

Division of Children and Family Services Protection and Safety Procedure Update #34-2016	
Regarding:	Ongoing Case Management
Rescinds:	#22-2016- Ongoing Case Management
Date Effective:	9/23/16
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Philosophy

The Division of Children and Family Services (DCFS) believes that families should be respected and valued. The family should lead and be an active part of the team that works toward ensuring their child’s safety, permanency, educational, mental health, physical and well-being needs are met. The overarching responsibility for the CFS Specialist is management of safety and risk factors of children and families involved with DCFS because of abuse, neglect, or dependency; the well-being of children in the custody of the agency and their siblings; and permanency for children for whom DCFS is responsible. This includes:

1. Providing for child safety and reducing risk of harm;
2. Establishing goals that address the reason for DCFS involvement, identifying the unmet needs that keep the family from achieving the goals, and developing strength based strategies to address the unmet needs;
3. Assisting families in identifying and accessing informal and formal supports and resources;
4. Increasing family self-sufficiency;
5. Empowering the family;
6. Promoting timely reunification when appropriate; and
7. Providing permanency for children for whom reunification or family preservation is not possible.

Procedure:

I. ONGOING CASE MANAGEMENT OVERVIEW

- A. At the conclusion of the initial assessment, the CFS Specialist determines if ongoing services should be offered to the family based on the safety and risk assessments. If courts are involved, ongoing case management will be provided. If courts are not involved, case opening for ongoing case management will be based on the results of the safety and risk or prevention assessment. A CFS Specialist will be assigned an ongoing case and assume case management activities.
- B. The CFS Specialist will work with the family and the Family Team to maintain the child in the home whenever it is safe to do so. It may be determined that a child can remain in the home with safety services. If it is determined that the child is not safe in the home, Law Enforcement may remove the child in an emergency or a court of competent jurisdiction can order a removal from the home. If the child is removed, the CFS

Specialist will make all efforts to reunify the child as soon as it is determined that the child can be safe in the home. In abuse, neglect, dependency cases and cases adjudicated as 3(c) Mentally Ill and Dangerous, the CFS Specialist will utilize the Structured Decision Making (SDM®) Reunification Assessment to determine if reunification should be recommended. A court of competent jurisdiction can also order that reunification occur.

- C. The decision on recommending case closure in abuse, neglect, dependency cases and cases where the youth is adjudicated as Mentally Ill and Dangerous is based on information gathered for the SDM® Risk Reassessment and the assessment of child safety. Family progress will be evaluated at Family Team meetings.

II. ONGOING SERVICES

- A. Families served through ongoing services: Ongoing services will be offered to all families where the children are determined to be:
 - 1. Unsafe;
 - 2. Conditionally safe;
 - 3. At high or very high risk for future maltreatment of their children; or
 - 4. In need of services and a court of competent jurisdiction has placed the child in the custody of the Department. This includes youth adjudicated as a 3(c) Mentally Ill and Dangerous.
- B. **Review available information:** The CFS Specialist assigned to the case will thoroughly review information gathered during the Initial Assessment and during ongoing case management. The review of the history will be conducted by the CFS Specialist on all new cases and whenever a case is reassigned or transferred to a new case manager. It is critical that all previous reports and information be analyzed and taken into consideration. The history of the family is important because it provides critical information on the pattern of behaviors and provides indicators of past trauma that may impact the parent's ability to safely parent their child.
- C. **Court Involved or Non-Court Involved:** Families may work with DHHS without the involvement of the court or DHHS's involvement may be mandated by the court. All cases will remain open until the safety threats have been mitigated. Cases will remain open until the risk level has reduced to the point that the likelihood of future maltreatment is low to moderate or based on supervisory consultation. No case will be closed if the child is determined to be unsafe.
- D. **Court Involved Cases:**
 - 1. Families whose children are placed in the care and custody of the Department are considered court involved with DCFS. A court involved case cannot be closed as long as the child is in the legal care and custody of DHHS pursuant to a court order.
 - a) If the risk level is high or very high **and** the family is working with the Department **and** the CFS Specialist no longer sees a need for on-going court involvement, the CFS Specialist may ask the court to dismiss the court case and continue working with the family on a non-court involved basis. The Court must approve this request and issue an order discharging the child from the legal care and custody of DHHS.
 - b) If the child is safe and risk is low or moderate the CFS Specialist will ask the court to dismiss the case.
- E. **Non-Court Involved Cases**
 - 1. Non-court involved cases require that the family voluntarily agrees to work with

DCFS on the identified safety and risk issues.

