St. Clair County Community Mental Health Authority

Wraparound Initial Plan

WA Facilitator: _____

Name:_____ Date:_____ Case #:_____

Family Mission:

Team Vision:

Needs Statements:

Outcomes:

Outcome #1: _____

_____

Method of measurement: _____

Frequency of measurement: _____

Who will measure: _____

Baseline measurement: _____

_____

Goal measurement: _____

_____

Outcome #2: _____

_____

Method of measurement: _____

Frequency of measurement: _____

Who will measure: _____

Baseline measurement: _____

_____

Goal measurement: _____

_____

Strategies:

Need 1:

Need 2:

Need 3:

_____

Wraparound Coordinator Date

_____

Individual Date

_____

Parent/Guardian Date

_____

Supervisor Date

_____

Team Member Date

_____

Team Member Date

_____

Team Member Date