

The TEAM Program provides the opportunity for family teams to identify needs, develop goals and connect the family with supportive services.

The whole team is involved in utilizing available resources and in working toward change.



Surround yourself with people who provide you with support and love and give back as much as you can in return.
Karen Kain

For more information on our TEAM program or to make a referral,

Please contact:

Allicia Woodhouse,
TEAM Coordinator
at

608-649-5715

E-mail:

allicia.woodhouse@co.richland.wi.us



TEAM is a program offered through Richland County Health and Human Services
221 West Seminary Street
Richland Center, WI 53581
608-647-8821

Richland County

*Coordinated Services
Team (CST) Program*

TEAM

**Together
Everyone
Accomplishes
More**



Each person supports the other; they lift each other up.
Taylor Swift

TEAM—Together Everyone Accomplishes More



What is TEAM?

The Richland County TEAM program works with families who are struggling and who are experiencing difficulties that may feel insurmountable.

This is a voluntary program. Families choose their team, which may include: other family members, friends, counselors, teachers, social workers, and other supportive people.

Families choose their goals and direct the focus of the team. Everyone works together toward positive change for the family.

How does TEAM work?

- A family is referred, or refers themselves to this program.
- A screening is done to confirm that the family meets criteria, is eligible for TEAM, and that the family would benefit from the TEAM program.
- Next the family meets with a coordinator to determine team members, goals, and logistics for team meetings.

Additional information about TEAM?

- Family teams meet regularly, the frequency will be determined by the team.
- All team members are encouraged to share their observations, their opinions, and their suggestions.
- Decisions are reached by team agreement, as much as possible.
- If something is not working, then services will change to best meet the family's needs.
- Teams identify and celebrate progress and successes

*"I can do things the you cannot,
You can do things that I cannot,
Together we can do
great things."
- Mother Teresa*

| | |
|---|--|
| <i>Office Use Only (created 1/2023)</i> Completed by Project Coordinator | Date Received: Assigned to Service Coordinator: |
| Completed by Service Coordinator | Intro Meeting Date: Enrollment Date: |



CST TEAM - Referral Form

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Coordinated Services Team Program of Richland County
Phone: (608)647-8821 Fax: (608)647-6611

Child Being Referred: _____

Date of Birth: _____ Age: _____ Gender: _____

Primary Caregiver(s): _____

Relationship to Child: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Parents' Names and Address(es) if different from above:

REFERRED BY: _____ Referral Date: _____

Contact Information: _____

Reason for Referral: _____

Yes No

| | | |
|--|--|--|
| | | Child is involved in multiple services PLEASE CIRCLE: mental health therapy and/or medication management, special education, medical supports, child welfare services, youth justice, OTHER: |
| | | Child is at risk of out-of-home placement. |
| | | Other interventions have been tried and have not been successful |
| | | Family is willing to be involved in the TEAM program. |



Consent for Referral and Participation

CST TEAM - Together Everyone Accomplishes More

Coordinated Services Team Program of Richland County

PLEASE INITIAL EACH STATEMENT AND SIGN AT THE BOTTOM

- I consent to (*referring person*) _____ referring my child and family to Richland County's TEAM program.
- I consent to information, regarding my child and family, being shared by the referring person with TEAM staff for the purpose of determining program eligibility.
- I consent to being contacted by TEAM staff.
- I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realize that as long as I am involved in TEAM, it will be necessary for service providers to routinely review and share information.
- If enrolled in TEAM, I agree to participate in the team process and to play an active role in assessment and case planning.

Signature of Child (if over age 12)

Date

Signature of Parent/Guardian

Date

Signature of Witness

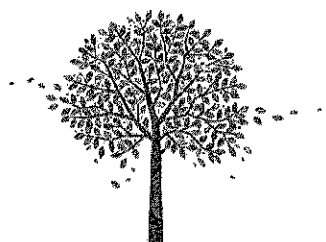
Date

Demographics: Race

- White Black or African American American Indian or Alaska Native
 Asian Native Hawaiian or Pacific Islander Other More than One Race

Ethnicity Non-Hispanic/Latino Hispanic/Latino

Languages spoken in the home _____



TEAM

Together Everyone Accomplishes More
Coordinated Services Team Program of Richland County

Family Team Process

Step 1: Identification and Referral

See Referral Procedure for details. This process identifies children and their families most appropriate for the program.

- Family is approved for the program.
- Service coordinator is identified.

Step 2: Family Engagement, Strengths and Needs Exploration

The service coordinator meets with the child and family to:

- Get to know the family and hear their story
- Identify their needs, as well as, their strengths and supports
- A CANS assessment is completed (*CANS should be completed within 30 days of enrollment.*)

Step 3: Preparation for the First Family Team Meeting

The family and the service coordinator meet to:

- Identify members of the family team.
- Sign Releases of Information so that potential team members may be contacted.

Service coordinator provides family orientation to Teaming.

Service coordinator and family contact potential team members, request their participation, and provide orientation.

Service coordinator sets up first meeting date and time, making sure that everyone can attend, and establishes an agenda for the first meeting.

(During steps 4 & 5, the Team typically meets once every 1 to 2 weeks for 45 - 60 minutes. This phase typically lasts 2 - 3 months.)

Step 4: First Team Meeting

- Introductions
 - * Participant Roles - strengths and resources brought to the team
- Overview and Orientation for all team members
- Team Rules/Guidelines
- Participant Rights
- Identifying family's needs and establishing goals
- Crisis Plan developed
- Transition discussed - How will we know that teaming is no longer needed?
What will that look like for this family?
- Schedule future team meetings - time and place that works for everyone

Step 5: Plan of Care

The team prioritizes the top needs as identified in the CANS and develops an individualized Plan of Care to address needs.

(During steps 6 & 7 the Team usually meets once every 3 - 6 weeks or as often as needed for 45 - 60 minutes, for an average of 9 - 15 months.)

Step 6: Ongoing Team Meetings

The Team meets as necessary to identify progress and problem-solve challenges, adjusting the goals, the Plan of Care, and the Crisis Plan, as needed.

The child, family and their network continue to learn new approaches and find more support in their community with the help of the entire team. The team effort supports the family in moving toward stability and self-reliance.

Step 7: Transition

- The service coordinator is no longer necessary to sustain the team.
- Family goals have been achieved and on-going supports are in place, including an effective Crisis Plan.
- The team may continue with leadership from the parent or another team member.