

Permanency Plan for Child in DCF Custody  
 Administrative Requirements

This form may be filled out prior to the case planning conference.

<b>Child's Name:</b>		<b>FACTS Case</b>
<b>Section 1</b>		
Previous Case Planning Conference Dates From:		To: <input type="text"/>
This Case Plan Effective Dates:		To: <input type="text"/>
If the Permanency Goal Changed, State Reason: <input type="text"/>		
List all siblings, including full/half, step, adopted, etc.:	<input type="text"/>	
List all siblings in DCF custody.:	<input type="text"/>	
<b>Section 2 For DCF Use Only</b>		
Candidacy of Care Determination: (For children in DCF custody placed at home.)		
Absent the provision of services listed in the case plan to assure the safety and well-being of the child, the child will be determined to be at imminent risk of removal from the home and therefore, a Candidate for Care.		
<input type="checkbox"/> Candidate for Care	Reason for Imminent Risk of Removal: <input type="text"/>	
<input type="checkbox"/> Non-Candidate for Care		
_____ DCF CPS Specialist Signature		_____ Date
<b>Section 3</b>		
Information will be shared with case plan participant at each case planning conference and any changes noted.		
Child's Information:		
Primary Health Provider:	<input type="text"/>	
Address:	<input type="text"/>	
Dentist:	<input type="text"/>	
Address:	<input type="text"/>	
Optometrist:	<input type="text"/>	
Address:	<input type="text"/>	
Mental Health Provider:	<input type="text"/>	
Address:	<input type="text"/>	
Other Health Provider	<input type="text"/>	
Address:	<input type="text"/>	
Educational Advocate:	<input type="text"/>	
Address:	<input type="text"/>	
KBH Screening is Current <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Last KBH: <input type="text"/>		
Diagnosis/Disabilities (See Appendix 1J)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Conducted <input type="checkbox"/> Not Yet Determined
If Yes, Documentation Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Documentation Received <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Diagnosed	<input type="text"/>	Disability Codes <input type="text"/>
Is child on an HCBS Waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
If Applicable, Types of HCBS Waiver	<input type="checkbox"/> I/DD <input type="checkbox"/> SED	<input type="checkbox"/> TBI <input type="checkbox"/> TA <input type="checkbox"/> Autism
SSI Referral to KLS <input type="checkbox"/> Yes <input type="checkbox"/> No If no, documented reason: <input type="text"/>		
At the time of the case plan, is the father incarcerated? (JA02N) <input type="checkbox"/> Yes <input type="checkbox"/> No		

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At the time of the case plan, is the mother incarcerated? (JA01N)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child adjudicated a Juvenile Offender?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: <input type="text"/>
Is the foster youth pregnant? (FC01N)	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA
Is the foster youth parenting a child who is in DCF custody? (FC02N)	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA
Is the foster youth parenting a child who is not in DCF custody? (FC03N)	<input type="checkbox"/> Yes <input type="checkbox"/> No/NA

