SECTION 5 OVERVIEW

This section describes the manner in which case records are composed, maintained, and expunged. This section also explores a person's access to records and case transfer procedures.

The following guidelines relate to the sharing of confidential information maintained by the Division. Staff shall share confidential information using the guidelines provided for the specific type of information sought.

For policy regarding a client's right to insert a statement into his/her record, see related subject below:

Related Subject: Section 1 Chapter 2.8 Client's Right to Insert a Statement into His/Her Case Record

Chapter 1 Overview

This chapter describes how records are established and maintained, as well as guidelines for inclusion of specific information.

Table of Contents

Attachments:

Attachment A: FCS Opening and Monthly Summary

Attachment B: AC Opening and Monthly Summary

Chapter Memoranda History: **(prior to 1-31-07)**

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

CD07-54, CD07-61, CD09-05, CD14-21

1.1 Record Composition

Each family will have one record. This also applies to families with a child(ren) in out-of-home care, under the jurisdiction of the family/juvenile court, and placed in the legal custody and/or supervised by the Children's Division (CD).

If termination of parental rights occurs or reunification is no longer the case goal, a separate file for each child should be established. The new file is to contain any child specific information from the family file. Most of this information is contained in the child's section of the family record. Include in the new record any other pertinent information regarding the child such as the case narrative, court orders, Older Youth Program services information etc. Once a new file is established, maintain the record according to current case recording policy.

Following is the required outline for record organization for all families, including those with children in out-of-home care and when family reunification is the goal. Use of this standard format will assist in record review when records are transferred across county lines.

The information contained in each record will be organized chronologically into the following sections. The cover sheet of each section will be color coded for quick reference.

1.1.1 CA/N Investigation Section – (Cover Sheet: Pink)

This section will include the CA/N investigation records that pertain to the household members. A child abuse/neglect investigation record contains information generated/obtained by the Division regarding a specific CA/N incident. A CA/N family record maintained on behalf of an individual may include one or more child abuse/neglect investigation records.

Specific guidelines and procedures exist for CA/N record information. When a Children's Service Worker receives a CA/N report through the CA/N Hotline Unit they shall establish a family record under the first parent/substitute listed on the CA/N-1. If a family record exists for this individual and/or another parent/substitute in the same household, prepare one cover sheet "CA/N Investigation Section" for each reported incident of CA/N. The cover sheet should be on pink paper for quick reference. Label each cover sheet with the incident number. (Example: Investigation Record Incident # 20001767001.) All hotline reports with findings of "Preponderance of Evidence" must be filed in the family record, if there is one.

All forms and documents related to the investigation of a specific incident should be filed in the following sequential order:

- Child Abuse/Neglect Reporting form, CA/N-1

- Child Abuse/Neglect Investigation/Family Assessment Summary (CPS-1) and any supplemental narrative recording pages
- Safety Assessment (CD-17) and Safety Plan (CD-18), (if applicable)
- Physical Examination Diagram (if applicable)
- Letters and/or release of information forms including the Medical Information Request (CS-30), and the Authorization for Release of Medical/Health Information (SS-6)
- Documents and/or letters requesting and/or authorizing services
- Evidentiary/collateral reports such as medical reports, school reports, psychiatric/psychological reports, police reports, written witness statements, transcripts of tape-recorded statements, and other reports or statements as appropriate
- CA/N Disposition Form Letter (CS-21)
- Reporter Disposition Notification Letter, CS-21b (if applicable)
- First Steps Cover Letter (CD-21c) (if applicable)
- Report of Death or Serious Injury (CS-23), and
- Other material/forms collected and relevant to the investigation.

File all narrative recording and documents obtained/generated **subsequent** to the investigative conclusion and unrelated to the investigation in the family file sections other than “CA/N Investigation” section or “Family Assessment” section.

The county designee (a supervisor or above) should provide **only** the “CA/N Investigation” section to subjects or their designee who request to view the record, if the requesting person is someone other than the family member for whom the case file is maintained.

1.1.2 Family Assessments Completed in Response to CA/N Reports – (Cover Sheet: Pink)

All forms and documents related to the investigation of a specific incident should be filed in the following sequential order:

- Child Abuse/Neglect Investigation/Family Assessment Summary (CPS-1), Safety Assessment (CD-17), Safety Plan (CD-18) (if applicable)
- Community Services Referral (CS-16c)

- Child Abuse/Neglect Reporting form, CA/N-1
- Physical Examination Diagram (if applicable)
- Letters and/or release of information forms including the Medical Information Request (CS-30) and the Authorization for Release of Medical/Health Information (SS-6)
- Documents and/or letters requesting and/or authorizing services
- Evidentiary/collateral reports such as medical reports, school reports, psychiatric/psychological reports, police reports, written witness statements, transcripts of tape-recorded statements, and other reports or statements as appropriate
- Reporter Disposition Notification Letter (CS-21b) (if applicable)
- CA/N Disposition Form Letter (CS-21a), and
- Other material/forms collected and relevant to the assessment.

1.1.3 Assessment and Services Section – (Cover Sheet: Blue)

This section includes:

- A copy of the most recent Family-Centered Services screen (SS-63), which is to be used as a face sheet
- NCFAS G+R (intake, interim and closure fields)
- Written Service Agreement (CD-14b)
- Community Services Referral (CS-16c),
- Termination of Services After Care Plan (CD-14d), for closed cases
- Risk Assessment (CD-14e) if not completed with a hotline
- Culturagram (CD-14f)
- Genogram (CD-14g)
- Safety Assessment (CD-17),
- Safety Plan (CD-18) (if applicable)

- Family Risk Reassessment for In-Home Cases (CS-16e)
- Case narrative, and
- Child Assessment and Service Plan (CS-1). Only put the CS-1 in this section if a separate record is being established for a child for whom reunification is no longer the goal. Otherwise the CS-1 is to be filed in the child's section of the family file).

1.1.4 Child's Section – (Cover Sheet: White)

This section is created only if a child is placed in out-of-home care. Make a separate section for each child in out-of-home care. The Child's Section includes:

- Child/Family Health and Developmental Assessment, (CW-103)
- Indian Child Welfare Act Checklist (CD-123)
- Indian Ancestry Questionnaire (CD-116)
- Reports which relate specifically to the child, i.e., counseling, school, medical, etc.
- Income Entry Log, (CS-KIDS-1)
- Residential Treatment Referral (CS-9)
- Title XIX FFP Application/Eligibility Determination Worksheet (CS-66) (SSI referral)
- A copy of the most recent Alternative Care Client Information screen (SS-61) is to be used as a face sheet
- Birth certificate
- Social security card, and
- Child Assessment and Service Plan (CS-1).

A separate record is established for a child if parental rights are terminated.

1.1.5 Correspondence Section – (Cover Sheet: White)

This section includes:

- Computer generated service authorization letters
- Letters sent/received through outside mail, excluding court-related and ICPC correspondence, and
- Any information that the family requests to be included in the record should be filed in this section.

1.1.6 Reports Section – (Cover Sheet: Green)

File all reports which are unrelated to investigations or assessments and which are not specific to a child in out-of-home care, such as:

- CTS reports
- Educational reports
- Medical reports, and
- Psychiatric reports

Reports about the parents of the child(ren) in out-of-home care should be filed here.

1.1.7 Forms Section – (Cover Sheet: Canary Yellow)

File all forms (except ICPC forms, those related to the CA/N investigations, CS-1, and the Family Assessment Packet), such as:

- Individualized Child Care Plan (CS-40)
- Service Authorizations
- Child Care Authorization (CD-150)
- Authorization for Release of Medical/Health Information (SS-6)
- Financial Statement for Parents of Children in Children's Division (CD) Alternative Care (CS-99) and
- Emergency Assistance Services Request (CS-EAS-1).

1.1.8 Legal Section – (Cover Sheet: Buff/Tan)

This section includes:

- Court orders

- Court reports
- Subpoenas
- Summons
- Petitions
- Depositions
- Court-related correspondence
- Court-ordered Written Service Agreement (if the court requires this in addition to the Written Service Agreement utilized by the Children's Division).