2. Non-court involved cases must be provided the same access to services as court involved cases.
3. Non-court involved cases may move to be court involved if the family's situation changes to such a degree that child safety cannot be maintained in the home or the family is not making sufficient progress in remedying child safety concerns and risk of harm. The CFS Specialist will consult with his/her supervisor to determine if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention. This is a mandatory consultation point.
4. In cases where there is no identified safety threats but there is high or very high risk and the family refuses to work with DCFS, the CFS Specialist will consult with his/her supervisor to determine if DCFS should make a referral for a Child Abuse and Neglect Investigative or Treatment Team to review or if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention. This is a mandatory consultation point.

III. ENGAGING FAMILIES WITH SERVICES:

- A. The CFS Specialist will make efforts to engage the family and offer interventions prior to requesting the County Attorney to file a petition.
- B. When a CFS Specialist has made efforts to engage a family in services and the family refuses to actively participate or their participation is such that child safety or risk cannot be managed the CFS Specialist will consult with his or her supervisor to determine if a request to file should be prepared and forwarded to the County Attorney's office.
- C. Despite the parent's engagement with services, a request to file must be sent to the county attorney when the CFS Specialist has information the parent/custodian has been using methamphetamine.
- D. If a safety threat is identified during an assessment or the family's risk level is high or very high and the evidence leading to those decisions is based on one of the situations listed below. A request to file should be based on:
 1. The presence of any safety threat(s) and the family is unwilling to engage in interventions.
 2. There are no safety threat(s), but the family's risk level is high or very high and the evidence leading to those decisions is based on one of the situations listed below. A mandatory staffing with a supervisor is required to determine whether a request to file should be forwarded to the County Attorney's office. These include:
 - a) Domestic Violence;
 - b) Previous Termination of Parental Rights;
 - c) Serious Physical Abuse (e.g. head trauma, broken bones, multiple injuries); or
 - d) Sexual Abuse by a Parent.
- E. There are no safety threat(s), but the family's risk level is high or very high and the family is unwilling to engage in interventions the CFS Specialist will consult with his or her supervisor to determine next steps.
- F. The CFS Specialist is encouraged to involve the Investigative and/or Ongoing (LB1184) Team in discussion of all cases in which the family's risk level is high or very high and the family is unwilling to engage in interventions.

IV. ONGOING RESPONSIBILITIES OF THE CFS SPECIALIST:

- A. The CFS Specialist will work collaboratively with the family, the Family Team, supervisors and other relevant persons involved with the family in order to:
1. Ensure safety of the child;
 2. Establish and implement safety plans;
 3. Assist the family in identifying and accessing informal and formal supports and resources;
 4. Establish and implement the case plan;
 5. Work toward timely permanency for the child;
 6. Ensure child well-being (education and physical/mental health); and
 7. Plan for transition and discharge from CFS intervention.

V. ONGOING ASSESSMENTS-

- A. Ongoing assessment of the family will be conducted regularly to provide information as to the progress the family is making toward goal achievement. Assessments include:
1. SDM® Family Strengths and Needs Assessment (FSNA)(all court and non-court cases: abuse/neglect; dependency; 3(c)). (Conducted at least every 6 months)
 2. SDM® Risk Reassessment of In-Home Cases (Conducted at least every 90 days); and
 3. SDM® Reunification Assessment for families with children placed out of the home. (Conducted at least every 90 days.)

VI. SDM® SAFETY ASSESSMENTS AND SAFETY PLANNING.

- A. The ongoing CFS Specialist is always be assessing for safety. The on-going CFS Specialist is responsible to assess for child safety and update the safety plan as often as needed based on the family's circumstances.
- B. If a subsequent report of abuse or neglect is reported to the Hotline, the Initial Assessment process will be implemented as described in the Initial Assessment Section. A new safety and risk assessment will be completed.

