NEW JERSEY DEPARTMENT OF
CHILDREN AND FAMILIES

Temporary Emergency Home Assessment Form

Name(s) of Child(ren) for Placement* Sending State

1.
2.
3.
4.
5.

** For this data field and all other fields, please attach information in a separate document if the field does not provide sufficient space.*

Dates of Phone Contacts

Dates of Home Visits

CROSS-JURISDICTIONAL RESOURCE INFORMATION

Name:

Home Phone Number(s):

Work Phone Number(s):

Marital Status Single Married Living With

Employer Name: Employer Phone:

Employer Address:

Resource's Net Monthly Income: (Please provide proof of income as an attachment)

Number of Household Members

Name(s) of Household Member(s)	Relationship to Resource	Is Household Member in Favor of Placement?
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No

Agreement by and Among the State of New York Office of Children and Family Services, the City of New York Administration for Children's Services, and the State of New Jersey Department of Children and Families for Temporary Emergency Placements.

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Resource's Reasons for Wanting to Care for Child(ren)

How Resource Learned About Need for Temporary Emergency Placement

Does Resource Indicate Understanding of the Situation Giving Rise to Temporary Emergency Placement Request
Yes No

Resource's Ability to Protect Child(ren) from Risk Factors

Resource's Child Care Plans

Forms of Discipline to be Used by Resource

Resource's Plan for Providing Financially for Self and Child(ren)

Sending State's Financial and Medical Plan Pending Full Home Study

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LOCAL CHILD ABUSE REGISTRY CHECK, LOCAL CRIMINAL BACKGROUND CHECK AND OTHER CLEARANCES

Name of Individual	Clearance Type	Date	Results

HEALTH

Do the Resource and (if applicable) all adult members of Resource's household state they and the children living in the home (if applicable) are in good basic health and free of communicable diseases?

Yes No

If "no," please explain

Home Environment and Housekeeping Standards (Description)

Sleeping Arrangements (Description)

Any Area(s) of Concern

Description of Neighborhood

Proximity of School

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Proximity of Medical Services

Proximity of Social Activities

Proposed Changes to Sending State's Case Plan, if Any

Recommendation

Approval Deferral

Explanation of Recommendation

List any Conditions Required of the Sending State Prior to Placement

Name of Case Worker / Case Planner

Phone Number Email Address

Name of Supervisor

Supervisor's Phone Number Supervisor's Email Address

Signature of Case Worker / Case Planner ______________________ Date

Signature of Case Worker / Case Planner Supervisor ______________________ Date