

State of New Jersey
 DEPARTMENT OF CHILDREN AND FAMILIES
 Division of Child Protection and Permanency

FAMILY SUMMARY/ CASE PLAN

Case Name:	Case ID:	Case Plan Date:	Local Office:
Primary Worker:	Supervisor:	Developed By:	
Case Plan developed with		Case in litigation: <input type="checkbox"/> Yes <input type="checkbox"/> No	

HOUSEHOLD COMPOSITION

PARTICIPANT NAME	DOB	GENDER	TYPE OF PLACEMENT	PLACEMENT AUTHORITY	REPEAT PLACEMENT	LFBC

FAMILY RELATIONSHIPS

PARTICIPANT NAME	DOB	RELATIONSHIP	TO PARTICIPANT NAME	DOB

CASE GOALS

Participant Name:				DOB:			
Case Goal:							
Goal Effective Date:		New Goal:		Anticipated Goal Achievement Date:		Goal Achieved Date:	
Concurrent Goal:							
Goal Effective Date:		New Goal:		Anticipated Goal Achievement Date:		Goal Achieved Date:	

FAMILY SUMMARY

1. DESCRIBE CURRENT DCP&P INVOLVEMENT

State the current reasons for DCP&P involvement. Include the family's perception and expected outcomes. Discuss safety and risk factors as follows:

For In-Home Child(ren), include safety and risk factors identified, including those identified by the SDM tools.

For Out-Of-Home Child(ren), discuss safety and risk factors that led to placement. Include efforts made to prevent placement. Describe placement circumstances.

2. DESCRIBE DCP&P HISTORY

State reasons for prior involvement, number and findings of CPS reports, number of CWS referrals, length/dates of involvement, dispositions, and any services provided including placements.

3. FAMILY STORY AND SIGNIFICANT EVENTS

Summarize the family's view of their history.

4. HOW HAVE THE FAMILY, DCP&P, AND OTHERS WORKED TOWARD GOAL ACHIEVEMENT FOR THE FAMILY/CHILD?

Discuss the progress to date. Identify obstacles to goal achievement/barriers to service delivery and how adjustments were made to address the family's needs. Describe services/activities offered, used, provided or engaged in to advance or facilitate movement toward the goal. State if any service is court ordered. Discuss the pattern of visitation. Address relative and community supports available to, or needed by, family from whom child was removed.

For the Out-Of-Home Child(ren), all information relates to the family from whom the child was removed.

5. CHILD/FAMILY CHARACTERISTICS AND FUNCTIONING

For In-Home and Out-Of-Home Child(ren), identify needs of each family member. Address education/employment/health issues/life skills and daily living issues; include how they impact on the well-being of the child. State the views of the child, parent(s) or legal guardian(s), and identify any issues pertaining to the case plan.

For Out-Of-Home Child(ren), include an assessment of the safety and appropriateness of current placement and the plan to assure that child receives safe and appropriate care. Discuss child's adjustment to placement, and resource family's commitment to the child. Include the views of the placement provider(s). Discuss how the placement is consistent with the child's needs. If child has special needs, address how those needs are being met.

6. DESCRIBE REASONABLE EFFORTS TO ACHIEVE REUNIFICATION OR OTHER PERMANENCY GOAL

For Out-Of-Home Child(ren) only, include plan for meeting permanency goal time frame. If case goal is adoption or KLG, document steps to finalize placement including child specific recruitment efforts, if appropriate. Describe efforts made to find missing mother and father or relative(s), including status and time frame of search efforts. Indicate how paternity is being resolved, if applicable. Is the child in a licensed resource home? If the home meets presumptive eligibility requirements, indicate status of the Home Study, state if the home is licensed. If KLG is the goal, has the home been licensed for at least six months?

