LA CROSSE COUNTY HUMAN SERVICES DEPARTMENT
COURT AND INTERVENTION UNIT

ANNUAL REVIEW OF PROTECTIVE PLACEMENT / SERVICES

Court File Number: ____________________

1. Client Name (first, middle, last): ____________________
2. Birth Date (month, day , year): ____________________
3. Client Address: ____________________
4. MA: ☐ No ☐ Yes If yes, MA #: ____________________
5. Contact Person: ____________________
6. Contact Person's Telephone: ____________________
7. County of Fiscal Responsibility: ____________________
8. Review Period: From: ____________ To: ____________

COURT

9. Name of Circuit Court (Judge): ____________________ Branch: ____________

   Guardian Ad Litem (Attorney): ____________________
10. Court Orders: Type of placement: ____________________
11. Date(s) of Court Order(s): ____________________
12. Is Client Under Chapter 51 Commitment? ☐ Yes ☐ No
13. Primary Target Group: (check one)
    - ☐ Serious and Persistent Mental Illness
    - ☐ Degenerative Brain Disorder
    - ☐ Other Like Incapacities
    - ☐ Developmental Disabilities
14. Reason Client Was Referred for Original Placement / Services: ____________________

GUARDIANS

15. Name of Guardian (Person): ______________________________

16. Relationship to Ward: ______________ 17. Telephone #: ______________

18. Address of Guardian (Person): ______________________________

19. Name of Guardian (Estate): ______________________________

20. Relationship to Ward: ______________ 21. Telephone #: ______________

22. Address of Guardian (Estate): ______________________________

LIVING ARRANGEMENT

23. Type of Living Arrangement:
☐ Hospital ☐ Nursing Home
☐ Group Home ☐ Own Home
☐ Other (Specify): ______________

24. Is Client residing in a Locked Unit: ☐ Yes ☐ No

25. Changes in Placement, Guardian, or Services During the Review Period:

MEDICAL AND MENTAL CONDITION

26. Physician (Name): ______________________________

27. Date Last Saw Client: ______________________________

28. Diagnosis of Client:

29. Ongoing Treatment Prescribed:

30. Client's Physical Condition and Functioning During the Review Period:

31. Clients Mental Status and Functioning During the Review Period:

32. Client's Current Psychiatric / Behavioral Treatments and Medications:

CLIENT'S NEEDS FOR SOCIAL, EDUCATIONAL AND REHABILITATIVE SERVICES

33. Client's Social Programming, Functioning and Interaction During the Review Period:

34. Client's Rehabilitative and Educational Programming and Participation During the Review Period:

ASSESSMENT

35. Was Client Assessed or Referred for Any Program Providing Long-Term Community Support Services During the Review Period? ☐ No
☐ Yes ☐ Assessment ☐ Referral

36. If There Was an Assessment, Identify the Program and Summarize the Results.

If There Was a Referral but No Assessment, Explain Why:

37. Is There a Plan to Transfer to a Less Restrictive or Community Setting?

☐ Yes. If yes, describe the plan and identify placement dates, INCLUDING COST OF SERVICES AND COUNTY FUNDS NEEDED:

☐ No. If no, explain why:

RECOMMENDATIONS

38. Does Client Currently Meet Standards for Protective Placement Under Chapter 55?
☐ Yes ☐ No. If "no", explain why not:

39. Is Any Change Recommended in Client's Current Living Arrangement, Such as Placement in Another Facility with Fewer Restrictions on Personal Freedom, Placement Closer to Home, or Placement That Better Meets the Clients Needs?

☐ Yes. If "yes", explain: ☐ No

40. Is Any Change Recommended in Currently Ordered Protective Services?

☐ Yes. If "yes", explain: ☐ No

41. Is Continuation of Guardianship With the Same Guardian Recommended?

☐ Yes ☐ No. If "no", explain:

42. Is Any Change Recommended in Legal Rights as Under Current Order?

☐ Yes. If "yes", explain: ☐ No

COMMENTS

43. Comments of Client:

44. Comments of Guardian:

45. Comments from Staff at Placement Facility, If Any:

46. County's Response to Comments:

SOURCES OF INFORMATION

Review Completed by (signature): ______________________________

Agency: La Crosse County Human Services ______________________________

Telephone: ______________________ Date: ______________________

Date Guardian of Person Contacted: ____________ Date Client Visited: ______________________

Other Persons Contacted and Sources of Information, Including Records Used in the Process of Completing This Report: ____

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Cc: Attorney David Lange
Attorney
Guardian
Facility
File

(Revised 8/2011)