

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION
CHILD ABUSE/NEGLECT
INVESTIGATION/FAMILY ASSESSMENT SUMMARY

PURPOSE:

To assist the investigator/family assessor in documenting activities and assisting the worker in either the Investigation or the Family Assessment track.

INVESTIGATION TRACK:

- documenting the conclusion of the investigation;
- making a decision as to the conclusion;
- recording the category of abuse/neglect and the conclusion; and,
- determining the level of risk to the child subject to an abuse/neglect report with a conclusion of "Court Adjudicated," "Preponderance of Evidence" or "Unsubstantiated - Preventive Services Indicated."

Physical and behavioral indicators and evidence collected during the investigation must be clearly documented on this form. In addition, findings that support and/or are contrary to the reported CA/N allegations must be documented.

FAMILY ASSESSMENT TRACK:

- The process of initial assessment;
- Making a determination in response to a CA/N report regarding the family's need for further services from the division;
- Documenting the conclusion in response to a report of CA/N;
- Making a determination regarding the immediate safety of the child(ren);
- Identification of family strengths and needs;
- Assessment of Risk for future child maltreatment
- Summarizing the worker's activities during the process of assessment.

NUMBER OF COPIES AND DISTRIBUTION:

One copy is completed and placed as it's own section of the record.

INSTRUCTIONS FOR COMPLETION:

This form is to be completed after an investigative/family assessment conclusion has been determined, however, staff may want to record on this form as they contact collaterals/witnesses/subjects during the investigative/family assessment process.

CASE DATA

Investigation or Family Assessment: After a CA/N report has been screened for track response the worker puts an X in the appropriate box.

Track Change: When a decision has been made to switch from the Investigation track to the Family Assessment track or visa versa, the worker puts an X in the new track response and puts in the date of that decision.

Case Name: Enter the name(s) (last, first, middle initial) of the person under whose name the investigation was conducted. In most cases, this will be the parent/caretaker.

Investigation Worker: Enter the name of the worker.

County: Enter the County FIPS code.

Incident Number: Enter the incident number from the CA/N-1 of the investigation being recorded.

Address: Enter the street address, city, state, and zip code of the Case Name's household.

Telephone Number: Enter the area code and telephone number of the Case Name's household.

Date of Report: Enter the date the incident was reported, as indicated on the CA/N-1.

Date Assigned: Enter the date the case was assigned to the worker. In most cases this will be the same as the Date of Report.

Directions to Above Address: Enter explicit directions to the Case Name's household, if necessary.

PRIORITY RESPONSE: The worker puts an X in the appropriate box according to this report's priority level.

Level 1: Face-to-face contact with all child victim(s) must be made **within three hours** from the Child Abuse and Neglect Hotline Unit's receipt of the report; face-to-face contacts with all other children must be made within 72 hours from the Child Abuse and Neglect Hotline Unit's receipt of the report.

Level 2: Face-to-face contact with all child victim(s) must be made **within 24 hours** from the Child Abuse and Neglect Hotline Unit's receipt of the report; face-to-face contacts with all other children in must be made within 72 hours from the Child Abuse and Neglect Hotline Unit's receipt of the report.

Level 3: Face-to-face contact with all children in the home must be made **within 72 hours** from the Child Abuse and Neglect Hotline Unit's receipt of the report. Investigations must be initiated within 24 hours.

Note: Face-to-face contacts can be made by members of the team (reporter, police, etc.) Initiating contact can include phone calls, contact with appropriate persons in attempts to make a home visit.

Description/Action Taken for Level 1: If the report was screened priority 1, the worker describes the situation and action taken to address child safety.

Parents

- **Parent 1:** Enter the name and date of birth, if known, of parent 1 of subject child. Enter the name, street address, state and zip code if parent 1 does not reside in the same household as the case name. Check whether the parent is the custodial/non-custodial. Enter the DCN if known.
- **Parent 2:** Enter the name and date of birth, if known, of parent 2 of subject child. Enter the name, street address, state and zip code if parent 1 does not reside in the same household as the case name. Check whether the parent is the custodial/non-custodial. Enter the DCN if known.

Children: Enter the names of each child in the household. In the box marked V/O indicate whether the child is a (V) reported victim or (O) other child in the household. Put in the DCN number and the child's date of birth.