1.1.9 ICPC Section – (Cover Sheet: White)

All ICPC related forms and correspondence should be included in this section.

1.1.10 Administrative Review Section – (Cover Sheet: White)

Documentation of all local and regional reviews should be included in this section. This section also includes:

- Administrative Review Disposition Letter (CS-21d)
- Administrative Review Ineligibility Letter (CS-21e)
- Law Enforcement-Prosecuting Attorney Notification Letter (CS-21f)
- De Novo Judicial Review Disposition Letter (CS-21g)
- Administrative Review Checklist

1.1.11 Intensive In-Home Services Section – (Cover Sheet: White)

All Intensive In-Home Services related forms and correspondence should be included in this section.

1.1.12 Domestic Violence Section – (Cover Sheet: Red)

This section includes:

- Orders of Protection

- Police Record
- Written Statements
- Witness Statements
- Safety Assessment (CD-17), Safety Plan (CD-18) (if applicable), and
- Narrative summary of violent incidents

1.1.13 Older Youth Program Services Section – (Cover Sheet: White)

This section is to contain any referrals, assessments, forms or other information specifically related to the Older Youth Program which includes Chafee Foster Care Independence Services, Transitional Living Services, and Independent Living Services. This section should include all Older Youth Program information for all youth in the family who are receiving these services. If a separate file has to be established for a youth receiving Older Youth Program services, the youth's file needs to contain that youth's specific information.

- Referral Screen for Chafee Independence Services and Transitional Living Group Home/Scattered Site Services
- Adolescent FST Guide (CD94)
- Individualized Action Plan Goals (CD94)
- Casey Life Skills Assessment Report
- Individual Life Skills Progress Form (CD95)
- Life Skills Strengths/Needs Assessment Reporting Form (CD97)
- Transitional Living Program (TLP) Advocate and Independent Living Arrangement (ILA) Checklist (CS-TLP-1)
- Chafee Foster Care Independence Program Support Application (CS-ILP-4)
- The Planned Permanency Agreement (CD-129)
- "What's It All About? A Guidebook for Youth in Out-of-Home Care" acknowledgement form
- NYTD Older Youth Survey; and

- Automobile Insurance Consent Letter (CD-208).

1.1.14 Adoption/Guardianship Subsidy File - (Separate File Folder)

This file is to contain family adoption/guardianship subsidy information and should be created for the adoptive or guardian family at the time of their first adoption/guardianship involving subsidy. As the family adopts or receives guardianship of more children, the new child(ren)'s information is to be added to this file. This is to be a separate file used by the Children's Service Worker managing the subsidy. Any information post-adoption/guardianship should be placed in this file. Contents of this file are to include the Child's Placement summary, any reports for the child, the family's home assessment and updates, forms, payment related paperwork, legal paperwork, the subsidy contract, and any correspondence. Narrative that relates to the family should be entered in FACES. The following sections are to be a part of this file:

- Child Assessment – (Cover Sheet: White)
    - Child placement summary signed by the worker and family
    - Reports on the child
- Family Assessment - (Cover Sheet: White)
    - Home Assessment
    - Updates
- Forms – (Cover Sheet: Yellow)
    - Vendor Licensure/ Approval and Renewal screen in FACES
    - ICAMA forms
    - Third Party Resource Form (TPL-1) and Accident Reporting Form (TPL-2)
    - Release of Medical/Health Information (SS-6)
- Payment – (Cover Sheet: Green – to be retained for at least one (1) year. If needed, the computer system retains this information and can be obtained.)
    - Service Authorizations
    - Payment Requests

- Receipts

- Legal – (Cover Sheet: Buff/Tan)
  - In Legal Guardianship Cases – Proof of Children's Division Custody
  - Court orders:
    - Release of Jurisdiction (Adoption only)
    - Adoption Petition (if the worker receives one)
    - Transfer of custody order
    - Adoption decree
    - Award of Legal Guardianship
- Subsidy Contract – (Cover Sheet: Pink)
  - Adoption and Guardianship subsidy forms
- Narrative – (Cover Sheet: Blue)
  - Case contacts and summaries
- Correspondence – (Cover Sheet: White)
  - Annual review letter
  - Fair hearing review letter
  - Any other written correspondence
- Adopted Adult Information Request – (Cover Sheet: White)

  Documents in this section include information regarding adopted adults, biological siblings, biological parents, and lineal decedents of the adopted adult.
  - Non-Identifying Information Form (CS-50)
  - Court order or request from court
  - Narrative pertaining to request

- Court report
- Correspondence
- Documents including but not limited to:
  - Birth certificate
  - Death certificate
  - Driver's license or photo I.D.
  - Adoption decree

Related Subject: Section 5 Chapter 2: Record Access

This record should be used when completing Peer Record Reviews of Adoption cases.

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

CD09-05, CD10-59, CD10-120, CD11-75, CD11-86, CD12-97, CD13-56, CD14-51, CD15-16, CD15-70

1.2 Recording and Documenting E-mail Correspondence

E-mail correspondence pertaining to a case must be included in recording and documentation. The E-mail message shall be printed and included in the correspondence section of the case file. Staff should also note in the narrative section that contact was made with an individual through E-mail in the narrative section but the content of the message does not need to be included. Since E-mail correspondence shall be included in the case file, staff should give the same consideration to the content as they would for letters and other forms of correspondence. Only information pertaining to the case should be included in the message and discussion of topics unrelated to the case should not be contained within the message.

Staff are reminded that this form of correspondence is open to release when a request is made for a file. Since E-mail may be released with the rest of the file, it is important that staff are careful to only include necessary and pertinent information.

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

1.3 Recording Guidelines

1.3.1 Definition, Purpose, Style

The family record shall summarize all activities, including family strengths, efforts to address safety and risk issues, and a summary of the activities of any treatment agents and/or family support teams. The record must also include the family's involvement in and reaction to services provided.

The guidelines listed below are intended to provide a basic structure for capturing relevant information. They are designed to serve as a general framework for all recording. Emphasis is placed on being purposeful, specific, factual, and focused on the investigative, assessment and/or treatment process. The Children's Service Worker and supervisor are free to modify certain components, when appropriate, in order to accommodate the needs of specific situations.

The Children's Service Worker's use of "I" (first person pronoun) is preferred when describing his/her activities. This conveys a sense of ownership and accountability. Avoid using third person descriptors, such as "worker" for this purpose.

1.3.2 Recording Guidelines – Investigations

All CA/N investigation narrative recording is done on the CPS-1 and supplemental pages. Handwritten notes should be destroyed. Handwritten notes should only be maintained as part of the record if they are necessary as evidence to meet the Preponderance of Evidence standard for abuse/neglect. Any information maintained is subject to subpoena and the Children's Service Worker should keep this in mind when completing the investigation. Narrative recording serves as a means for the worker to document all investigative activities. It also assists the worker in making decisions by:

- Enhancing communication between the worker and supervisor;
- Serving as documentation of the worker's decision; and
- Gathering all information in one place to facilitate decision-making.

The investigative record aids the Children's Service Worker in planning for and conducting the investigation. In addition, it provides valuable information to staff who are subsequently assigned to provide services to the family. Thorough narrative recording will also demonstrate compliance with agency policy and legal mandates.

The purpose of narrative recording of CA/N investigations is to:

- Provide a chronological list of all the investigator's activities related to the investigation;

- List the facts and direct observations obtained by the investigator during the investigative process; and

- List the evidence that supports the facts.

To accomplish these objectives, the narrative must be thorough, accurate, clear, specific, timely, and factual.

1. **Thoroughness**: The investigator must secure and record all information necessary to make critical decisions affecting the conclusion. Narrative recording is thorough when it answers the following questions for the reader: who, what, when, where, why, and how the incident occurred. Some information, particularly reports from law enforcement/prosecution, may not be available to staff when the investigation is completed. Update the information at a later time, as the information becomes available.

2. **Accuracy**: Descriptions of observations, physical evidence, and statements must be recorded with accuracy and in detail. The following is a seven-point review, which is a good test of the accuracy of narrative recording:

    - Is the data contained in the recording accurate?

    - Is the data contained in the recording complete?