VII. SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT

- A. The CFS Specialist will complete the FSNA with the family. The purpose of the FSNA is to add to information gathered during the initial safety and risk or prevention assessments in order to identify safety related needs and strength based strategies so that a case plan can be developed. Using information gathered for the FSNA, case plan goals, strategies and services can be designed to effectively address the areas that directly impact child safety and risk of future harm for each family. The FSNA also addresses the well-being of every child in the family.
- B. The CFS Specialist will conduct a FSNA on every open case and closed cases in the aftercare system.
1. Each parent in a two parent household is assessed and scored separately.
 2. The child assessment portion is completed for each child who will be included in the case plan.
 - a) For non-court involved cases this includes all children in the household. For court involved cases, this includes siblings of wards.
 - b) If caregivers are no longer involved in the case plan, only the child assessment is required.

- C. Timeframe:
1. In order to complete the case plan within 60 days from case opening or initial placement in out-of-home care (whichever is earliest), the Family Strengths and Needs Assessment should begin within 7 calendar days of assignment or the completion of the initial assessment if the case is not transferred to a second CFS Specialist. Multiple contacts with the family may be necessary to gather sufficient information.
 2. The CFS Specialist will complete the initial FSNA prior to initial case plan development. The FSNA must be completed within 30 days after completion of the Risk or Prevention Assessment. (This includes cases transferred to another CFS Specialist for ongoing case management.)
 3. For all Child Abuse/Neglect, Dependency or 3(c) cases the initial FSNA and Case Plan will be completed within 60 days of the Intake being Accepted for Assessment.
- D. The CFS Specialist should review the caregiver and child domains and definitions of the FSNA. The CFS Specialist will notice that there are item areas they are already assessing. Once the CFS Specialist is familiar with the items that must be assessed to completed the FSNA, the CFS Specialist will complete the FSNA using good social work practice to collect information from the child, caregiver, and/or collateral sources.
- E. Reassessment of the FSNA occurs a minimum of every 6 months. The strengths and needs can be reassessed more frequently if necessary to coordinate with the dispositional review.
- F. Documentation: The FSNA will be documented on N-FOCUS within 30 days of case assignment to ongoing, but no later than 60 calendar days of the initial custody date. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the reunification assessment regardless of the final determination. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding decisions on each of the items.

VIII. COMPLETION OF THE FSNA

- A. For each category, there are four possible responses:
1. "a" This is a strength response. A caregiver/child with a response of "a" has exceptional skills or resources in this area. This is an enhanced capacity.
 2. "b" This is an "average" or adequate functioning response. This response is also used to score children who are too young to assess in some categories. A caregiver/child with a response of "b" has not achieved the exceptional skills or resources reflected by a response of "a" and may experience a degree of stress or struggle common to daily functioning, but is generally functioning well in the area. These responses are considered potential strengths, with the exception of children who are scored "b" in some categories because they are too young to assess. For example, an infant may be scored a "b" for delinquency because he or she is too young to be assessed in this area, but it should not be selected as a strength for case-planning purposes. This is a neutral capacity.
 3. "c" A caregiver/child is experiencing increased need in this domain. This is a diminished capacity.
 4. "d" A caregiver/child is experiencing extraordinary need in this domain. This is a diminished capacity.
- B. Completion of the FSNA requires gathering information from all family members,

collaterals, and a review of records. It may be completed or modified during the course of family meetings. The CFS Specialist must be aware of culturally specific interpretation of appearances and must engage the family in culturally appropriate ways to make an accurate assessment. When it is difficult to distinguish between responses, additional assessments may be helpful (e.g., psychological, developmental, substance use assessment), particularly if the difference between one rating and another is likely to impact the identification and selection of priority needs.

When scoring, consider the entire scope of available information, including the family's perspective, information from collateral sources, existing records and documents, and worker observations. Often, different sources will suggest different responses (e.g., father states he has no problem with alcohol, but has two DUIs in the last year; mother states she believes he is an alcoholic; a court-ordered chemical dependency evaluation suggests alcohol dependency; father's brother states father has no problem with alcohol). The worker must make a determination based on social work assessment skills, taking into account the merits of each perspective. The household is assessed by completing all the items. If there are two caregivers, each is assessed and scored separately.