Native American Heritage: List each child who has Native American Heritage. Specify Tribe. Specific guidelines for identifying Native American origin can be found in CWM *Section 4, Chapter 19.3*. For details regarding other procedures related to children with Native American Heritage see CWM *Section 4.19 Special Populations-Native American and Refugee*.

Initial contact: Indicate the date and time of the initial face-to-face contact with each child and indicate the location where that contact occurred.

Other Household Members/Significant Others: Enter the name, date of birth, and relationship to child of any other household member(s)/significant others. This includes any additional biological/legal parents of children in the household. Enter the address and phone number, if known. If they are not known, enter "Address and Phone Number Unknown."

Reported Concern: The worker enters the allegations as they were received from CANHU. The allegations should be factually recorded, not paraphrased or altered.

Reporter Contact: The worker puts an X in the box if the reporter was contacted, the date and time of the contact, and who made contact. Additional information provided by the reporter should be documented in the Chronological Narrative.

Type of Reporter: The worker should check the box of the appropriate reporter type:

- Mandated reporter--Mandated by law to report;
- Other Known Reporter--Not mandated, but identity is given; and
- Anonymous Reporter—Identity not given.

School Liaison contacted: The worker puts an X in the box if the School Liaison has been contacted. Includes date and time of the contact or puts an X in the box if it is not applicable, because there are no school aged victims. Additional information provided by the School Liaison should be documented in the Chronological Narrative.

Law Enforcement: Law Enforcement may be involved in either Investigations or Family Assessment as needed, but they are only mandatory in regard to Investigations.

- **Law Enforcement Contacted:** If the report was screened as an Investigation, the worker will put an X in the appropriate box after *law enforcement contacted* documenting the date and time of contact.
- **Co-Investigation:** Worker will put an X in the box marked co-investigation if law enforcement participated in a full co-investigation.
- **Law Enforcement Assisted:** Worker will put an X in this box if they did assist, but did not conduct their own investigation.
- **N/A (Family Assessment):** Worker will put an X if the report was screened a Family Assessment and law enforcement does not need to be contacted.
- **If Law Enforcement did not co-investigate was there written Documentation as to the reason they did not?:** If law enforcement chooses not to participate in a co-investigation, they should provide written documentation as to the reasons. The worker puts an X in the box yes or no depending on if written documentation has been provided. This documentation should be attached to this report and indicated in the *Documentation/Evidence* section.
- **Prior History with CD:** Summarize the families prior history with the agency: Enter a brief description of prior reports of abuse/neglect, as well as a summary of concerns identified in unsubstantiated reports. Due to expungement criteria for unsubstantiated reports, incident numbers will Not be listed here. Workers should use such phrases as "Concerns have been identified in the past that include...". Rather than stating "These concerns were from prior reports" in their documentation.

SAFETY ASSESSMENT:

CD-17 SAFETY ASSESSMENT

The purpose of the safety assessment is to help assess whether any children are safe or unsafe. When the finding of the CD-17 is “safe” and CD-18 Safety plan is not required. If the finding is “unsafe”, the worker shall develop a CD-18 Safety Plan with the family to control the identified threat of danger and lack of caregiver protective capacity.

CONTACT SHEET:

The worker will document the name/address/phone number and the individual’s professional title or relationship to the child, of all persons who appear in this report. Each individual who appears in this report should be documented only once in this section. It is not necessary to document contact information in this section for family members whose address information can be found in the Case Data section. Information regarding multiple contacts, attempted contacts and how the contacts were made, should be documented in the Chronological Narrative.

CHRONOLOGICAL NARRATIVE: Complete the chronological narrative explicitly describing:

- The presence or absence of physical and behavioral indicators of CA/N
- observations, and evidence gathered in the course of the Investigation or Family Assessment.
- All individuals contacted should appear chronologically and include:
 - a) Name of each person contacted
 - b) Date and time of each contact
 - c) How the contact was made. (In person, by phone, including all attempted contacts)
 - d) The content of each interview

Services Provided/Steps Taken to Prevent Placement during the Investigation/Family Assessment process:

- Describe services offered during the investigation process that helped to stabilize the family so that the child remained at home.
- If the child was placed in Alternative Care, services need to be recorded that describe reasonable efforts used to prevent removal.
- When a child is placed in emergency Alternative Care, and no services were provided prior to the placement, document the reason services were not provided.
- Services that enabled the child to return home shall also be described

Domestic Violence:

- If there are indications of domestic violence, alternatives discussed/reviewed with appropriate family members should be thoroughly documented in the chronological narrative.

