DPP-1293 (Rev.06/2022)

DIVISION OF PROTECTION AND PERMANENCY
REHABILITATIVE SERVICES
PLAN OF CARE APPROVAL FORM

Child name: _____
Date of birth: _____
Social Security number: _____

Plan of Care Status:
☐ New plan, requesting approval
☐ Initial six-month review, requesting re-approval
☐ Follow-up 6 month review, requesting re-approval

Presenting problems:

Diagnostic impression or DSM V diagnosis:

Summary of rehabilitative goals/objectives:

Rehabilitative services, activities that are to be provided, based on needs of child (check all that apply):

☐ treatment planning/support ☐ living skills development ☐ counseling, therapy, consultation, assessment

Please specify services to be provided

Need for services approved by:

Print name and title Signature

Effective date of plan:

EMAIL to:

1. Family Services Worker: _____
   DCBS Office: _____
   Address: _____
   City/State/Zip: _____

   Email address: _____

   Telephone: _____

2. Facility/Provider: _____
   Address: _____
   City/State/Zip: _____
   Telephone: _____