- C. Section 1: "Caregiver" Each of the domains below represents a significant area of family functioning that may support or impede a family's ability to maintain the safety and well-being of children. There may be some overlap or interactions between domains (e.g., a need in the domain of substance abuse may impact parenting skills, resource management, and/or several other areas of functioning). Keeping this in mind, the CFS Specialist needs to assess the caregiver's functioning in each domain as it relates to his/her ability to effectively parent and protect the child.
- D. The FSNA domains should be considered for each family/household member. The CFS Specialist will base the score on his/her assessment for each item, taking into account the family's perspective, child's perspective where appropriate, the CFS Specialist observations, collateral contacts, and available records. The definitions will be used to determine the most appropriate response.
- E. In most cases, a finding of average functioning ("b") will be consistent with functioning in the domain that allows for minimally adequate parenting.
- F. Minimally Adequate Parenting: Considering ethnic and cultural differences, an action whereby a caregiver ensures that the child is adequately fed; clothed appropriately for weather conditions; provided with adequate shelter; protected from severe physical, mental, and emotional harm; and provided with necessary medical care as required by law. A parent/parent substitute or caregiver may have personal and situational problems but meet minimum parenting standards.
- G. **SN1. Substance Abuse/Use** (Substances: alcohol, illegal drugs, inhalants, prescription/over-the-counter drugs)
 - 1. Teaches and demonstrates a healthy understanding of alcohol and drugs. The caregiver teaches and demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behavior and society. Children are able to describe ways parents have conveyed messages about the effects of drugs and alcohol and/or consequences. The caregiver may be abstinent, or may drink alcohol or appropriately take prescribed drugs, but only in ways that do not negatively affect parenting skills and functioning.
 - 2. Alcohol or prescribed drug use/no use. Caregiver's choices about legal use or abstinence do not negatively affect parenting skills and functioning. The caregiver may have a history of substance abuse, may currently use alcohol or prescribed

drugs, or may be abstinent.

3. Alcohol or drug abuse. The caregiver continues to use despite negative consequences in some areas such as family, social, health, legal, or financial. The caregiver needs help to achieve and/or maintain abstinence from alcohol or drugs.
4. Chronic alcohol or drug abuse. The caregiver's use of alcohol or drugs results in behaviors that impede ability to meet his/her own and/or his/her child's basic needs. He/she experiences some degree of impairment in most areas including family, social, health, legal, and financial. He/she needs intensive structure and support to achieve abstinence from alcohol or drugs.

H. **SN2. Household Relationships/Domestic Violence**

1. Supportive. Internal or external stressors (e.g., illness, financial problems, divorce, and special needs) may be present, but the household maintains positive interactions (e.g., mutual affection, respect, open communication, empathy) and shares responsibilities mutually agreed upon by the household members. Household members mediate disputes and promote nonviolence in the home. Individuals are safe from threats, intimidation, or assaults by other household members. The caregiver demonstrates an effective or adequate coping ability regarding past abuse, if any.
2. Minor or occasional discord. Internal or external stressors are present, but the household is coping despite some disruption of positive interactions. Conflicts may be resolved through less adaptive strategies such as avoidance; however, household members do not control each other or threaten physical or sexual assault, and there is no current domestic violence.
3. Frequent discord or some domestic violence. Internal or external stressors are present, and the household is experiencing increased disruption of positive interactions coupled with lack of cooperation and/or emotional or verbal abuse. This may be evidenced by the following:
 - a) A violent/controlling relationship has recently ended (i.e., within review period). One or both partners have decided to end the relationship, but the separation is recent and of uncertain finality.
 - b) Custody and visitation issues are characterized by frequent conflicts.
 - c) The caregiver's pattern of adult relationships creates significant stress for the child.
 - d) Adult relationships are characterized by occasional physical outbursts that may result in minor injuries, and/or controlling behavior that results in isolation or restriction of activities.
4. Chronic discord or severe domestic violence. Internal or external stressors are present and the household experiences minimal positive interactions. This may be evidenced by the following:
 - a) Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or DHHS.
 - b) The caregiver's pattern of adult relationships places the child at risk for maltreatment and/or contributes to severe emotional distress.
 - c) One or more household members use regular or severe physical violence. Individuals engage in physically assaultive behaviors toward other household members. Violent or controlling behavior has resulted in or may result in injury.
 - d) Neither caregiver or only one caregiver is willing to seek help in reducing threats of violence, **or** previous treatment efforts have not been successful in

reducing domestic violence incidents.