    - Are there persons or places in the report for which full identifiers are not given?

    - Are the events described in the recording understandable in that they are in proper sequence and the chronology is clearly set forth?

    - Are all articles of evidence, whether obtained by worker or others, identified and their location given?

    - Can the reader tell from the report the relevance of each item of data that has been presented?

3. **Brevity**: Effective writing is concise. Narrative recording should contain no unnecessary words or sentences. Lengthy run-on sentences only confuse the reader. Short declarative sentences convey information more efficiently.

4. **Separating Facts from Judgments**: It is important that the Children's Service Worker separate facts from judgments made about those facts.

This separation encourages the worker to detail facts of the investigation before forming judgments. The facts should support the judgments rather than vice versa.

When forming and recording professional judgments, the Children's Service Worker should be extremely cautious with "labeling" terms. The worker should avoid the use of psychological or medical diagnosis which he/she is not qualified to make when describing a condition/behavior.

5. **Timeliness**: Timeliness in recording information is important for two major reasons:

    - The sooner the information is recorded, the more accurate it is likely to be;

    - For information to be introduced as evidence in a court hearing, records must:

        - Be made during the regular course of the investigation;

        - Be made at or near the time the event(s) occurred; and

        - Be recorded by someone who has knowledge of the event(s).

6. **Discussions with the Division of Legal Services:** Discussions with the Division of Legal Services (DLS), including the name of the DLS attorney, dates of discussion or options discussed, should **not** be documented in the record as this waives the right to attorney/client privilege. Rather, the narrative should reflect the decision reached by the Children's Service Worker after discussions with DLS. If there would normally be an entry in the narrative concerning social work activity following a discussion with DLS that entry may indicate a contact with DLS, but must not be specific with regards to content or options/recommendations discussed.

If the Children's Service Worker desires to retain the content of the entire discussion, this information should be retained in a separate file in the circuit manager or supervisor's office. Information retained in a separate place is **not** subject to release or subpoena.

1.3.3 Policy Requirements Related to Narrative Recording

For consistency throughout the state, narrative recording must, at a minimum, follow the guidelines and format described in this section. Exceptions to these methods require supervisory approval and will be limited to rare situations.

Case contacts and activities shall be summarized in the case narrative:

- At the conclusion of the assessment process in the form of an opening summary;

- *At least monthly;*
- Upon transferring an open case to another worker or county;

- At the conclusion of the treatment plan; and

- At closing of services to family.

More frequent entries may be utilized if warranted.

To ensure legibility and a business-like appearance, all case narratives shall be typed. Case narrative entries are to be signed and dated by the worker as indication that narrative entries are accurate.

Information referring to unsubstantiated CA/N investigations shall not be included in the family record.

Unsubstantiated reports and family assessments (when a family is not opened for services) should be filed so that staff can quickly access the record.

Unsubstantiated reports are retained in the county that completed the investigation. The county completing the investigation will receive the expungement list for the unsubstantiated report. Unsubstantiated reports are not transferred to another county with open family records.

- The date of expungement, if unsubstantiated, must be noted at the time investigation is completed if there will be no record opened as a result of the investigation.

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

CD09-128

1.4 Recording Guidelines - Family Assessments (Ongoing Work with Families)

Instructions for this section describe how the Children's Service Worker is to maintain a written account of social service work activity.

Initial family assessments are completed using a Child Abuse/Neglect Investigation/Family Assessment Summary (CPS-1), Safety Assessment (CD-17), and If applicable, any Safety Plan(s) (CD-18). For ongoing work with a family, the Children's Service Worker will complete the NCFAS G+R and attachments.

In addition to the NCFAS G+R and attachments, it will be necessary to utilize the following recording guidelines to organize the massive amounts of information sometimes assembled by the Children's Service Worker.

Case narrative recording refers to the written documentation compiled and included in the case record to describe casework activity. This documentation will be written in a specific format that includes the following elements: an opening summary, case contacts, a monthly progress summary, a closing summary (when terminating services), and a transfer summary (when transferring an open case to another worker or county).

These narrative elements are defined below and are used to document the Children's Service Worker's efforts to address and eliminate the problem behaviors placing child(ren) at risk of abuse or neglect.

- **Opening Summary** - a brief descriptive summary used when opening a case. This should include the reason for case opening as well as any other pertinent information not already included in the NCFAS G+R (intake field).
- **Case Contacts** - contacts made during the course of service provision.
- **Monthly Progress Summary** - a treatment-focused summary completed monthly to summarize progress made towards treatment goals.
- **Transfer Summary** - a summary of case activity up to the point of case transfer.
- **Closing Summary** - a summary completed when terminating services with a family.

1.4.1 Initial Recording

Opening Summary

An opening summary begins the initial case narrative recording, after the completion of the NCFAS G+R intake field, and Written Service Agreement, CD-14B. This should include the reason for case opening, in addition to any relevant information that pertains to the family's presenting and underlying problems if this information is not clearly described in the NCFAS G+R intake field. The Opening Summary should not replicate information already contained in the NCFAS G+R,

but may supplement and expand on the descriptive information contained in this tool. Diligent search efforts to locate the absent parent(s), relatives, and kin should also be documented.

The sections below are mandatory in FACES for FCS and AC opening summaries. See Attachments A and B for case examples.

FCS Opening Summary
- Case Open Reason
- Prior History of the Family
- Cultural Diversity of the Family
- Know Your Rights Brochure
- Identify the Needs of the Family

AC Opening Summary
- Case Open Reason
- MSW Consultation Completed (Who/When)
- Initial Diligent Search
- Cultural Diversity of the Family
- Know Your Rights Brochure
- Indian Child Welfare Act (CD-116 and CD-123)
- Identify the Needs of the Family
- Least Restrictive Placement Section

1.4.2 Subsequent Recording

Subsequent (on-going) case narrative recording is composed of monthly Case Contacts, a Monthly Progress Summary using the NCFAS G+R interim field (every 90 days), a Risk Reassessment, CS-16e (every 90 days), and a Termination of Services After Care Plan, CD-14D, at the time of closing. These elements must focus on observable changes occurring during the treatment process. They must summarize and record the Children's Service Worker's pertinent observations regarding the case contacts.

- **Case Contacts** must be entered in FACES at least every 30 days following the assessment and initiation of the service plan.

- A **Monthly Progress Summary** must be completed in FACES at least every 30 days following the assessment and initiation of the service plan to determine and document progress towards treatment goals.

All narrative recording must be authorized by the worker and approved by the supervisor as indication of accuracy and accountability.

1.4.3 Subsequent Recording Outline

Case Contacts – contacts made during the course of service provision which includes:

- Purpose of contact: Give a brief explanation of the purpose of each contact or what it intended to accomplish, and
- Result of Contact: Describe information obtained during contact when it is pertinent to the treatment process or changes occurring in the family system. Include the family's reaction and response to contact if applicable.
- Contacts include, but are not limited to:
    - Case consultation with supervisor
    - Consultation with any external consultants
    - Family Support Team meetings
    - Court hearing (type of hearing, who present, and the outcome or order of the court)
    - Mail sent and received
    - Certification for CTS, child care, etc.
    - Date and type of any review done on the case record (Peer Record Review, Program Development Review, etc.)
    - Home visits, and
    - Telephone calls

Case Contact Examples:

- Joanie Smith conducted a home visit with Alison. She was alert and appeared healthy. She was crawling on the floor and exploring her surroundings. I said hello to her and she looked at me. She is responsive to her name. While I was there, she handed me a toy and I gave it back to her to play with. I did not observe any safety issues.

  I spoke to Susie Davis, relative provider, who stated that Alison was doing well in her home. She said that Alison has learned how to stand while holding onto the couch since my last visit. She said that Alison is also beginning to talk. She said that she can say a few words. She said that

she just took her to the doctor for a check-up. The doctor reported that Alison is developmentally on target. She said that Alison's parents came along to the doctor visit. She said that they were appropriate during the visit. I asked her how the supervised visits between Alison and the parents were going. She said that they were going well. She said that she is supervising visits four days a week. She said that the parents are very attentive to Alison's needs. She said that they help feed Alison and they get on the floor and play with her. I asked her how Parents as Teachers was going. Susie reported that Parents as Teachers is coming to the home once a week to meet with her and Alison. She said that they have been helpful. She said that she is still receiving assistance from WIC. I asked her if she had any problems with the child care facility. She said that Alison was still attending Sunny Days and appears to enjoy it there. We scheduled our next home visit.

- I received a telephone call from Mary Brady, mother's therapist regarding her last counseling session. Mary told me that she had discussed the allegations with the mother. I told Mary that I had concerns regarding the mother's lack of boundaries and her lack of remorse for the incident that occurred. Mary mentioned that the mother was abused as a child. She said that she was going to approach this issue with the mother to see if she can find any correlations between her abuse and the child's abuse.

Monthly Progress Summary - A monthly service-focused summary which summarizes the case contacts. It summarizes the progress, or lack of progress, being made towards established service goals. Use behavioral descriptions where possible to accurately summarize and illustrate the observed changes taking place in the family system. Record the family's reaction and response to services provided. Briefly summarize the outcome or consequences of the treatment services provided to date. Describe how treatment services have changed the underlying sources of family dysfunction that may have led to the presenting problem. Diligent search efforts to locate the absent parent(s), relatives, and kin should also be documented. Address issues such as:

- Changes in the observed safety or risk
- Changes that are observed in the presenting problem(s). Describe these changes using an individual and systems viewpoint
- Changes in resource usage and interaction with outside systems, and
- Changes in the service strategy for the next 30 days if services are to continue

The sections below are in FACES. See Attachments A and B for case examples.

FCS Monthly Summary

- Household Makeup

- Safety Concerns
- Parent Protective Capacities
- Parent's Progress towards WSA
- Collateral Contact
- Court Outcome (if applicable)
- Absent Parent Role
- Cultural Diversity of the Family
- Case Goal (if applicable)
- Additional Information
- Supervisor Consultation

AC Monthly Summary

- Safety Concerns
- Parent Protective Capacities
- Permanency Plan/Concurrent Plan
- Parent's Progress towards WSA
- Visitation Plan
- Parent/Child Visits
- Worker Visit with Parent
- Type of Placement and Why
- Sibling Separation (if applicable)
- Child's Health/Dental/Medical/HCY
- Child's Education
- FST/PPRT Meetings
- Court Outcome (if applicable)
- On-going Diligent/Parent/Extended Family Search Efforts
- Absent Parent Role
- Incarcerated Parent Contact (if applicable)
- Cultural Diversity of the Family
- Additional Information
- Supervisor Consultation

1.4.4 Treatment-Focused Summarized Recording

A vast collection of information, unless required for legal purposes, tends to inhibit an accurate reflection of treatment. It requires others to weigh and interpret information in order to glean important facts. Treatment-focused summarized recording, on the other hand, reduces the amount of peripheral information in order to focus staff on the family's progress and treatment.

Since the Children's Service Worker's efforts to improve family functioning must be guided by a precise recognition of the presenting problems and specific unacceptable behaviors to be modified, as well as the strengths of the family, the ongoing narrative should focus on clear, behavioral definitions of the current problems to be addressed. Focusing on specific behaviors is essential if the worker is to respond appropriately to the family system's evolving character,

needs and priorities. The narrative must describe strategies for resolving these problems.

As no record can accurately reproduce everything that is said and done, the Children's Service Worker must sift out and select items of information which he/she thinks are of the greatest significance. Generally, the narrative should not include all that happened during any one interview, conference, or time period. Treatment-focused summarized recording briefly describes what took place between the worker and family or collateral. It should summarize events based upon the worker's evaluation of their significance to the treatment process.

Omit excess material and communicate only the important activities and events relating to the treatment process. Carefully appraise the facts pertaining to the reasons for Division involvement with the family and the family's reactions to treatment and intervention and record only information that is essential to an understanding of the family system and its dysfunction.

Treatment-focused summarized recording is useful to describe ongoing trends, progress, or regression, within a certain time period (i.e., 30 days). Topical headings may be used to further organize the content of events, which occurred within the time period.

The following guidelines will assist in the preparation of treatment-focused summarized recording. The Children's Service Worker should:

- Keep complete and accurate notes by date in a notebook/pad so meaningful material can be selected for the record
- Evaluate and organize the material before recording it. Identify items that pertain to the treatment process
- Omit unnecessary and repetitious words
- Avoid lengthy explanations or detailed accounts of activities that do not focus on the treatment process. Activities such as searching for a record or attempting to reach someone by phone do not require much attention
- Describe people in a few words with clarity. Recognizing the significance of their appearance and behavior is important. Lengthy description of an individual for the sake of description is not purposeful
- Avoid repetition. Even when there is a change of Children's Service Workers, there is no need for repeating information already in the record, and
- Pay particular attention to items that may be critical in court testimony.

Case Transfer Summary - In the event a child or family moves from the county of jurisdiction, a transfer summary must be completed within 10 days by the worker in the case managing county prior to transfer of case record. The transfer summary should include:

- Reason for opening and reason for transfer
- Current status of child and family with regard to established goals
- List of upcoming appointments as well as with whom they are scheduled (e.g. upcoming FST meetings, medical appointments, court dates etc.)
- Visitation plan if applicable
- Any other information pertinent to the case that is necessary for optimal service delivery to the family.

Transfer Summary Example

On 2/24/2014, a case was opened as a result of a substantiated report of educational neglect and substandard living conditions in the home. On 4/1/2014, the entire family is moving to an adjoining county where they have procured housing closer to Mr. Jones's place of employment. Family will continue with parent aide services on a weekly basis to assist them towards goal of learning appropriate housekeeping skills. Billy Jones will continue with IEP in his new school in order to achieve his goal of advancing to the next grade level. Billy has an appointment on 3/15/2014 with Dr. Jones (573-999-6666) for a psychological evaluation.

The transfer summary should be submitted to the immediate supervisor for review and approval in FACES.

Closing Summary - This summary is done within thirty (30) days of terminating services with a family. The closing summary should include:

- Reason for opening
- Current status of child and family including safety status of child
- Justification for case closure which should include behaviorally specific description of how the family has stabilized and achieved the goals in the original or updated case plan
- Family reaction to termination of services
- Community referrals made by worker to support family after case closure

- Any ongoing aftercare services the family will be receiving (e.g., continued counseling). (Reference the Risk Reassessment, CS-16E, and the Termination of Services After Care Plan, CD-14D)

- For all youth exiting care to independence, an identified plan for self-sufficiency which addresses the nine domains of independent living and an exit verification letter stating the dates the youth was in care. Documentation of when the Exit Packet and the Exit Verification letter were provided to the youth is included in the narrative.

The closing summary should be submitted to the immediate supervisor for review and approval in FACES.

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

CD07-34, CD07-38, CD09-05, CD09-128, CD11-48, CD11-86, CD13-90, CD14-21, CD15-28

1.5 Recording Guidelines – Out-of-Home Placement

Instructions for this section describe what and how, the Children's Service Worker is to record when an out-of-home placement has occurred.

1.5.1 Initial Recording

1. The Children's Service Worker should identify reason(s) for removal and the date of removal.

2. If there have been preventive and protective services, specify why the written service agreement developed with the parents failed to prevent placement, or document the reasonable efforts to prevent placement in an emergency placement.

3. In the case plan, the Children's Service Worker should state the specific placement plan, such as "temporary foster care – goal to return child to birth parents." Address the following specific components of the case plan:

    - Child's Progress - Describe the out-of-home placement and provide details of the appropriateness of the placement such as:

        - Is the child getting proper care?

        - Is the child in the least restrictive placement environment and in proximity to the birth family? If close proximity is not advisable, explain. Provide reasons a relative placement is not advisable;

        - Are appropriate services being provided to the child, and the foster parents?

        - What are the child's needs and are they being met?, and

        - What is the child's present health or what are the child's health needs?

    - Parental Progress -

        - Are they receiving services?

        - Are these services appropriate?

        - Is the parent(s) cooperating? Are they making progress?

