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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **Initial Adoption Transfer Summary** | |  |
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| Case Opening (LS1) Date: |
| Name(s) of Child(ren) and DCN (s): | | | |
| Name(s) of Adoptive Parent(s) and DVN(s): | | | |
| 1. What brought the child into care? Were there preponderance-of-evidence findings of abuse/neglect that occurred? (Do not include any identifying information regarding the birth parents/relatives). | | | |
| 1. When was the case goal changed to adoption? When was the adoptive family chosen for placement? (Include the date of the goal change and the date of the staffing and the date the family was selected). | | | |
| 1. How many families were interviewed during the adoption staffing process? Were the current placement providers invited to participate in the staffing if they were not being staffed? | | | |
| 1. If there are siblings, what is the visitation plan with siblings and where are the siblings placed? | | | |
| 1. How was child prepared for adoption? | | | |
| 1. When were home visits conducted with the child and adoptive family? (List dates from the date of adoption staffing through the date you are transferring the record.) (For adoptive families who already had the child placed with them prior to the adoption staffing, visits are supposed to occur one time per month until transfer of custody. For new placements, visits are to occur weekly for the first month, then monthly until transfer of custody). | | | |
| 1. On what date did the adoptive parent/s review the child’s record, if applicable? | | | |
| 1. Are there any open Service Authorizations that are not providing current services for the child? If so, please close and document.  Yes  No | | | |
| 1. What services (i.e. daycare) does the family plan to continue after the adoption? Please list the providers, DVN and frequency of use. | | | |
| 1. Does the child have any medical, emotional, and/or developmental needs? (Please list the current service providers) | | | |
| 1. Did the biological parents have a psychological evaluation? If so, please include a summary of their evaluation in this section including any diagnosis made and information about their behaviors that might be important for the future care of the child. If not, please document the reason (i.e. “The biological mother refused to complete and evaluation”, etc.).   Please document for BOTH parents, even if parent is unknown (i.e. “The biological father is unknown, therefore an evaluation was not completed”, etc.). | | | |
| 1. Describe any non-identifying medical information regarding the birth parents (i.e., “Birth parents/relatives have Type 2 diabetes.”). Please document for BOTH parents, even if parent is unknown (i.e. “The biological father is unknown, therefore no medical history is available”, etc.). | | | |
| Case Manager | | Date | |
| Children’s Services Supervisor | | Date | |