Room, Board and Watchful Oversight
CCI Placement
Child's Monthly Summary Report

Date of Report:	Report Period:
Provider Name / Site:	
Completed By:	Title:

CHILD INFORMATION	
Child's Name:	SHINES ID:
Legal County:	DFCS Case Manager:
Date of Last Provider ECEM:	Date Documented into SHINES Portal:

Answer the Following Questions Based Upon the Report Period:

Is the child safe in this placement? ☐ Yes ☐ No (If no, please explain)

Are there any service or support needs that are currently unmet? ☐ No ☐ Yes (If yes, please explain)

Is this the least restrictive and most appropriate placement for the child? ☐ Yes ☐ No (If no, please explain)

Is the placement in jeopardy of disruption? ☐ No ☐ Yes (If yes, please explain)

Did the child experience any DJJ or other law enforcement involvement? ☐ No ☐ Yes (If yes, please explain)

Did the child experience any Emergency Safety Interventions? ☐ No ☐ Yes (If yes, please explain)

Was the child the subject of a CPS or ORCC investigation? ☐ No ☐ Yes (If yes, please explain)

Did the child experience any other Significant Events? ☐ No ☐ Yes (If yes, please explain)

Did the child have a visit with a parent or other family / caring adult? ☐ Yes (If yes, indicate date (s)). ☐ No (If no, please explain.)

If the child has siblings in care, did a sibling visit occur? ☐ N/A ☐ Yes (If yes, indicate date (s)). ☐ No (If no, please explain)

Individual Service Plan Progress Summary

Child's Social, Emotional and Behavioral Strengths and Challenges:

Counseling : Is the child being seen for counseling? ☐ No ☐ Yes (If yes, please describe frequency, type, barriers, purpose and progress)

(If no, please confirm that counseling is not indicated or recommended.)

Psychotropic Medications: Is the child prescribed psychotropic medications? ☐ No ☐ Yes (If yes, please list name of medication(s), dosage, purpose, response to medication and date of last medication review.)
Academic Performance, IEP Changes/Meetings, Advocacy, Support Provided and Unmet Needs:
Health (Emergencies, Routine, Treatments):
Family Connections (sibling, parent, caring adult visitation and contacts):
Provider Permanency Support:
Peer Relationships :
Relationships and Interactions with Staff:
Other Information (Meetings, Court, FTMs, Panel Reviews, etc):
Services or Supports Needed from DFCS Case Manager:

SIGNATURES	
Completed By:	Date:
Provider Director / Designee:	Date:
Date Sent to DFCS Case Manager:	☐ Via Email ☐ Via Fax: ☐ Via Mail ☐ Hand-Delivered

Georgia Department of Human Services

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Other Comments or Continuation of Comments: