Case Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TWIST #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assigned Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanency Goal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When & why did DCBS get involved with this family?
2. What is therisk?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What safetythreats are preventing reunification at this time?
4. From your assessments, what will it take to achieve permanency for the child?
5. Have all parents been identified and contacted?

1. Identify all family and any non-relative connections in this child’s life that might promote permanency, be considered as a placement, be a positive support, and/

or strengthen a positive future connection.

1. What is the status of the family’s case plan progress on the FLO, ILO, and CYAP?
2. How has DCBS engaged the birth family, foster family/placement provider, youth, and community partners?
3. Were all case members and other appropriate parties invited to case planning meetings?
4. Do the service recordings reflect that DCBS has developed a partnership plan

and that the plan is being reviewed with all parties on an ongoing basis?

1. Has this child received CANS?
2. Is the child being considered for residential treatment?
3. If the answer to #12 is yes, please complete the following:
	* Has an exception been approved for the child 12 and under to be referred for residential treatment within the past 30 days?­­­­­
	* Has the child been referred for a QRTP assessment?
4. Has this child been determined to have a cognitive and/or intellectual disability (IQ below 70)? If so, please describe.
5. If the answer to #14 is yes, please complete the following:
	* Have applicable accommodations been put in place?
	* Has a psychological exam been completed?
	* Has the child’s file been reviewed for SSI eligibility?
	* Has the Medicaid Waiver Management Application (MWMA) been completed?
	* Has Guardianship been notified that services may be needed when the youth ages out of care (for youth age 17 and older)?
6. Does the child have the following in the file:
	* Certified birth certificate
	* Original Social Security card
	* State identification card (youth age 16 years and older)
7. What community resources/services will need to be coordinated for the family and/or child prior to reunification to promote ongoing permanency?
8. Date(s) of monthly face-to-face contact with the child(ren):
9. Is the child placed in residential treatment?
10. If the answer to #19 is yes, for how many months have they been in residential treatment (total, not specific to program/placement) in this removal episode?

 Consecutive months: ­­­­­­­

 Nonconsecutive months:

1. Is the child approaching or exceeding timeframes for placement in residential treatment established under FFPSA?
	* Six nonconsecutive months for children 12 and under
	* Twelve (12) consecutive months or 18 nonconsecutive months for children 13 and older
2. If the child meets the criteria established in #21, please answer the following:
	* Has a **Residential Treatment Placement Extension Request been submitted?**
	* **If an extension has been approved, when is an updated request due?**
	* **If an extension has been denied, please describe the efforts and plan to transition the child to an appropriate placement:**

**Additional Comments**:

**How can we help support you the worker/supervisor?**

**ACTION PLAN**

**(Include specific tasks, individuals assigned, timeframes, and required follow-up)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Required Action by Whom** | **Due date** | **Status** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |
| **6** |  |  |  |
| **7** |  |  |  |
| **8** |  |  |  |
| **9** |  |  |  |
| **10** |  |  |  |

**Social Service Worker’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: \_\_\_\_\_\_\_\_**

**Supervisor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: \_\_\_\_\_\_\_\_**

**Regional office Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: \_\_\_\_\_\_\_\_**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next Review Date: \_\_\_\_\_\_\_\_\_\_**