Note: The worker may refer to Family Assessment Tools, attached evidence/documentation, reports from other agencies or information contained in other sections of this report in lieu of a lengthy description in this section.

STRENGTH/NEEDS ASSESSMENT: This section is designed to provide a basic framework for both Investigations and Family Assessments to develop a more comprehensive picture of family functioning. It is divided into basic categories:

- Basic Needs
- Living Conditions
- Support System
- Health/Education
- Family Interaction

Beneath each category, there is a list of domains relative to family functioning. Beside each variable are a list of responses designed to identify areas of strengths and needs. The worker will put an X into each box that best describes the situation. There is a space for comments and clarifying statements below each category. The worker should also indicate how the information was received, such as worker's observation, family reported, collateral reported and CD history/documentation. The worker should document identified strengths and concerns. Identified concerns should be considered in connection to specific service needs. Strengths and concerns should be documented in the Summary and Conclusion section. This will be beneficial to the next worker in the event that a case is opened.

DOCUMENTATION OF INTENSIVE IN-HOME (IIS) SERVICES SCREEN/REFERRAL

This section is completed when a child is at immediate risk of out-of-home placement. Document factors considered through the screening process to make, or not make, an IIS referral. If the family was referred but excluded, this section should document the reasons the family was excluded from the program.

- Indicate if there was a preliminary screening for IIS by checking yes or no.
- Indicate whether the family was referred to IIS by checking yes or no.
- If the family was referred to IIS, indicate whether they were accepted into the program by checking yes or no.
- If the family was referred to IIS, but not accepted into the program, document the reasons the family was rejected from the program.

Contacts with IIS, factors considered during preliminary screening and factors considered for the acceptance or the rejection of a family into the IIS program should be documented in the chronological narrative.

DOCUMENTATION OF DOMESTIC VIOLENCE SCREENING:

This section must be completed on all CA/N Reports.

- If domestic violence is occurring put a check in the appropriate box.

Note: If indications of domestic violence exists alternatives discussed/reviewed with appropriate family members should be thoroughly documented in the chronological narrative.

FAMILY RISK ASSESSMENT:

The risk assessment identifies families, which have low, moderate, high, or very high probabilities of future abuse or neglect. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 18 to 24 months. The difference between risk levels is substantial. High risk families have significantly higher rates of subsequent referral and substantiation than low risk families, and are more often involved in serious abuse or neglect incidents.

When risk is clearly defined and objectively quantified the agency can ensure that resources are targeted to higher risk families because of the greater potential to reduce subsequent maltreatment. The risk assessment is based on research on cases with substantiated abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect. The tool does not predict recurrence, but simply assess whether a family is more or less likely to have another incident without intervention by the agency.

Which Cases: All investigations and family assessments, including new investigations/assessment as a result of a new report on an open case. Also FCS/FCOOHC openings that have not had risk assessment prior to current opening.

When: The risk assessment is completed at the conclusion of the investigation/ assessment.

Who: The assigned CPS worker.

Note: Complete the family risk assessment only if one was not completed prior to the case opening. If there is a recent risk assessment or risk reassessment (CS-16E), it should be attached to the CS-16. See form instructions for completing the Risk Reassessment (CS-16E).

The SDM Risk Assessment and the Risk Reassessment are used only with families where there are children in the home.

The risk assessment form is composed of two indices: the neglect assessment index and the abuse assessment index. Only one household can be assessed on a risk assessment form. If two households are involved in the alleged incident(s), separate risk assessment forms should be completed for each household.

The household includes all persons who have significant in-home contact with child(ren), including those who have a familial or intimate relationship with any person in the home.

The primary caretaker is the adult living in the household where the allegation occurs who assumes the most responsibility for childcare. When two adult caretakers are present and the social worker is in doubt which one assumes the most child care responsibility, the adult with legal responsibility for the child(ren) involved in the report should be selected as the primary caretaker.

