

A. Family Case Plan Face Sheet

Child Name:		FACS ID:		State ID:		Plan Date:	
Permanency Goal:	Court Docket NBR:		Next Type of Hearing:			Next Court Date:	
Date of Birth:		Financial County:		Legal Status:		Sex:	
Placement Type: <input type="checkbox"/> Voluntary Placement Agreement <input type="checkbox"/> Court Order <input type="checkbox"/> Home with Parent(s) <input type="checkbox"/> Relative Placement				Assigned Worker:			
Current Placement and Address:						Phone Number:	

Family Members					
Sex: Male (M), Female (F)					
Name	DOB/ DOD	Sex	Role	Address/ Phone #	Comment

Service History - DHS Involvement			
Without Family Centered Services, removal is imminent:			
Primary Removal Risk Reason:			
Service Dates: From: To:		Reason For Involvement:	
Provider Name:		Reason services discontinued:	
Provider Address:			
Purchased Services Provided:			
Provider Name	Service Provided	From	To

A. Family Case Plan Face Sheet

Placement History - DHS Involvement			
Placement Dates		Reason For Involvement:	
Provider Name:		Service Provided:	
Provider Address:		Reason services discontinued:	
Purchased Services Provided:			
Provider Name	Service Provided	From	To

Additional Services Provided	
Service Dates: From To	Reason for Involvement:
Provider Name:	Services Provided:
Provider Address:	Reason Services Discontinued:

Court Involvement				Next scheduled hearing date and type
Date Hearing Set:	Date of Hearing:	Type of Hearing:	Court Docket #	Outcome:

B. Family Case Plan

Child Name:	FACS ID:
Family Plan Participants:	Date of Initial Plan:
Parent/Caregiver:	
Child:	Family Team Meeting: <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	
DHS Social Worker:	Anticipated date of case closure:
Parent/Caregiver:	
Other:	DHS social worker:
Other:	

Household Composition:	
Caregiver:	Caregiver:
Child's Name:	Child's Name:
Child's Name:	Child's Name:
Other:	Other:

B. Family Case Plan

Family Functioning Domain

Child Well-Being <i>(Identify the strengths or needs that impact the safety of the child, the well-being of the child and family, and permanency for the child)</i>		
<input type="checkbox"/> Child's mental health	<input type="checkbox"/> School performance	<input type="checkbox"/> Relationship with caregiver(s)
<input type="checkbox"/> Child's behavior	<input type="checkbox"/> Motivation/Cooperation to stay with family	<input type="checkbox"/> Relationship with siblings
<input type="checkbox"/> Relationship with peers		
Narrative:		
Goal:	Date Modified	Date Completed
Steps: Who does what, where and when		
1.		
2.		
3.		
Comments:		

Parental Capabilities <i>(Identify the strengths or needs that impact the safety of the child, the well-being of the child and family, and permanency for the child)</i>		
<input type="checkbox"/> Supervision of children	<input type="checkbox"/> Disciplinary Practices	<input type="checkbox"/> Developmental/enrichment
<input type="checkbox"/> Mental health	<input type="checkbox"/> Physical health	<input type="checkbox"/> Use of Drugs/Alcohol
Narrative:		
Goal:	Date Modified	Date Completed
Steps: Who does what, where and when		
1.		
2.		
3.		
Comments:		

B. Family Case Plan

Family Safety <i>(Identify the strengths or needs that impact the safety of the child, the well-being of the child and family, and permanency for the child)</i>		
<input type="checkbox"/> Physical abuse of child	<input type="checkbox"/> Sexual abuse of child	<input type="checkbox"/> Emotional abuse of child
<input type="checkbox"/> Neglect of child	<input type="checkbox"/> Domestic violence	
Narrative:		
Goal:	Date Modified	Date Completed
Steps: Who does what, where and when		
1.		
2.		
3.		
Comments:		

Family Interactions <i>(Identify the strengths or needs that impact the safety of the child, the well-being of the child and family, and permanency for the child)</i>		
<input type="checkbox"/> Bonding with child	<input type="checkbox"/> Expectations of child	<input type="checkbox"/> Mutual Support within the family
<input type="checkbox"/> Relationship between Parent/caregivers		
Narrative:		
Goal:	Date Modified	Date Completed
Steps: Who does what, where and when		
1.		
2.		
3.		
Comments:		

B. Family Case Plan

Home Environment <i>(Identify the strengths or needs that impact the safety of the child, the well-being of the child and family, and permanency for the child)</i>		
<input type="checkbox"/> Housing Stability <input type="checkbox"/> Safety in community <input type="checkbox"/> Habitability <input type="checkbox"/> Food/Nutrition <input type="checkbox"/> Financial Management <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Transportation <input type="checkbox"/> Learning Environment <input type="checkbox"/> Income/Employment		
Narrative:		
Goal:	Date Modified	Date Completed
Steps: Who does what, where and when		
1.		
2.		
3.		
Comments:		

Other <i>(Specify and Identify the strengths or needs that impact the safety of the child, the well-being of the child and family, and permanency for the child)</i>		
Narrative:		
Goal:	Date Modified	Date Completed
Steps: Who does what, where and when		
1.		
2.		
3.		
Comments:		

B. Family Case Plan

Review	
Date of Review:	Was this review conducted through a Family Team Meeting? <input type="checkbox"/> Yes <input type="checkbox"/> No
Review Summary and Recommendations:	

B. Family Case Plan

Signatures and Notifications

Reflects Participation in Family Plan: Initial Plan Review Date of Plan:

PARTICIPATION: We agree to help this plan succeed to the best of our ability; will work hard to meet the expectations outlined above. We also agree that any one of us can pull the group together as is reasonable to work out unforeseen issues and to celebrate successes along the way.

Participated in Planning	Role	Signature of Participants: Enter Name if not present and Family Plan is to be provided <i>(Leave blank if non-applicable)</i>	Date Sent:
	Parent/Guardian		
	Parent/Guardian		
	Child (if appropriate)		
	Custodian		
	DHS Caseworker		
	DHS Supervisor		
	JCO		
	CASA		
	Child's Attorney		
	Guardian Ad Litem		
	Mother's Attorney		
	Father's Attorney		
	County Attorney		
	Foster Care Review Board		
	Judge		
	Other		

Other Comments:

DHS Caseworker Signature: _____ Date: _____

DHS Supervisor Signature: _____ Date: _____

C. Child Placement Plan

Child Name	FACS ID:
DOB:	Anticipated Date of Return Home:
Date of Family Plan:	Date of initial placement:
Placement Type: <input type="checkbox"/> Court Order <input type="checkbox"/> VPA	Date of current placement:
Contrary to Welfare Language in appropriate Court Order: <input type="checkbox"/> Yes <input type="checkbox"/> No	Reasonable Efforts Language in appropriate Court Order: <input type="checkbox"/> Yes <input type="checkbox"/> No

Permanency Goal	
<input type="checkbox"/> Remain in home	<input type="checkbox"/> Adoption
<input type="checkbox"/> Return child to home	<input type="checkbox"/> Transfer custody or guardianship to relative
<input type="checkbox"/> Transfer custody to other parent	<input type="checkbox"/> Transfer custody and guardianship to suitable person
<input type="checkbox"/> Another planned permanent living arrangement	

Concurrent Goal Assessment
<p>Is there a good prognosis for rehabilitation of the child or parental condition that would enable the child to safely return home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the child expected to return home within the first six months of placement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No to either, a concurrent permanency goal is required.</p>

Concurrent Goals <i>(complete only if indicated by the Concurrent Goal Assessment)</i>

Child Well-Being Domain			
Mental Health	<input type="checkbox"/> S <input type="checkbox"/> N	Relationship with Peers	<input type="checkbox"/> S <input type="checkbox"/> N
Behavioral	<input type="checkbox"/> S <input type="checkbox"/> N	Relationship with Siblings	<input type="checkbox"/> S <input type="checkbox"/> N
School Performance	<input type="checkbox"/> S <input type="checkbox"/> N	Motivation to maintain Family	<input type="checkbox"/> S <input type="checkbox"/> N
Relationship with Caregiver	<input type="checkbox"/> S <input type="checkbox"/> N		