I. **SN3. Coping Skills/Mental Health/Developmental Disability**

1. **Strong coping skills.** The caregiver demonstrates the ability to deal with adversity, crises, and long-term problems in a constructive manner. The caregiver demonstrates realistic and logical judgment. The caregiver displays resiliency and has a positive, hopeful attitude. The caregiver has taken action to address current concerns, and is able to actively contribute to the development of safety strategies.
2. **Adequate coping skills.** The caregiver demonstrates emotional responses that are consistent with circumstances and displays no apparent inability to cope with adversity, crises, or long-term problems. For example, a caregiver may be experiencing stress, sadness, or anger related to the current case, but is able to manage these feelings to the extent that he/she can participate in case and safety planning. The caregiver is not currently experiencing any symptoms that impair his/her ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.
3. **Mild to moderate symptoms.** Caregiver has difficulty coping with periodic stresses in his/her life. This may be related to a cognitive disability or demonstrated by periodic mental health symptoms such as depression, low self-esteem, or apathy, or the consistent use of a coping mechanism that exacerbates the situation. These symptoms periodically impair the caregiver's ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.
4. **Chronic/severe symptoms.** Caregiver has severe and chronic difficulty recognizing or coping with routine stress and daily challenges. The caregiver may have a cognitive disability or display chronic, severe mental health symptoms such as depression, apathy, severe low self-esteem, or unfounded mistrust of professionals and others who want to help. The caregiver is debilitated by these symptoms to the extent that he/she is consistently unable to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter. The caregiver may require hospitalization or intensive psychiatric care to control symptoms.

J. **SN4. Social Support System**

1. **Strong support system.** The family regularly engages with a strong, constructive, mutual support system. Individuals interact with extended family, friends, cultural, religious, and/or community support or services that provide a wide range of positive and available resources.
2. **Adequate support system.** As needs arise, the family uses extended family, friends, cultural, religious, and community resources to provide support and/or services such as child care, transportation, supervision, role modeling for caregiver(s) and child, parenting and emotional support, guidance, etc.
3. **Limited support system.** The family has limited support system, is isolated, or is reluctant to use available or identified support; **or** the family's social support system is neutral regarding caregiver choices that place the child(ren) at threat of harm.
4. **No support system or support system is harmful.** The family has no support system and does not utilize extended family and community resources; **or** the family's social support system enables or encourages the caregiver to make choices that place the child(ren) at threat of harm.
 - a) Background check information alone does not indicate a harmful support

system member. When identifying a harmful support system, consider the behavior encouraged by the individuals and its impact on child safety.