For example, when a mother and her boyfriend reside in the same household and appear to equally share care taking responsibilities for the child, the mother is selected. If this does not resolve the question, the legally responsible adult who was a perpetrator or alleged perpetrator should be selected.

For example, when a mother and a father reside in the same household and appear to equally share care taking responsibilities for the child and the mother is the perpetrator (or the alleged perpetrator), the mother is selected. In circumstances where both parents are in the household, equally sharing care taking responsibilities, and both have been identified as perpetrators or alleged perpetrator, the parent demonstrating the more severe behavior is selected. Only one primary caretaker can be identified.

The secondary caretaker is defined as an adult living in the household who has routine responsibility for childcare, but less responsibility than the primary caretaker. A partner may be a secondary caretaker even though he/she has minimal responsibility for care of the child.

Appropriate Completion:

The risk assessment is completed based on conditions that exist at the time the incident is reported and investigated/assessed, as well as the prior history of the family. Only one household can be assessed on the risk assessment form. Choose the household in which the child abuse/neglect incident is alleged.

Scoring Individual Items: A score for each assessment item is derived from the worker's observation of the characteristics it describes. Some characteristics are very objective (such as prior CA/N history or the age of the child). Others require the worker to use professional judgment based on his or her assessment of the family. Sources of information used to determine the worker's response to an item may include statements by the child, caretaker, or collateral persons; worker observations; reports; or other reliable sources.

The worker should refer to definitions to determine their response for each item. After all items are scored, the worker totals the score and indicates the corresponding risk level for each index. Next, the scored risk level (which is the higher of the abuse or neglect index) is entered.

Policy Overrides: After determining the scored risk level, the worker determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns, and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. Policy overrides are as follows:

1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
2. Non-accidental injury to a child under age two years.
3. Severe non-accidental injury (for example, brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child(ren) which requires medical treatment).
4. Parent/caretaker action or inaction resulted in death of a child due to abuse or neglect (previous or current), and other children remain in the home.

Discretionary overrides: A discretionary override is applied by the worker to increase the risk level by one risk classification in any case in which the risk level set by the assessment tool is too low. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. Discretionary overrides require supervisor approval.

After completing the override section, indicate the final risk level.

In the case status section, the worker indicates whether the investigation/assessment will be closed or opened for ongoing services, and indicate the reason using the codes provided. Both the worker and the supervisor sign and date the form.

Family Risk Assessment Definitions:

NEGLECT INDEX

N1. Current Report is for Neglect

Score 1 if the current report is for any type of neglect. This includes:

- severe and general neglect;
- exploitation (excluding sexual exploitation); and
- caretaker absence/incapacity.

This includes reported allegations as well as allegations made during the course of the investigation/assessment.

N2. Prior Investigations/Assessments

- a) Score 0 if there were no investigations/assessments (do not include referrals that were not assigned for investigation/assessment) prior to the current investigation/assessment.
- b) Score 1 if there was one or more investigations/assessments (do not include referrals that were not assigned for investigation/assessment), substantiated or not, for any type of abuse prior to the current investigation/assessment. Abuse includes physical, emotional, or sexual abuse/sexual exploitation.
- c) Score 2 if there was one or two investigations/assessments (do not include referrals that were not assigned for investigation/assessment), substantiated or not, for any type of neglect prior to the current investigation/assessment, with or without abuse investigations.
- d) Score 3 if there were three or more investigations/assessments (do not include referrals that were not assigned for investigation/assessment), substantiated or not, for any type of

neglect prior to the current investigation/assessment, with or without abuse investigations/assessments.

Neglect includes:

- severe and general neglect;
- exploitation (excluding sexual exploitation); and
- caretaker absent/incapacitated.

If reports indicate history from other state jurisdictions, the reports should be verified. Exclude investigations/assessments of out-of-home perpetrators (e.g., day care) unless one or more caretakers failed to protect.

N3. Household has Previously Received Services as a Result of a CA/N Investigation/Assessment

Score 1 if household has previously received services or is currently receiving services as a result of a prior investigation/assessment. Do not include delinquency services or cases opened at family's request (SS-63 open reason=A or E).

Number of Child Victims Involved in the CA/N Report

Score based on the number of children under 18 years of age for whom abuse or neglect was alleged or substantiated in the current investigation/assessment.

N5. Age of Youngest Child in Household

Score based on the current age of the youngest child presently in the household where the maltreatment incident reportedly occurred. If a child is removed as a result of the current investigation/assessment, count the child as residing in the home.

N6. Primary Caretaker Provides Physical Care Inconsistent with Child Needs

Score 1 if physical care of child(ren) (age-appropriate feeding, clothing, shelter, hygiene, and medical care of child[ren]) threatens the child(ren)'s well-being or results in harm to child(ren). Examples include but are not limited to:

- repeated failure to obtain standard immunizations;
- failure to obtain medical care for severe or chronic illness;
- repeated failure to provide child(ren) with clothing appropriate to the weather;
- persistent vermin infestations;
- inadequate or inoperative plumbing or heating;
- poisonous substance or dangerous objects lying within reach of small child(ren);
- child's functioning is impaired due to poor hygiene as indicated by filthy clothes, lack of bathing, dirt caked on skin and hair, and/or strong odor.

N7. Primary Caretaker has a Past or Current Mental Health Problem

Score 1 if credible and/or verifiable statements by the primary caretaker or others indicate that the primary caretaker:

- has been diagnosed with a Diagnostic and Statistical Manual (DSM) condition by a mental health clinician;
- had repeated referrals for mental health/psychological evaluations; or
- was recommended for treatment/hospitalization or treated/hospitalized for emotional problems at any time.

N8. Primary Caretaker has Historic or Current Alcohol or Drug Problem that Interferes with his/her/family's functioning

Interference with functioning is evidenced or verified by:

- substance use that affects or affected:
- employment,

- criminal involvement,
- marital or family relationships, or
- ability to provide protection, supervision, and care for the child(ren);
- an arrest in the past two years for driving under the influence or refusing breathalyzer testing;
- self report of a problem;
- treatment received currently or in the past;
- multiple positive urine samples;
- health/medical problems resulting from substance use;
- child(ren) was diagnosed with Fetal Alcohol Syndrome or Exposure (FAS or FAE) or child had a positive toxicology screen at birth and primary caretaker was birthing parent. Note: May include previous drug-related referrals at birth.

Score the following characteristics and record the sum as the item score

- Score 0 if no past or current substance abuse problems.
- Score 1 if past or current alcohol abuse.
- Score 1 if past or current drug abuse.
 - Legal, non-abusive prescription drug use should not be scored.

N9. Characteristics of Children in the Household

Score based on each characteristic present and record the sum as the item score:

- Score 0 if no child in the household exhibits characteristics listed below.
- Score 1 if any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention or diagnosed as failure to thrive.
- Score 1 if any child is developmentally or physically disabled, including any of the following: mental retardation, learning disability, other developmental problem or significant physical handicap.
- Score 1 if any child had a positive toxicology report for alcohol or another drug at birth. Note: May include previous drug-related referrals at birth.

N10. Housing

- Score based on each characteristic present and record the sum as the item score:
 - Score 0 if the family has housing that is physically safe.
 - Score 1 if the family has housing but the current housing situation is physically unsafe such that it does not meet the health or safety needs of the child(ren) (for example: exposed wiring, inoperable heat or plumbing, vermin infestations, human/animal waste on floors, rotting food).
 - Score 2 if the family is homeless or about to be evicted at the time the investigation began.

ABUSE INDEX

A1. Current Report is for Abuse

Score 1 if the current report is for any type of abuse. This includes:

- physical abuse;
- emotional maltreatment; or
- sexual abuse/sexual exploitation.

This includes reported allegations as well as allegations made during the course of the investigation/assessment.

A2. Number of Prior Abuse Investigations/Assessments

Score based on the number of all investigations/assessments, substantiated or not, which were assigned for investigation/assessment for any type of abuse (physical, emotional, or sexual abuse/sexual exploitation) prior to the report resulting in the current investigation/assessment. Where possible, abuse history from other county or state jurisdictions should be checked.

Exclude investigations/assessments of out-of-home perpetrators (e.g., day care) unless one or more caretakers failed to protect.

A3. Household has Previously Received Services as a Result of a CA/N Investigation/Assessment

Score 1 if household has previously received services or is currently receiving services as a result of a prior investigation/assessment. Do not include delinquency services or cases opened at family's request (SS-63 open reason=A or E).

A4. Prior Injury to a Child Resulting from CA/N

Score 1 if a child(ren) sustained an injury resulting from abuse and/or neglect prior to the report which resulted in the current investigation/assessment. Injury sustained as a result of abuse or neglect may range from bruises, cuts and welts to an injury which requires medical treatment or hospitalization such as a bone fracture or burn.

A5. Primary Caretaker's Assessment of Incident

Score based on each characteristic and record the sum as the item score:

- a) Score 0 if none of the characteristics below is applicable.
- b) Score 1 if the primary caretaker blames child(ren) for incident. Blaming refers to caretaker's statement that maltreatment incident occurred because of child(ren)'s action or inaction (for example, claiming that child seduced him/her, or child deserved beating because he/she misbehaved).
- c) Score 2 if the primary caretaker justifies maltreatment of child(ren). Justifying refers to caretaker's statement that their action or inaction, which resulted in harm to the child, was appropriate (for example, claiming that this form of discipline was how they were raised, so it is alright).

A6. Domestic Violence (two or more incidents) in the Household in the Past Year

Score 2 if credible statements or observations indicate there have been two or more incidents of domestic violence in the household within the past year, or multiple periods of intimidation/threats/harassment between caretakers or between a caretaker and a past or present intimate partner within the past year.

A7. Primary Caretaker Characteristics

Score based on each characteristic present and record the sum as the item score:

- a) Score 0 if the primary caretaker does not exhibit characteristics listed below.
- b) Score 1 if the primary caretaker provides insufficient emotional/psychological support to the child(ren), such as persistently berating/belittling/demeaning child(ren) or depriving child(ren) of affection or emotional support.
- c) Score 1 if the caretaker's disciplinary practices caused or threatened harm to child(ren) because they were excessively harsh physically or emotionally and/or inappropriate to the child(ren)'s age or development. Examples include but are not limited to:
 - locking child(ren) in a closet or basement;
 - holding child(ren)'s hand over fire;
 - hitting child(ren) with dangerous instruments; or
 - depriving young child(ren) of physical and/or social activity for extended periods.
- d) Score 1 if the primary caretaker is domineering, indicated by controlling, abusive, overly-restrictive, or unfair behavior, or over-reactive rules.

A8. Primary Caretaker has a History of Abuse or Neglect as a Child

Score 1 if credible statements by the primary caretaker, others, or through the registry indicate that the primary caretaker was maltreated as a child (maltreatment includes neglect or physical, sexual or other abuse).

A9. Secondary Caretaker has Historic or Current Alcohol or Drug Problem that Interferes with his/her/family’s Functioning

Interference with functioning is evidenced or verified by:

- substance use that affects or affected:
- employment,
- criminal involvement,
- marital or family relationships,
- ability to provide protection, supervision, and care for the child(ren), or
- an arrest in the past two years for driving under the influence or refusing breathalyzer testing;
- self report of a problem;
- received or is receiving treatment;
- multiple positive urine samples;
- health/medical problems resulting from substance use;
- child(ren) was diagnosed with Fetal Alcohol Syndrome (FAS or FAE) or child had a positive toxicology screen at birth and secondary caretaker was birthing parent.

Note: May include previous drug-related referrals at birth.

Score the following:

- a) Score 0 if no past or current substance abuse problems.
- b) Score 1 if past or current substance abuse.
- Legal, non-abusive prescription drug use should not be scored.

A10. Characteristics of Children in Household

Score based on each characteristic present and record the sum as the item score:

- a) Score 0 if no child in the household exhibits characteristics listed below.
- b) Score 1 if any child in the household has been referred to juvenile court for delinquent or status offense behavior. Status offenses not brought to court attention but which create stress within the household should also be scored, such as children who run away or are habitually truant.
- c) Score 1 if any child is developmentally disabled, including any of the following: mental retardation, learning disability, or other developmental problem.
- d) Score 1 if any child in the household has mental health or behavioral problems not related to a physical or developmental disability (includes ADHD/ADD). This could be indicated by:
 - a DSM diagnosis;
 - receiving mental health treatment;
 - attendance in a special classroom because of behavioral problems; or
 - currently taking psychoactive medication.