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IN-PERSON VISITATION SCHEDULE

(MVR – Minimum Visitation Requirement as determined by using the SDM Assessment)

Child Name:		MVR Schedule:	
Parent/Caregiver Name:		MVR Schedule:	
Collateral(s)		MVR Schedule:	

CURRENT PLACEMENT INFORMATION					
Child Name:		Child DOB:			
Date of placement:		Type of placement:	<input type="checkbox"/> Licensed	<input type="checkbox"/> Pending	
Name of current placement:					
Physical address of placement:					
Phone 1:		Phone 2:		Fax:	
Is the current placement safe and appropriate based on assessment tools?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Describe why?					
<input type="checkbox"/> The child's placement is the least restrictive setting and is the closest placement to the parent's home, given availability and the child's needs. The current placement is in the best interest of the child and the most family-like setting available. Explain:					
<input type="checkbox"/> No setting available in close proximity to the parent's home that could respond to all the issues and needs that are part of this placement. Reason:					
Are all siblings that are in out-of-home placement placed together?					
If no, name the child(ren) not placed together, explain why; include attempts to place siblings together:					

CHILD PLACEMENT REVIEW INFORMATION					
Child Name:		Child DOB:			
Date of removal:		Authority for placement:			
Child Placement Review Date:		Internal placement review Date:		CPRB/Court Permanency Hearing Date:	
Docket Numbers:					
Current Legal Status:			Date order signed:		
The next CPR or Internal Placement Review will be held:					

ADOPTION AND SAFE FAMILIES ACT (ASFA) TERMINATION OF PARENTAL RIGHTS (TPR) INFORMATION					
Child Name:		Child DOB:			
Has the child been out of his or her home 15 of the most recent 22 months?					
Has the court made a finding that either reasonable efforts to prevent placement were made or were not required?			Date:		
Has the court made a finding that either reasonable efforts to safely return the child to his or her home were made or were not required?			Date:		
Date TPR Filed:					
Reason why TPR is not being pursued at 15 of 22 months:					
<input type="checkbox"/> Child is placed with a fit and willing relative:					
<input type="checkbox"/> Compelling reason why TPR is not in the child's best interest:					

<input type="checkbox"/>	Reasonable efforts to safely return the child to his or her home have not been made:		
Legal result/ASFA exception:		Date:	

KINSHIP LEGAL GUARDIAN INFORMATION

Child Name:		Child DOB:	
1. Discuss why a permanent placement with the kin caregiver and KLG finalization is in the child's best interest.			
2. Discuss the child's attachment to the kin caregiver. If child is age 14 or older, document that discussions were held with the child about KLG and the child's feelings about the KLG arrangement.			
3. Discuss kin caregiver's attachment to the child and his or her commitment to care permanently for the child.			
4. Describe steps taken to determine that reunification or adoption is not appropriate or feasible.			
5. Document your discussion with the child's kin caretaker about adoption and KLG, including why caregiver believes adoption is not an option. Include results of discussions with parents about KLG. If mother or father is missing, discuss the efforts to locate them. Include your efforts to discuss KLG with the parents or the reasons why the efforts were not made. Include reference to provision of DCP&P Form 4-18, Fact Sheet - Differences Between Adoption and KLG, Acknowledgement Receipt to kinship caregiver.			
6. Document that the child was removed from his or her home as a result of a judicial determination that continuation in the home would be contrary to his or her welfare.			
7. Document that the child has been placed with the kin caregiver for at least 12 consecutive months or 15 of the last 22 months, with the kin caregiver being a licensed resource parent for the last six consecutive months prior to the KLG court order being awarded.			
8. At the time KLG is approved as the primary case goal, discuss if the child is part of a sibling group and whether or not the siblings are placed together. If not, why not? Discuss visits or contacts that the siblings will have with each other, if they are not placed together.			
9. If the child is under the age of 12, note Area Director's approval of KLG as an appropriate case goal.			

INDEPENDENT LIVING INFORMATION

Child Name:		Child DOB:	
<input type="checkbox"/>	Independent Living Skills Assessment completed	Date Completed:	
<input type="checkbox"/>	Transitional Plan for Adolescents (DCP&P Form 5-43) completed	Last Update:	
<input type="checkbox"/>	Adolescent is 14 years of age or older and is currently receiving Independent Living services/training		
<input type="checkbox"/>	Adolescent is 16 years of age or older and in an Independent Living placement		
Summarize goals and progress of youth to date:			
Independent Living Services/Transitional Services:			
Describe:			

EDUCATIONAL INFORMATION

Child Name:				Child DOB:	
Name of previous school attended:					
Previous School Address:					Phone Number:
Name of Current School:					
Address of Current School:				Phone Number:	
Current School Type:					
Grade:			Special Placement, if any:		
School Performance:					
School attendance problems?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please explain:	
Classification:					
Date of last Child Study Team Evaluation:				Date of Current IEP:	<input type="checkbox"/> Copy of IEP in Record
Is a Best Interest Determination required for this placement?					
Is child placed in a therapeutic foster home or group home?					
Best Interest factor(s) used to justify school placement decision:					
Did the child remain in the school of origin he/she attended prior to entering Resource Home Placement?			Date of Enrollment:		
If this is a change in placement, will the child continue to attend current school?					
Is this Court ordered?					
Is the child unable to attend school on a full time basis due to a documented medical condition?					
If yes, explain why:					