- K. **SN5. Parenting Skills:** If the current referral involves concerns regarding an only child who is a newborn at the time of referral, consider the caregiver's preparation for parenthood when making an initial assessment of this item. Subsequent reassessments should be based on caregiver behavior in the assessment period.
1. **Strong skills.** The caregiver displays good knowledge and understanding of age-appropriate parenting skills and integrates use on a daily basis. The caregiver expresses hope for and recognizes the child's abilities and strengths and encourages participation in family, school, and community. The caregiver actively participates with the child, for example, monitoring homework completion, participating in school meetings, etc. The caregiver is able to protect the child and plan ahead to ensure the child's safety. The caregiver advocates for family and responds to changing needs.
 2. **Adequately parents and protects child.** The caregiver displays adequate parenting patterns that are age-appropriate for the child in areas of expectations, discipline, communication, protection, education, and nurturing. The caregiver is able to protect the child, but may have some difficulties with advance planning. Encourages and supports all children's social and emotional well-being, for example, participation in family, school, and community.
 3. **Inadequately parents and protects child.** Improvement of basic parenting skills is needed by the caregiver, or child has exceptional needs for which parent requires specialized training. The caregiver has some unrealistic expectations and gaps in parenting skills; demonstrates limited knowledge of age-appropriate disciplinary methods or need for supervision; and/or lacks knowledge of child development, which interferes with effective parenting. The caregiver may have difficulty placing the child's needs ahead of his/her own or be unable to plan for child protection. Caregiver demonstrates an inability to support children's social and emotional well-being, for example, participation in family, school, and community; parent may model illegal behavior.
 4. **Destructive/abusive parenting.** The caregiver displays destructive/abusive parenting patterns that result in significant harm to the child. The caregiver has unrealistic expectations and significant gaps in parenting skills; demonstrates poor knowledge of age-appropriate disciplinary methods or need for supervision; and/or lacks knowledge of child development, which interferes with effective parenting. The caregiver often does not place the child's needs ahead of his/her own and rarely or never plans for the child's safety. Caregiver discourages or prohibits participation in family, school, and community; caregiver may involve child in illegal behavior.
- L. **SN6. Resource Management/Basic Needs**
1. **Resources are sufficient to meet basic needs and are adequately managed.** The caregiver has a history of consistently providing safe, healthy, and stable housing; nutritious food; and clothing. The caregiver successfully manages available resources to meet basic care needs related to health and safety.
 2. **Resources may be limited but are adequately managed.** The caregiver provides housing, food, and clothing that meet minimal standards. The caregiver adequately manages available resources to meet basic care needs related to health and safety. This includes adhering to any assistance program requirements.
 3. **Resources are insufficient or not well-managed.** The caregiver provides housing, but it does not meet the basic needs of the child due to conditions such as inadequate

plumbing, heating, wiring, or housekeeping. Food and/or clothing do not meet basic needs of the child. The caregiver does not adequately manage available resources, or does not adhere to assistance program requirements, which results in difficulty providing for basic care needs related to health and safety.

4. No resources, or resources are severely limited and/or mismanaged. In at least one of the following areas, household resources are limited or mismanaged to the extent that harm to household members has occurred. Conditions exist in the household that have caused illness or injury to family members, such as inadequate plumbing, heating, wiring, or housekeeping; there is no food, food is spoiled, or family members are malnourished. The child chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair. The family is homeless. The caregiver severely mismanages available resources, which results in unmet basic care needs related to health and safety.
- M. **SN7. Cultural Identity** For this item, cultural identity may refer to an ethnic, religious, or social identity (community norms); sexual orientation; or gender identification that reflects the unique characteristics of the caregiver. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict and/or generational norms. Consider norms to be patterns of behavior that are accepted as appropriate within family or community.
1. Cultural component is supportive and no conflict is present. The caregiver identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.
 2. No cultural component that supports or causes conflict.
 - a) The caregiver identifies with a culture and its community; however, that cultural identity is not serving as a resource to him/her. He/she experiences no conflict related to cultural identity; **or**
 - b) The caregiver identifies with a culture and its community, and that identification causes some conflict, which affects the child. However, the caregiver is making appropriate and reasonable efforts to support the child and minimize negative effects; **or**
 - c) The caregiver has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.
 3. Cultural component that causes some conflict.
 - a) The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences some conflict related to cultural identity; **or**
 - b) The caregiver has no particular identification with a culture, the absence of cultural identity is resulting in some conflict with family or community; this is having or may have an adverse impact on the child; and the caregiver is unable to unwilling to work to resolve the conflict.
 4. Cultural component that causes significant conflict.
 - a) The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences significant conflict related to cultural identity; **or**
 - b) The caregiver has no particular identification with a culture; the absence of cultural identity is resulting in significant conflict with family or community; and this is having or may have an adverse impact on the child.