Risk-Based Case Open/Close Guidelines: The risk assessment identifies the level of risk of future maltreatment. And is used to guide the decision to close or open the investigation/ assessment for ongoing services. The following chart shows the recommended case open/close decisions based on the risk level for investigations and family assessments:

Risk-Based Case Open/Close Guidelines			
Risk Level	Investigations		Family Assessments
Low	Close	Close	Close
Moderate	Open/Close	Close	Open/Close
High	Open	Open/Close w/referral	Open/Close w/referral
Very High	Open	Open/Close w/referral	Open/Close w/referral

Note: There may be unique circumstances in which it is appropriate to open low risk cases (for example, court-ordered services), or close very high risk cases (for example, family moved out of state). Reasons for opening or closing cases outside of the recommended guidelines should be clearly documented in the case record.

DOCUMENTATION/EVIDENCE: Complete this section as follows:

Description: Enter a description of the Documentation/ Evidence, i.e., police record, school report, hospital/ physician report, photograph, correspondence, written and signed witness statement, etc.

Obtained From: Enter the name of the person and title, if appropriate, from whom the Documentation/Evidence was obtained.

Location: Enter the current location of the Documentation/Evidence. Indicate if the document is attached or if it is forth coming.

Date: Enter the date the Documentation/Evidence was obtained.

This section is optional for unsubstantiated reports as long as this information is included in Chronological Narrative.

RESULTS OF CA/N REPORT: The worker enters the appropriate Investigation or Family Assessment conclusion code.

CA/N REPORT SUMMARY AND CONCLUSION: The CA/N Report Summary should include the following:

- Brief statement of allegations
- Investigation or Family Assessment
- CA/N report results
- In bulleted form, what the result was based on
- A statement of family's Strengths
- A statement of family's needs
- Whether an FCS case was opened or not connected to level of risk

NOTIFICATION: The worker completes this section as follows:

“Know your rights” Information requested/given: A statement of the clients rights are contained in the CS 24 and the CS 24A. If the family requests more information the family should be given the “Know your Rights” brochure and the “Service Delivery Grievance” form. Put a check in the box if more information was requested and given to the family.

School Liaison Notification: Put an X in the box if the School Liaison finding notification letter was sent and enter the date.

Mandated Reporter Notification: Put an X in the box if a Mandated Reporter finding notification later was sent and enter the date.

Investigations

- **CS 24 given/sent:** Fill in the names of each recipient of a CS 24 and date given/sent.
- **CS 21 Sent:** Fill in the names of each recipient of a CS 21 and the date sent.

Family Assessments

- **CS 24A Given/sent:** Fill in the names of each recipient of a CS 24 A and the date given/sent.
- **CS-21A Sent:** Fill in the names of each recipient of a CS 21A and the date sent.

SIGNATURES: This section and/or title of the person is completed as follows:

- Signature of Investigative Worker and Date: The worker signs the form and enters the date the form is completed.
- Signature of the Supervisor and Date: Supervisor reviews the form, assigns a priority of client contact according to the SDM risk level, dates and signs the form. (See explanation below)

Priority of Client Contact:

- Supervisor shall assign "preponderance of evidence" or "unsubstantiated - preventive services indicated" cases within one (1) working day of the CA/N investigation conclusion or receipt of the case from the CA/N Investigation Unit/worker.
- Other preventive services and court involved cases will be assigned in a timely manner and according to the supervisor's discretion, not to exceed five (5) working days from receiving the case, based upon existing risk factors and the overall urgency of the family's situation.
- The Supervisor shall review the CPS-1, if case referral was due to a CA/N investigation/family assessment, arrangements shall be made to conduct an initial face-to-face interview with the family based on the following SDM risk levels;
 - High or Very High Risk - within one (1) working day;
 - Moderate Risk - within five (5) working days; and
 - Low Risk - within ten (10) working days.

If the case referral was not due to a CA/N investigation/family assessment, the supervisor's appraisal of the potential risk to the children and overall family situation will determine when treatment follow-up contact by the social worker is needed. **THIS SHOULD NOT EXCEED TEN (10) WORKING DAYS FROM CASE ASSIGNMENT.**

Memorandum History:

CD04-79, CD11-86, CD12-68