSC
Member:	Role:
Member:	Role:

<b>Overview – Please complete a brief background on the juvenile</b>
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<b>Community Safety</b>
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Goal:	
Empirically Supported Approach:	
Provider:	

<b>Family</b>
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Goal:	
Empirically Supported Approach:	
Provider:	

<b>Education / Employment</b>
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Goal:	
Empirically Supported Approach:	
Provider:	

<b>Peer Relations</b>
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Goal:	
Empirically Supported Approach:	
Provider:	

Substance Use	
Goal:	
Empirically Supported Approach:	
Provider:	
Leisure / Recreation	
Goal:	
Empirically Supported Approach:	
Provider:	
Personality / Behavior and Attitudes / Orientation	
Goal:	
Empirically Supported Approach:	
Provider:	
Accountability to Victim (s)	
Goal:	
Empirically Supported Approach:	
Supervision:	

*To ensure the CIP and Re-Entry programs fill gaps in comprehensive case plans, please complete each section of this case plan regardless of the funding source or provider. Plans that do not include information for each domain will not be approved.*

## Provider Certification

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Evidence-Based Treatment(best practice):

Source(s) of Best Practice Endorsement: (ie. SAMHSA, OJJDP, etc.)

Protocol for Model Fidelity:

Start Date:

End Date:

Frequency:

Contact Person:

Phone:

Fax:

Business Name and Address

Tax ID or SS Number

Name of Chief Executive Officer:

Signature \_\_\_\_\_

Date: \_\_\_\_\_

*Signature certifies that treatment listed above will be provided with fidelity using the protocols noted for quality assurance and provider agrees to reviews by IDJC staff or contractors; and  
 Certifies that the placement can be made on the requested start date and the length of the requested treatment is consistent with the project period in the application from the county; and  
 Provider agrees to abide by all program guidelines and provide the referring probation department with monthly status reports on all juveniles placed through the program; and  
 Provider understands that the service agreement is between the County and the provider and while IDJC will process payments to providers once reimbursement forms are received from the County, payments are based upon reports being current and IDJC can not pay late fees, interest, or other chargers not related to direct services for the identified juvenile including no-show appointments.*