FAMILY AGREEMENT			
A discussion with the family on what needs to be done to accomplish desired outcomes took place on:			
Agreement developed at Family Team Meeting?			
Participants:			
Other Relatives/Kin:			
Facilitator/Co-Facilitator:		Location:	
The Team identified the strengths of the individual family members. The following strengths were identified:			
Outcome			
This is one of the things that I (we) agree is an identified need:			
In the space below identify the tasks, who will be doing each task, and the date by which each task will be completed			
Task / Who / When			
Task / Who / When			
Task / Who / When			
Shared View: What will success look like when this outcome is achieved?			
Describe what could go wrong:			
This Plan will be reviewed at our next child and family meeting, which we have agreed will occur on:			

VISITATION PLAN

Visitation Plan:			Period Covered:		to	Date of first visit:
Visit Participants Case Members:				Other Relatives/Kin:		
Visitation Details						
Visit Frequency, Length, and Location:						
Special Instruction / Visit Parameters:						
Transportation/Supervision Arrangements:						
Visitation Change / Cancellation Procedure:						
Focus of Visit:						

ATTACHMENTS

- DCP&P Form 11-10, Health Passport and Placement Assessment, is attached (for each parent, resource parent and congregate care provider only).
- DCP&P Form 26-87, Desired Family Outcomes and Specific Activities, is attached.
- DCP&P Form 5-16, Child's Education Record, is attached.
- If child is placed out-of-state, attach the most recent report from the out-of-state agency. Report must address visits to the home or facility by the out-of-state agency.

My signature indicates that I participated in the development of this case plan.

Worker Name:
Worker Signature: _____ **Date Signed:** _____

Supervisor Name:
Supervisor Signature: _____ **Date Signed:** _____

Parent/Guardian Name:
Signature: _____ **Date Signed:** _____

Parent/Guardian Name:
Signature: _____ **Date Signed:** _____

Child Name:
Signature: _____ **Date Signed:** _____

Child Name:
Signature: _____ **Date Signed:** _____

Caregiver Name:
Caregiver Signature: _____ **Date Signed:** _____

Caregiver Name:
Caregiver Signature: _____ **Date Signed:** _____

Family Member Name/Relationship:
Signature: _____ **Date Signed:** _____

Out-of-Home Placement Provider Name:
Signature: _____ **Date Signed:** _____

Third Party Representative Name:
Signature: _____ **Date Signed:** _____

Other Name/Relationship:
Signature: _____ **Date Signed:** _____

Other Name/Relationship:
Signature: _____ **Date Signed:** _____

Other Name/Relationship:
Signature: _____ **Date Signed:** _____

**NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES
 FORM FOR EMERGENCY ASSISTANCE**

I. Request and Agreement (Completed by Applicant)

I request and agree to receive for myself and my family the following Title IV-A Emergency Assistance (EA) services from the N.J. Department of Children and Families, Division of Child Protection and Permanency case management; information; referral; assessment; education services; health and behavioral /mental health services (not covered by Medicaid); transportation; shelter; child care; referral for legal services; family preservation services; juvenile/family crisis services; day and residential treatment services (including assessment, therapy and aftercare); resource family care (except where provided by Title IV-E); homemaker services; and/or respite care.

Child's Name	Child in Open Placement

a) I am receiving TANF. Yes No
 -OR-

According to the Family Size Per Year Income scale, my income is at or less than 200% of the 1989 State median income for my family's size Yes No

-OR-

I have been advised of the costs of the care and services required but do not have cash immediately available to purchase them. Yes No

b) The child(ren) for whom this service is requested resided with me within the last 6 months. Yes No

INCOME CHART	
Family Size	Per Year Income 200% 1989 State Median
1	\$ 54,078
2	79,714
3	87,354
4	103,990
5	120,630
6	137,270
7	140,386
8	143,510
<i>Add \$3,120 for each additional family member.</i>	

 Parent/guardian name (print)

 Parent/guardian signature

 Date

 Parent/guardian name (print)

 Parent/guardian signature

 Date