C. Child Placement Plan

Level of Placement Review Considerations <i>(Based upon your observations, contacts, and assessment of the individual child's strengths and needs, determine the level of placement most appropriate for this child.)</i>	
<input type="checkbox"/> Level One (non-RTSS)	A child who has no or no more than occasional mild emotional and/or behavioral management problems that interferes with his or her ability to function in the family, school and/or community. The child has no specialized medical needs. The focus of care is on reassurance, consistency and regular parenting-type activities with guidance and supervision needed to maintain or enhance social skills and ensure emotional and physical well-being. Services may be provided in a relative foster home, family foster home, supervised apartment living foster care or shelter care.
<input type="checkbox"/> Level Two RTSS Community Group Care (D16x)	A child has mild emotional and/or behavioral management problems that interfere with the child's ability to function in the family, school or community. This child is likely to have a mental health diagnosis or a minor medical problem that requires monitoring by a specialist. Behaviors include infrequent impulsive or deliberate acts that may result in minor property destruction, nonviolent anti-social acts and some oppositional behavior. The child is not a threat to self or others. Services may be provided in relative foster home, family foster home, treatment family foster care, shelter care or group care. Services must include at least one skill development intervention per day (either social skill or restorative living skills), and a defined 1-4 hours of group or individual therapy and counseling.
<input type="checkbox"/> Level Three RTSS Comprehensive Group Care (D2-6x)	A child who has moderate or occasional serious emotional and/or behavioral management problems that interferes with his or her ability to function in the family, school or community when outside a therapeutic setting. The child has a mental health diagnosis or a serious medical problem or is medically fragile. The child's behaviors may include sexual acting out without harm and/or aggression, mild or moderate self-injurious behavior, suicidal intent, running away with brief absences, pre-delinquent or delinquent behavior that are not chronic. Services are provided in a treatment family foster care or group care. Services must include at least two skill development interventions per day (either social skill or restorative living skills), and a defined 0-8 hours of either group or individual therapy and counseling.
<input type="checkbox"/> Level Four RTSS Enhanced Group Care (D3-6x)	The child has moderate to serious emotional and/or behavioral management problems that interfere with his or her ability to function in the family, school or community. The child has a mental health diagnosis with inconsistent response to treatment and may have had psychiatric hospitalization and/or incarceration in a juvenile facility. The child has serious medical problems which require time-intensive procedures to be performed on a daily basis by the caregiver. Behaviors include sexual acting out without injury, self-injurious behavior or suicide intent which has not manifested itself in the past 30 days, running away with longer absences, delinquency, bizarre or eccentric behavior that is not dangerous to self or others and little remorse for inappropriate or delinquent behavior. Services are provided in a therapeutic setting including treatment foster family care or group care. At least two skill development interventions per day (either social skill or restorative living skills) and a defined 0-12 hours of either group or individual therapy and counseling.
<input type="checkbox"/> Level Five RTSS Highly Structured Group Care (D4-6x)	The child has severe emotional and/or behavioral management problems that interfere with his or her ability to function in the family, school or community. The child has a mental health diagnosis with multiple interventions that have not been successful and requires intensive and/or specialized support services to be safe. Child has a history of incarceration and/or psychiatric hospitalization. A child with serious medical problems requiring constant 24-hour a day care provided by medical professionals or persons specially trained to meet medical needs and who are closely supervised by medical professionals. Behaviors include sexual acting out, self-injurious behavior or suicide intent, running away with prolonged absence, delinquency, non-compliant with medications, cruelty to animals, fire-setting and risk to the community. Services are provided in a therapeutic setting including treatment foster family care or group care with 24 hour supervision. At least two social skill development interventions per day, restorative skill interventions as needed, and a defined 0-12 hours of either group or individual therapy and counseling.

C. Child Placement Plan

Indian Child Welfare Act	
Date parents were asked if they were a member of, eligible for membership in, or considered by a tribe to be a member of their tribal community: Mother: _____ Father: _____	Date child was asked if they were a member of, eligible for membership in, or considered by a tribe to be a member of their tribal community:
Is the child a member of, eligible for membership in or considered by a tribe to be a member of their tribal community: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, the name of the tribe: Date the tribe was notified:
Is the child placed with extended family or other tribal member, in a foster home or facility licensed or approved by the tribe, or in a Native American foster home licensed by a non-Indian licensing authority? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If No, explain:
If the child was placed in foster care under a voluntary foster care agreement, was it executed before a judge who certified that the terms and conditions of the voluntary agreement were fully explained to the child's parents? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If No, explain:

Placement Status Information	
Is current placement stable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, explain:
Is the current placement sufficient to achieve the permanency goal without further need to move the child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, explain:
Is the placement the least restrictive setting to meet the child's needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, explain:
Is the placement within the child's community of origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, explain:
Did the child change schools at the time of placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, explain:
Are the child and siblings placed together? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If No, explain:
Are the primary connections and characteristics of the child being preserved in the placement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If No, explain:

C. Child Placement Plan

Efforts Made by DHS to Support the Placement and Prevent Disruption

- Assessed the needs of the child
- Matched the child's needs with the substitute family's or facility's abilities
- Prepared the child and the family for the placement
- Assisted children with feelings about living apart from family
- Provided adequate support to the child, family, and substitute caregivers
- Maintained family connections by allowing visits early and often
- Developed crisis plans that address predictable behaviors or patterns of behavior that threaten or destabilize the placement.
- Other:

Placement History *(include current and previous placements)*

Date Placed:	Type of Placement:	Name and Address of Placement Resource:	Exit Date:	Exit Reason:

ASFA

Has the child been in foster care 12 months or longer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, permanency hearing date(s):
Has the child re-entered foster care within 12 months of the child being discharged from foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Has the child been in foster care for 15 of the last 22 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exception <i>See Below</i>	If yes, date TPR petition filed: If TPR petition has not been filed, note the reason below.
Termination is not appropriate because: <input type="checkbox"/> Child is being cared for by relatives <input type="checkbox"/> Family has not been provided services necessary to safely return the child home <input type="checkbox"/> Compelling reasons exist: <i>(Explain)</i>	

C. Child Placement Plan

Visitation							
<input type="checkbox"/> There are no safety issues during visitation <input type="checkbox"/> Provisions to assure safety during visitation are:							
Name	Relationship to Child:	Frequency:				Supervised by:	Restricted by Court Order Dated:
		Restricted	Weekly	BiWeekly	Monthly		
	Mother						
	Father						
	Sibling						
	Sibling						
	Sibling						
	Other						
	Other						
If visitation is restricted, give reasons and/or circumstances under which visiting is contrary to the child's safety or best interest:							
Efforts made by the agency to promote and support visitation:							
If child is in out-of-state placement, date of the last face-to-face annual visit:					Name of person who visited the child:		

Documentation	
Has Certified Birth Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, plan to obtain:
Has Social Security Number/Card: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, plan to obtain:

Health Records				
Treatment & Evaluations	By Whom & What Organization	Address	Date	Date given to Caregiver or Provider

C. Child Placement Plan

Mental Health / Psychological / Psychiatric				
Treatment & Evaluations	By Whom & What Organization	Address	Date	Date given to Caregiver or Provider

Education Record			
Is youth enrolled in school? <input type="checkbox"/> Yes <input type="checkbox"/> No		Early access or AEA referral (age 0-5) : <input type="checkbox"/> Yes <input type="checkbox"/> No	
School Name: Address:	Current Grade:	Anticipated date of graduation:	
Regular Attendance? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain:		Working at Grade Level? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain:	
IEP Date: NA <input type="checkbox"/>		School Advocacy Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Educational Records given to caregiver/Provider:		IEP and/or Educational Records located in the case file section:	

Transition Plan (Required For Youth 16 & Older)	
Date of Initial Transition Plan:	Referral to Transition Planning Specialist: <input type="checkbox"/> Yes <input type="checkbox"/> No
Has Photo ID: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, steps to obtain (who, what, where, when):
Has Driver's License: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Want	If No, steps to obtain (who, what, where, when):
If Delinquent, Date of Adjudication:	Level of Offense:

C. Child Placement Plan

Youth Life Skills Assessment							
Area of Assessment	Satisfactory	Making Progress	Need	Area of Assessment	Satisfactory	Making Progress	Need
Daily living skills: Laundry, cleaning, shopping, cooking				Community Resources: Knowing what is available and how to access			
Self Care: Hygiene, access to physical/mental health care				Positive Support System			
Housing: Awareness of future options and how to obtain				Employment Skills			
Money Management				Education Plan			
Social Skills Development				Transportation			
Emergency/Safety Skills				Parenting Skills: If the youth is pregnant or parenting			
Other:				Other:			
Date Life Skills Assessment Completed:				Date Reviewed by Transition Planning Committee:			

Steps for improving areas identified as a Need (who, what, where, when):
Describe progress youth has made on areas of need indicated:

C. Child Placement Plan

Discharge Preparation (Youth has been advised of the following services prior to discharge)			
Service:	Date Advised:	Service:	Date Advised:
Voluntary Foster Care to complete high school / GED:		Title 19:	
Education and Training Voucher (ETV):		Aftercare Services:	

Youth Signature: _____ **Guardian Ad Litem Signature** _____