

State of Illinois  
Department of Children and Family Services  
**Placement Review: Action Plan**

Date: \_\_\_\_\_

**Identifying Information:**

Child Name: \_\_\_\_\_

ID #: \_\_\_\_\_

Worker: \_\_\_\_\_

Agency: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Team: \_\_\_\_\_

**Present:**

**Role and Phone Number**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Verification of Completion: Date Due** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

The supervisor is responsible to ensure the worker completes the identified tasks on the following page. Upon verification of completion the supervisor shall initial the "Verification of Completion" column. The second page of the Action Plan shall be faxed to the Review Convener by the due date.

**Placement Review: Action Plan**

Case Name: \_\_\_\_\_

ID: \_\_\_\_\_

Objective/Intended Outcome:		
Task	Time Frame	Verification Of Completion