Arkansas Department of Human Services
Division of Children and Family Services
TEAM DECISION MAKING ACTION PLAN

Caregiver(s) Name: _____
Child(ren) Name/Age: _____
Referral/Case Number: _____
Family Service Worker: _____
FSW Supervisor: _____
Facilitator: _____
Date/Time & Location: _____

TDM MEETING TYPE:

☐ **Initial TDM**

☐ **Placement Stability TDM**

DECISION:

ACTION STEPS

Who:	What:	By When:

ACTION STEPS

The Division of Children and Family Services values your opinion concerning the assessment and planning for your child(ren) as a result of concerns that were identified in a report made to DCFS.

Each person's signature below means that they were present and he or she understands the action steps outlined in this Team Decision Making Meeting.

Print Name and Role	Signature	Date
Print Name and Role	Signature	Date
Print Name and Role	Signature	Date
Print Name and Role	Signature	Date
Print Name and Role	Signature	Date
Print Name and Role	Signature	Date
Print Name and Role	Signature	Date

Please feel free to contact me if you have any questions about this summary as reported.

Sincerely,

Family Service Worker	Phone	Date
Family Service Worker Supervisor	Phone	Date