- What is the frequency of the visitation schedule? Are the parents participating? Interacting with the child during visits?
- Are the parents providing child support?
- What is the status of the parents' compliance with the Written Service Agreement?, and
- What are the efforts to locate absent parents, if applicable?

- Coordination of Services -
  - Are services to the child, the resource providers, and birth parents coordinated toward a specified goal?
  - Are services being provided in accordance with the recommendations of the Family Support Team/Permanency Planning Team? and,
  - Are plans/services appropriate to the permanency plan, court order, and/or special court instructions?

The Children's Service Worker should identify that the rights of the parents were safeguarded. He/she should identify the date that the procedural safeguards and parent's rights were provided to and discussed with, the parents regarding the removal of the child. The worker should also document that the procedural safeguards were given to the parents regarding intended changes in placement and/or visitation. If this was not done, explain.

The Children's Service Worker should identify the service plan and outline the next steps in the provision of services to be directed toward the return of the child or other permanent plan. The worker should then project the next review date.

1.5.2 Interim Recording

All contacts shall be recorded chronologically in the narrative section of the family record. Chronological dictation will include the date, time, person(s) contacted, and a description of the content of the communication. Contacts include:

- All personal contacts such as home visits, office visits, and telephone calls;
- Conferences with supervisors regarding specific family situations;
- Court hearing information such as the type of hearing, persons present, and the outcome of the hearing;

- Permanency Planning Review Team (PPRT) meetings, including the date parents and foster parents were notified, those present, and the PPRT recommendations;

- An indication of the date when the Child Assessment and Service Plan, CS-1, was completed and sent to court;

- An indication of the date when the Adolescent FST Guide (CD94) & Individualized Action Plan Goals (CD94), Life Skills Strengths/Needs Assessment Reporting Form (CD97), and Casey Life Skills Assessment (CLSA) for youth fourteen (14) and older was completed.

- The date youth age fourteen (14) and older were referred for Chafee Foster Care Independence Program Services and Transitional Living Program Services.

- All correspondence sent and received;

- Documentation of the need for purchased services such as child care and Children's Treatment Services and all referrals that have been completed and all services authorized;

- The date the Vendor Licensure/Approval and Renewal and the Alternative Care Client Information screen in FACES were submitted for an opening, a closing, or an updating of the case situation; and

- An evaluation of the progress made toward achieving a permanent plan.

1.5.3 Assessment of the Case Plan in Initial and Interim Recording

The Children's Service Worker will include in the case plan review the following:

- An evaluation of the child, parents, and resource providers' progress in completing the case plan;

- An assessment of the appropriateness of the services being provided to the child, such as counseling, medical, educational, and child care services;

- A description of how these services are meeting the specific needs of the child;

- An assessment of how the services provided are meeting the needs of the parents;

- A description of how the terms of the Written Service Agreement and/or court approved service plan are being met by the parent, the child, and the worker; and

- A description of the child and resource provider's involvement in the development of the services and visitation plans. This will include narrative on how these plans are beneficial to meeting the goal of permanence for that child.

1.5.4 Documentation of Discussion with the Division of Legal Services

As stated in sec5.ch1.sub 3.2, regarding investigation documentation, discussions with the Division of Legal Services (DLS) should **not** be documented in the case record. See that section for further clarification and information about where content of those discussions or documents may be retained.

1.5.5 Documentation of Information Regarding Domestic Violence

The disclosure and documentation of domestic violence may dramatically increase the risk of harm to the child and adult victim. Therefore, any specific information disclosed by the child or adult victim that is requested to be kept in confidence shall be. However, it is imperative to share with the family up front that all issues compromising the safety of the child will be addressed openly. Consultation with a supervisor on making this distinction is recommended. Any reference to domestic violence in the case narrative or narrative summaries is not protected and will be released. Staff should be cautious of including this information in any section other than the domestic violence section.

Documentation of instances of domestic violence and any collateral information to back up the allegations (order of protection, police reports, witness statements, etc.) shall be kept in the domestic violence section of the file that will be marked by a red cover page. This section will not be released to the domestic violence offender. If this information must be shared per court order, the adult victim should be notified in advance so that he/she may consider safety plans.

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

CD09-05, CD09-128, CD12-84, CD13-56

1.6 Recording Guidelines and Record Composition – Resource Provider Records

Case recording for resource provider records should be completed quarterly, signed by the worker, and reviewed and signed by the supervisor. This documentation should include, at a minimum, the dates of the licensing worker's home visits (which must be conducted quarterly) and who was seen at the visit, current number and type of placements, changes in household composition, licensing concerns, and progress on the Professional Family Development Plan, CD-100, (see Section 6 Chapter 2, In-Service Training). Documentation of progress on the CD-100 should include any training attended during the quarter and any training scheduled that addresses the needs identified in the plan. Quarterly documentation should also address any identified safety issues. The case narrative and documentation should be reviewed and signed quarterly by the licensing worker's supervisor.

1.6.1 Record Composition

Documentation and file maintenance are as important in resource provider files as they are for foster youth's case files. These files may be accessed by the general public (See Section 5 Chapter 2, Record Access, for information on who may access resource provider records and requirements for obtaining this information). No child-specific information should be placed in the resource file with the exception of the CD-104 located inside the front cover of the file. The following is a guideline for file set up and maintenance. Items identified by an asterisk (*) must be in all records:

Forms Section (Yellow)
Assessment Application, CS-42*
Resource Home and Safety Checklist, CS-45*
Out of County Home Assessment Request, CD-174
Resource Parent Acknowledgment of Home Assessment & Case File Information Access, CD-128 *
Well Water Check (Health Department), if applicable
Discipline Agreement, CD-119*
Safe Sleep Practices, CD-117*
Notification of Hazards, CD101; Swimming Pool, Trampoline, household smokers, etc.
Current Authorization for Release of Information, SS-6*
Current Vendor Licensure/Placement Resource Report, formerly referred to as the SS-60, now the Vendor Licensure/Approval and Renewal screen in FACES.*
Sanitation Inspection, CS101j, if applicable
Fire & Safety Inspection, CS101i, if applicable
Resource Family Exit Interview, CD-112

HIPAA (White) (Information in this section is not available to the public)
Resource Provider Health Insurance Portability and Accountability Information, CD-194
Foster/Adoptive Medical Report, CW-215*
Psychological Evaluations/Therapists Reports

TB Test

Background Section (Green)
Current Fingerprint Based Criminal Background Check Results or Letter*
Case.Net Check*
Family Care Safety Registry*
Sex Offender List by Address, Search Missouri Sex Offender Registry

Correspondence (White)
Letters to Foster Family
Any other written correspondence (including business E-mail)

Training (Buff)
All Training Certificates*
Training sign in sheets*
Training record screens*
Resource Family In-service Training Request, CD-114
All flyers and notifications of In-service training opportunities

Cooperative Agreements (Yellow)
Alternative Care, CM-3*
Professional Parenting, CM-14*
Respite, CM-10
Elevated Needs Level B Respite, CM-9
Elevated Needs Level B, CM-8
Level A Foster Care, CM-3 Amendment
Medical Home, CM-3 Amendment

Family Assessment (White)
STARS Initial In-Home Consultation
Resource Provider Family Study and Addendums*
Personal Reference Questionnaire, CS-101f* Utilized at initial licensure and only at re-licensure if warranted
School Reference Request, CS101e* Utilized at initial licensure and at re-licensure for all children in the home. Do not place foster youth's CS101e in the resource provider file
Employer Reference Questionnaire, CS-101c* Utilized at initial licensure and only at re-licensure if warranted
Reassessments*
Professional Family Development Plan, CD-100*
Outdated CD-56's
Quarterly Summaries, CD-118

OHI Reports (Pink)
The cover sheet should include:
- Case Name
- Date of Report

- Incident Number
- Expungement Date

Administrative (White)
Resource Home Adverse Action Report, CS-20
Notification of Resource Home Adverse Action, CS-20a
Alternative Care Grievance Review Request, CS-70
Service Delivery Grievance Form, CS-131
Notification Letter for Adoption and Guardianship Subsidy Denial, CD-87
Application for Fair Hearing, CD-53
Withdrawal of Request for Hearing, CD-54
CA/N Check

Narrative (Blue)
Dictate when a Family is licensed/re-licensed
Dictate when a child moves in and out
Record all home visits and meetings with resource provider family
Record when training notices have been mailed
Record when foster parents have participated in training
Record any licensing concerns noted and action taken
Document closing narrative
Level A/Level B/Medical Staffing Outcomes (non-child specific)

Emergency Plan/Disaster Plan (Red)
Required information as outlined in memo CD06-33

1.6.2 Initial Recording

The initial recording should document the date the Specialized Training Assessment Resources and Support (STARS) assessment was reviewed and signed by the family and Children's Division staff. Staff should also meet with the family's biological/adopted children separate from the parents to discuss their feelings on alternative care placements and sharing their household. An overview of the Foster Family Profile, CD-56, and the types of placements and children desired, as well as the strengths and needs identified in the assessment and during the initial contact with the family should be included. The date the vendor was opened in the system should also be noted. The STARS class work/homework documents are to be returned to the resource provider(s) once their license has been approved and opened in the system.

The next recording should be to document the discussion of and agreement to the Professional Family Development Plan, CD-100. Within thirty (30) days of the family becoming licensed, the worker is to schedule a meeting to develop a Professional Family Development Plan, CD-100, with the resource family.

Any placements made, contacts with the family, staff concerns with the family, and trainings attended should be documented by the licensing worker. A summary should be completed at the end of each quarter that addresses any

concerns or issues noted during the quarter, number and types of placements made, reasons for any moves out of the household, and training attended.

1.6.3 Subsequent Recording

Subsequent recording should document the date of the licensing worker's home visits (which must occur a minimum of once each quarter) and contact with the family's biological/adopted children. The worker should also document discussion of any licensing issues, placement concerns, progress and/or changes to the Professional Family Development Plan, CD-100, or the Foster Family Profile, CD-56, and any other issues/concerns noted by the Children's Services Worker.

Ongoing documentation should include anytime the home is considered for placement and why the home was chosen or not, and the date any children moved from the household and why.

The quarterly summary is attached to the home assessment. The quarterly summary should include the number and types of current placements, changes in household composition (i.e. divorce, death, illnesses, adoptions, births, etc.), and changes to the physical environment (moves, additions, remodels, etc). There should also be a discussion of any hotline reports, incidents, issues or concerns involving the foster, relative or kinship family and any action taken. It should also be noted if no action was taken and why.

The quarterly summary is documented on the Resource Parent Quarterly Home Visit Checklist and Quarterly Summary, CD-118. Space is provided for the resource provider(s) to sign the form. A copy of the completed form should be provided to the resource provider(s).

Quarterly visits are conversational allowing for the sharing of concerns as well as accomplishments and development of a mutual relationship of trust. The visits are to be used as a prompt to have meaningful conversations about pertinent issues and assure compliance with licensing requirements. The conversation must include how the Reasonable and Prudent Parenting Standard is being applied in the home.

The CD-100 should be reviewed and updated quarterly, annually and at each license renewal and this should be documented in the case record.

Yearly updates should include the families' progress in the CD-100 and with documentation of any changes made to the plan. A summary of the family's performance should also include whether the family is meeting the core competencies including the Reasonable and Prudent Parenting Standard, if there are areas of need identified for the family, and what strengths have the family demonstrated.

1.6.4 Documentation of Contact with Children in Division Custody

Contact with all household members should be documented. However, only initials should be utilized when making reference to children in Division custody. This is true of all current and previous placements in the household. Resource family records are not confidential and may be requested by the public but information on children in Children's Division custody is confidential. Using initials only will help to maintain confidentiality of the children in Division custody.

A list, Placement Report for Resource Home Record, CD-104, should be maintained in the front of the file with the names, placement and removal dates of all children in the resource family home. This form will be removed prior to the records being made public.

1.6.5 Foster Family Profile

A photograph of the resource provider's family and the Foster Family Profile, CD-56, are to be placed under separate cover sheets and placed in the front of the resource provider's record. The Foster Family Profile is to be accessible to the Family Support Team in making its determination and selection of placements for children. A new CD-56 is to be completed at the time of re-licensure or when there are changes in the household composition that impact the information gathered on the Foster Family Profile. The most recent CD-56 is to be kept in the front of the resource provider's record. The obsolete CD-56 should be placed in the Family Assessment Section of the resource provider's file, with a notation on the front page of the profile identifying it as obsolete.

1.6.6 Documentation of Criminal History

Staff should not list specifics in the narrative section of the file when documenting criminal history. The narrative should simply reflect one of the following:

- Fingerprint based criminal background check results meet eligibility requirements;
- Fingerprint based criminal background check results do not meet eligibility requirements; or
- Fingerprint based criminal background check results require further review to determine if applicant is precluded from licensure.

Specific criminal history information may be included in the Resource Home Adverse Action Report, CS-20, when it is the basis for denial or revocation.

At the time of re-approval or re-licensure, staff should destroy the criminal history report obtained for the last approval/licensure period. The previous record is obsolete and no longer required to be maintained in the record. Staff should document that the report was destroyed. This should be done only after

receipt of the new criminal history report. Staff should not maintain any electronic copies of criminal history records.

1.6.7 Closing Summary

There should be a summary completed whenever a resource home is closed. For those closed voluntarily, the narrative should include why the family chose to close their license as well as any concerns or strengths of the family noted by staff. For those closed due to revocation, the licensing issue that led to the revocation and any other concerns should be **documented clearly**. The date of the exit interview and the discussion with the family should be documented in the closing summary. Provide a copy of the Resource Family Exit Interview, CD-112, for the resource provider to complete. The CD-112 shall be placed in the forms section of the case record. The CD-112 can be used to assist the worker in conducting the exit interview with the resource provider.

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60,

Memoranda History:

CD07-54, CD07-61, CD08-108, CD09-105, CD10-63, CD10-70, CD11-97, CD12-111, CD13-101, CD14-08, CD14-27, CD15-75, CD16-65

Attachment A: FCS Opening and Monthly Summary Example

FCS Opening Summary

Case Open Reason:

An FCS case was opened on Mr. and Mrs. Smith due to an investigation for physical abuse of their son, Randy Smith. Mr. and Mrs. Smith were found to have been using unreasonable punishment in the form of using a belt to whip Randy, leaving numerous bruises on his back and buttocks. Mr. and Mrs. Smith agreed to open a FCS case to help them learn more appropriate discipline techniques and to help them get services including marital counseling to improve the overall family dynamic.

Prior History of the Family:

The family has had two prior assessments, one in April of 2013 and one in October of 2013 for allegations of physical abuse on Randy. One assessment was concluded as "No Services Needed". The other assessment linked the family to services for 30 days. The family was referred to The Guidance Center and CD confirmed the family was participating in services when the assessment was concluded.

Mr. Smith has prior reports listing him as a victim child for physical abuse in 1995 and 1997. One report was substantiated for physical abuse. Mr. James Smith, father to Mr. Smith, was listed as the alleged perpetrator. Services were provided to the home.

Mrs. Smith has no other prior reports.

Cultural Diversity of the Family

The Smith family is made up of two parents and one six year old child, Randy. Mr. and Mrs. Smith married very young due to Mrs. Smith getting pregnant at 16 and they felt "they had to". They expressed their love for one another, but felt "tied down" at a very young age. The family reports they practice the Catholic faith and are very involved with their local church. They are also involved with several community activities such as league bowling and the YMCA. Mr. Smith stated he learned his disciplining skills from his father, and he turned out ok, so he is having trouble understanding why spanking Randy is inappropriate. Mrs. Smith appears to disagree with the way Mr. Smith disciplines Randy. She reports she was never spanked as a child. Both Mr. and Mrs. Smith's parents are in the area and are reportedly supports for the family. Mrs. Smith also has a sister that helps out with babysitting Randy**.**

Know Your Rights Brochure:

Mr. and Mrs. Smith were given the Know Your Rights Brochure, and each point was explained to Mr. and Mrs. Smith. They stated they understood and had no questions pertaining to the paperwork.

Identify the Needs of the Family:

The identified need includes age appropriate discipline techniques. I will connect the family to resources that teach appropriate discipline. The family has also requested marital counseling. Referrals will be given to the family based on their insurance. I will continue to assess the needs of the family as the case progresses.

FCS Monthly Summary

Household Makeup:

The household is made up of Jenny Smith, age 22, her husband, John Smith, age 22, and their six year old son, Randy. The family lives in a one story house on 3rd Street. The family has a cat and a dog, both of which appear to be house trained and cause no health issue in the home. Jenny's sister, Jamie, occasionally spends the night at the home and is helpful in babysitting Randy. The house currently is clean and tidy. There is plenty of food in the refrigerator and cabinets. Randy has his own room and it appears appropriate for a six year old boy. No safety concerns are noted with the home at this time.

Safety Concerns:

Mrs. Smith contacted me on February 16 and was concerned that Mr. Smith spanked Randy again with a belt. I met with the family and completed a safety assessment, CD-17, and revised the Safety Plan, CD-18, to include no physical discipline. Mr. Smith was upset with regret and noted he had been tired and "just got mad". Randy is currently safe.

Parent Protective Capacities:

Mr. and Mrs. Smith have the skills to keep their child safe. They have several supports in their family as well as in the community. They appear mentally and financially stable. Mr. Smith works outside the home and provides a lifestyle that allows Mrs. Smith to stay home and take care of the house. There are no known drug or alcohol issues.

Parent's Progress towards WSA:

After an initial assessment of the family, a written service agreement was developed with Mr. and Mrs. Smith. We discussed things that could improve their knowledge of appropriate discipline and also improve their communication. Mrs. Smith noted she saw a class at the YMCA that might be helpful. I asked her to get information about the class and we could discuss if it might be good to attend. Mr. and Mrs. Smith have also spoken to their priest at church about marriage counseling. I also gave them referrals to other

marriage counselors in the area. We agreed they would make an appointment for counseling before our next home visit.

Collateral Contact:

Based on the moderate risk level, two collateral contacts are required. Mr. and Mrs. Smith noted several collateral contacts. This month the following were contacted. See actual contact in FACES for further information:

2/3/14—Phone contact with Bailey Bush, Randy's teacher. She reported Randy seemed happier and reported no concerns.

2/5/14—Phone contact with Jill Russell, Jenny's mother. She stated she had been in the home several times over this month and noted no concerns.

2/27/14—Phone contact with Sara Starr at the YMCA. The Smith's had signed up for the 123 Magic Class at the YMCA and had attended one session so far.

Court Outcome (if applicable):

There is no court involvement at this time. If the family is unsuccessful with the FCS case and safety becomes an issue for Randy, the Smith's are aware a court referral could be made.

Absent Parent Role:

Not Applicable.

Cultural Diversity of the Family:

The Smith family is made up of two parents and one six year old child, Randy. Mr. and Mrs. Smith married very young due to Mrs. Smith getting pregnant at 16 and they felt "they had to". They expressed their love for one another, but felt "tied down" at a very young age. The family reports that they practice the Catholic faith and are very involved with their local church. They are also involved with several community activities such as league bowling and the YMCA. Mr. Smith stated he learned his disciplining skills from his father, and he turned out ok, so he is having trouble understanding why his spanking Randy was inappropriate. Mrs. Smith appears to disagree with the way Mr. Smith disciplines Randy. She reports that she was never spanked as a child. Both Mr. and Mrs. Smith's parents are in the area and are reportedly supports for the family. Mrs. Smith also has a sister that helps out with babysitting Randy.

I learned this month Mr. James Smith, John's father was a strict father that never let them bend the rules. Sometimes that resulted in harsh spankings with his belt.

Case Goal (if applicable):

The goal for the Smith family is for Mr. and Mrs. Smith to learn and use appropriate discipline techniques for their six year old son. Prior forms of discipline by Mr. Smith have left bruising. Mr. Smith reports Mrs. Smith does not discipline at all. It is the goal of the case to be able to come to a compromise in discipline that is appropriate not only for Randy, but appropriate for his parents to execute in a safe manner.

Additional Information:

Due to the safety concerns this month, I will also be referring Mr. Smith to anger management counseling. He admitted he was tired and "just got mad". Randy received a referral from school. Mrs. Smith stated it was dealt with at home by taking away his Ipad for two days. Mrs. Smith reported she is pregnant again. She is about four months along. The family appears happy about the idea of another child.

Supervisor Consultation

I met with Jill Cane, Children's Service Supervisor, on February 2, 16, and 28. Updates on the case were given at each consult. The family is stable. Mrs. Smith reported she is pregnant again. We discussed the safety issue of Mr. Smith spanking Randy. Jill recommended an anger management assessment and for Mr. Smith to follow recommendations of the assessment. See contact in FACES for more detail.

Related Subject: Section 5 Chapter 1.4 Recording Guidelines - Family Assessments (Ongoing Work with Families)

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

CD07-34, CD07-38, CD09-05, CD09-128, CD11-48, CD11-86, CD13-90, CD14-21

Attachment B: AC Opening and Monthly Summary Example

AC Opening Summary

Case Open Reason:

Natalie Jones (age 9), and Anna Burke (age 5) were removed from their mother's home, Mary Jones, on January 15, 2014. The Children's Division received an assessment on January 14, 2014, alleging the children were residing in unsanitary living conditions, being locked into a room with human feces smeared through the children's bedroom. Mary refused access to the children to Children's Division and Law Enforcement. Mary was not cooperative with the investigation and Children's Division only gained access into the home through the Housing Authority. The home was found to be in disarray, severely cluttered with human feces smeared in the bedrooms, dog feces, urine throughout the home, dirty dishes with rotten food left in them, masses of flies and roaches, and foul smells. The children were taken into protective custody. Placement of the children was discussed and Natalie was placed with her father, the non-offending parent. Custody of Natalie was released at the 72 hour Protective Custody Hearing. Anna was placed in a foster home.

MSW Consultation Completed (Who/When):

MSW consultation occurred with Jill Cane, Children's Service Supervisor prior to removal. She agreed who agreed that safety could not be assured and that a recommendation for protective custody was necessary.

Initial Diligent Search

Mary Jones was asked for placement options for Anna at removal. Mary provided the Children's Division with the names of her mother, step-mother, aunt, and Natalie's father as possible placements. Due to past hotlines Joanne Wilson, Mary's mother, was not appropriate. Mary's step-mother, Carol Smith was also explored. The team did not approve her for placement as her home would not meet licensing standards because she lives in a one bedroom apartment. Jenny Wilson, Mary's aunt, was contacted for placement of Anna. She stated she was having health issues and would not be able to take placement at this time. We also explored Natalie's father as placement for April as he is not her biological father. Jim stated he was not able to take Anna. Anna's father and paternal grandparents' whereabouts are currently unknown.

Cultural Diversity of the Family

Mary is a single parent who lives with her paramour in the city housing development. Mary is unemployed at this time and has a history of only having employment for short periods of time. Mary is heavily reliant on family members and friends for her basic necessities. Mary does receive services through the Family Support Division. Family's home is suitable, but along with the disarray, it was found that Mary was behind on rent. She has until the end of the month to vacate the home.

Mary was in foster care as a child. She was brought into care due to mental instability of her mother. Her father was deceased. Mary was found in a home to be unsanitary for a child of her age. Mary was in foster care until she was age 10. She was then placed in a guardianship placement with her Aunt, Jenny Wilson, who is still a support for Mary and her children.

Natalie's father has been active in Natalie's life. She spent every other weekend with him prior to removal. She is currently placed with her father as he was found to be an appropriate placement.

Anna's father, Riley Burke, has not been active in Anna's life. He is a known felon and drug user. He also has a history with the Children's Division as a child. There were numerous reports listing him as a victim with allegations of physical abuse and drug use in the home.

Know Your Rights Brochure:

Mary was given the Know Your Rights Brochure at the 24 hour meeting. Each point was explained to her and she stated that she understood and had no questions pertaining to the paperwork. Jim Johnson, Natalie's father, was also given the Know Your Rights Brochure at the 24 hour meeting. He stated he understood the paperwork. Upon location, Mr. Burke will be give paperwork.

Indian Child Welfare Act (CD-116 and CD-123)

The Division inquired with Mary about any Indian Heritage. She reported no ancestry and completed the CD-123 (see form in file).

Identify the Needs of the Family:

The needs in the home at the time of removal were unsanitary living conditions. Mary's mental health needs also need to be evaluated as she reported she has bipolar disorder and is not on any medication at this time. Since Mary reported that she will be evicted from her home, a new residence will need to be found before it is appropriate for the children to return to her care. The children are in need of a medical exam and a developmental screening. Referrals for Section 8 housing will need to be completed and a mental health referral to the Guidance Center will need to be made.

Least Restrictive Placement Section

Natalie was placed with her biological father as he was a non-offending parent and found to be appropriate for placement. Maternal grandparents were sought for initial placement of Anna but were found to be inappropriate. The whereabouts of the paternal grandparents are currently unknown. Anna is placed in a foster home while other relative placements are being explored. I made a home visit with Anna, assured safety, and assisted her in transitioning to her new living situation.

AC Monthly Summary

Safety Concerns:

Due to the conditions of the home and the age of the children, the Division did not feel the children could safely reside in the home. For the children to safely return to Mary's home, she needs to obtain stable housing and show it is a sanitary environment for her children to reside in.

Parent Protective Capacities:

Mary has a history of mental illness and not taking medication. She reports she has bipolar disorder, but states she does not want to take medication as it "messed up" her mother and that is why she was in foster care herself. Mary has shown she is not able to function adequately while not on medication. Mary does have family support. They have supported her and the children financially. Mary does love her children and states she will work hard to get them back to her home.

Riley Burke's whereabouts are unknown at this time. He has been in prison for drug possession and distribution.

Permanency Plan/Concurrent Plan:

The case goal for Anna is reunification with her mother, Mary. The concurrent plan is guardianship with Mary's aunt, Jenny Wilson.

Parent's Progress Toward WSA:

After initial assessment of the family, Mary signed a written service agreement on February 2, 2014. Mary agreed to a mental health assessment and the appointment is scheduled for February 15, 2014. She has filled out Section 8 referrals and is waiting to hear back where she is on the waiting list. She is currently living with her aunt, Jenny Wilson while waiting on housing. She is no longer with her paramour and says she is focused on her own health and getting her children to return to her care.

Visitation Plan:

Mary has visitation with Anna three times a week at House for Hope. The visits are supervised by a House of Hope employee. The visits are appropriate and going well. Mary brings a game to each visit. Anna and Mary play the game during the visit and talk about their day.

Parent/Child Visits:

Visits were held at House of Hope on Monday, Wednesday and Friday each week during the month of February. Stacy Horn from House of Hope reported that these visits went well and Mary was active in taking care of the Anna's needs. Anna appeared happy to

see her mother upon arrival and upset upon departure. No concerns noted with the visits at this time.

Sibling Visits:

Anna has weekly visits with Natalie once a week at the home of Jim Jones.

Worker Visit with Parent:

Visits were held in Mary's home on February 7, 10, and 27, 2014. During the home visits this month the family assessment process (NCFAS G+R) was initiated. Mary and I completed the Genogram CD14G, and Culturagram CD14F

Attempts to contact Riley Burke were made to his last known address on February 4 and 24, 2014. He is reportedly "in and out", but the tenants did not know when he would return. Attempts will be made again next month.

Type of Placement of Why:

Anna is placed in a traditional foster home. Relative placement is being sought through a home study with Jenny Wilson. Mary currently lives with Ms. Jones, so placement of Anna will not be approved until Jenny acquires housing outside of Ms. Jones' home**.**

Sibling Separation:

N/A

Child's Health/Medical/Dental/HCY:

Health: The initial health exam was completed at Mercy Clinic on January 16, 2014, within 24 hours of placement. No concerns were noted at that time. A comprehensive medical exam was conducted on February 26, 2014.

Medical/HCY: Prior medical reports were requested from Mercy Hospital. See file for medical records. The HCY exam forms were also included in medical records obtained from Mercy. Their primary care physician is Dr. S. Cooper.

Dental: A dental appointment has been scheduled for Anna on March 15, 2014 at the Small Smiles Dental Clinic.

Child's Education:

Anna attends kindergarten at Benton Elementary. She is slightly behind but is making improvements. She does not have an IEP at this time, but her teacher said they would like to explore that possibility in a couple of months, depending on her progress.

FST/PPRT Meetings:

There have been three meetings in the month of February; Mary has been in attendance at all three meetings. Relatives and other placement options were discussed at each meeting. Updates about Anna's health and well-being were provided to the team during the meetings A Written Service Agreement was developed with Mary and updates provided about her progress during the meetings.

.24 hour meeting: February 2, 2014
72 hour: February 4, 2014
30 day meeting: February 28, 2014.

Court Outcome:

The protective custody hearing was held on January 18, 2014. The court ordered the children to remain in the Children's Division's custody for appropriate placement. The adjudication hearing scheduled for March 5, 2014.

On-going Diligent/Parent/Extended Family Search Efforts:

On February 26, 2014, CD learned Mr. Burke, Anna's father, had been arrested for possession of cocaine and was at the County Jail. Maternal and paternal grandparents have been located, but have not been approved for placement. The maternal grandmother, Joanne Wilson, has asked for visitation with the girls and this will be discussed at the next FST. The maternal aunt, Jenny Wilson, is being explored as a relative placement provider for Anna. Mary also mentioned a cousin, Sophia Rogers that could be an option for placement. Further information will be gathered on Mrs. Rogers. After speaking with Mr. Burke's mother, Penny Lane, she stated they have family in New York that would be appropriate for placement if necessary. Further information will be requested from them if needed.

Absent Parent Role:

Mr. Burke is currently at the County Jail. His mother, Penny Lane, noted he is aware Anna is in custody and he wants her "out of foster care". Mr. Burke has not contacted the Division nor sought information about his daughter from the court. I will schedule a meeting with him at the jail.

Incarcerated Parent Contact:

Mr. Burke was sent the Notice to Incarcerated Parent, CS-2 on February 28, 2014 at the county jail. I noted I will follow up with him in person on March 2, 2014 at the county jail.

Cultural Diversity:

Mary is a single parent who had lived with her paramour in the city housing development. Mary is unemployed at this time and has a history of only having employment for short periods of time. Mary is heavily reliant on family members and

friends for her basic necessities. Mary does receive services through the Family Support Division. Mary is now living with her aunt, Jenny Wilson, and still relies heavily on Ms. Wilson for money and food. Mary is currently on the Section 8 waiting list.

Mary was in foster care as a child. She was brought into care due to mental instability of her mother. Her father was deceased. Mary was found in a home to be unsanitary for a child of her age. Mary was in foster care until she was age 10. She was then placed in a guardianship placement with her Aunt, Jenny Wilson, who is still a support for Mary and her children.

During the assessment process, it was found that Mary's biological father left the family when Mary was three years old. Since that time, he has been in and out of her mother's life. They would always get into fights and he would leave soon after. Mary remembers always being very sad when he left and wished for a father figure. She also noted remembering her father hitting her mother when they fought.

Anna's father, Riley Burke, has not been active in the children's life and is a known felon and drug user. He also has a history with the Children's Division as a child. There were numerous reports listing him as a victim with allegations of physical abuse and drug use in the home.

Additional Information:

No additional information to report for this month.

Supervisor Consultation:

I met with Jill Cane, Children's Service Supervisor, on February 2, 16, and 28. Updates on the case were given at each consult. Mary had an appointment for a mental assessment on February 15. Jill asked that I get a release of information signed by Mary and obtain a copy of the assessment before the adjudication hearing.

Related Subject: Section 5 Chapter 1.4 Recording Guidelines - Family Assessments (Ongoing Work with Families)

Chapter Memoranda History: (prior to 01-31-07)

CS03-51, CD04-45, CD04-79, CD05-72, CD06-15, CD06-60

Memoranda History:

CD07-34, CD07-38, CD09-05, CD09-128, CD11-48, CD11-86, CD13-90, CD14-21