# Pathways To Well-Being

# PROGRESS REPORT TO CHILD WELFARE SERVICES

Fax form to Health Education Passport Office Assistant at Secure Child Welfare Services (CWS) region fax number below:

| | | | | | |
|---|---|---|---|---|---|
| ❑ Central | (619) 521-7325 | ❑ North Central | (619) 767-5471 | ❑ Residential & EFC | (619) 767-5418 |
| ❑ East | (619) 401-3792 | ❑ North Coastal | (760) 754-3530 | ❑ Adoptions | (858) 650-5832 |
| ❑ South | (619) 585-5174 | ❑ North Inland | (760) 740-5605 | | |

| Client Name (Last Name/First Name) | Client DOB (mm/dd/yyyy) | Protective Services Worker (PSW) | PSW Phone Number |
|---|---|---|---|
| | | | |

Provider may call **1-858-514-6995** for current CWS, PSW contact information.

❑ **Initial** (within 30 days of determining eligibility) ❑ **Update** (upon significant change or revised client plan) ❑ **Discharge**

**Choose one designation:**

❑ Youth meets Enhanced Services (Subclass) criteria **OR** ❑ Youth is open to CWS (Class) but does not meet Enhanced Services (Subclass) criteria

Date of Pathways to Well-Being Eligibility Determination: ___________________

## BHS Provider

**Please provide the following items to CWS PSW**

- ❑ Current Client Plan (may be utilized in court reports)
- ❑ Most recent CFT Summary and Action Plan (if CFT Meeting Facilitation Program was not utilized)
- ❑ Current completed CANS tool results
- ❑ Current Client Assignment history from CCBH
- ❑ Discharge Summary
- ❑ Other: ____

Comments: ____

## CWS • PSW

**Please provide the following items to BHS Provider:**

- ❑ Consent For Examination And Treatment
- ❑ Authorization to Use or Disclose Protected Health Information
- ❑ Most recent CFT Summary and Action Plan
- ❑ Child Welfare Services Case Plan
- ❑ Detention Report
- ❑ Jurisdiction/Disposition Report
- ❑ Status Review Court Reports (every six months)
- ❑ No Contact List (if applicable)
- ❑ Current completed CANS tool
- ❑ Other: ____

Comments: ____

**This side of form is administrative and NOT included in court reports.**
**PSW may provide Page 2 of this document and the Client Plan to the court.**



**Client:** ______________________

**Record Number:** ______________________

**Program:** ______________________

Pathways To Well-Being

# PROGRESS REPORT TO CHILD WELFARE SERVICES

**Client name:** ______________________________

**Client DOB:** ______________________________

**Client Admission Date to BHS Program:** ______________________________

**BHS Legal Entity:** ______________________________

**BHS Program Name:** ______________________________

**BHS Clinician/Provider:** ______________________________

**BHS Provider Phone:** ______________________________

**BHS Provider Email:** ______________________________

**BHS Secure Fax:** ______________________________

| ICD-10 Code | DSM-V Diagnosis |
| --- | --- |
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| | |

**BHS Provider Signature:** ____________________ **Credential:** ____________________ **Date:** ____________________





**Client:** ____________________

**Record Number:** ____________________

**Program:** ____________________