N. **SN8. Physical Health**

1. Consider the physical health of the caregiver as it relates to his/her ability to care for the child(ren) and/or to direct care for the children and him/herself.
2. Preventative health care is practiced. The caregiver teaches and promotes good health. The caregiver makes efforts to pursue resources and incorporate behaviors that promote health, such as modeling healthy eating habits, physical exercise, and personal hygiene for children in the household. The caregiver additionally displays the behaviors described in response "b".
3. Health issues do not affect family functioning. The caregiver has no current health concerns that affect family functioning. The caregiver accesses regular health services (traditional or effective non-traditional) for him/herself (e.g., medical/dental). The caregiver may have serious or chronic health problems, but is able to address these concerns and access resources to ensure that these concerns do not affect the care and protection of the child(ren).
4. Health concerns/disabilities affect family functioning. The caregiver has health concerns or conditions that affect family functioning and/or family resources.
5. Serious health concerns/disabilities result in inability to care for the child. The caregiver has serious/chronic health problem(s) or condition(s) that affects his/her ability to care for and/or protect the child.

O. **SN9. Identified Caregiver Strength/Need (not covered in SN1-SN8)**

1. Significant strength. A caregiver has identified an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.
2. Not applicable. The caregiver has no area of strength or need relevant for case planning that is not included in SN1-SN8.
3. Minor need. A caregiver has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.
4. Significant need. A caregiver has a serious need that has a significant impact on family functioning. The family perceives they would benefit from services and support that address the need.

P. **Section 2: Child** The CFS Specialist will rate each child according to the current level of functioning. For each item, if not applicable to the child's age, score as "b".

Q. **CSN1. Emotional/Behavioral**

1. Strong emotional adjustment. The child displays strong coping skills in dealing with crises and trauma, disappointment, and daily challenges. The child is able to develop and maintain trusting relationships. The child understands and accepts limits. The child is able to identify the need for, seek and accept guidance related to school, family, or community functioning.
2. Adequate emotional adjustment. The child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning. The child may demonstrate some depression, anxiety, or withdrawal symptoms that are situation related. The child maintains situationally appropriate emotional control. Developmentally appropriate acting out occurs. Child is able to understand and accept developmentally appropriate consequences.
3. Limited emotional adjustment. The child has a pattern of difficulty in dealing with situational stress, crises, or problems, which impairs functioning. The child displays periodic mental health symptoms including but not limited to depression, running

away, somatic complaints, hostile behavior, or apathy. Child has episodes of extreme acting out, which may include an inability to accept limits on or consequences for behavior.

4. Severely limited emotional adjustment. The child's ability to perform in one or more areas of functioning is severely impaired due to chronic/severe mental health symptoms, such as but not limited to fire-setting, suicidal behavior, or violent behavior toward people and/or animals. Child has a pattern of dysfunctional behavior that limits child or family activities (such as ability to play on a ball team, go to movies, eat at restaurants) or there is evidence that behavior is rapidly deteriorating.

R. **CSN2. Sexualize Behavior**

1. No sexualized behavior; child displays age-appropriate sexuality. The child does not display sexualized behaviors and his/her behavior is consistent with healthy sexual development.
2. Sexualized behavior is appropriately managed. The child may have experienced sexual abuse, but his/her responses do not interfere with his/her ability to interact appropriately with peers or adults. The child has no history of sexual acting out towards other children or towards adults. The child's behavior is consistent with healthy development, but may be inconsistent with the child's current setting (e.g., relationship with a foster sibling).
3. Concerning sexualized behavior. The child has occasional difficulty in maintaining appropriate behaviors and sexual boundaries. The child may engage in sexual attention-seeking behaviors with peers or adults.
4. Severely sexualized behavior. The child is unable to maintain appropriate boundaries to the extent that the child has created concern for his/her own safety or the safety of other children in the home and/or community.

S. **CSN3. Physical Health/Disability.** If the child is a state ward all required medical/dental/vision appointments and other requirements must be met regardless of item scoring. When scoring this item, the CFS Specialist will consider the child's needs independent of these regulations.

1. Good health. The child demonstrates good health and hygiene care involving awareness of nutrition and exercise. The child receives routine preventative and medical/dental/vision care and immunization. The child has no known health care needs, or has medical needs and demonstrates a strong understanding of and ability to monitor and meet these needs.
2. Adequate health. The child has no health care needs or has minor health problems, hygiene concerns, or a disability that can be addressed with minimal intervention that typically requires no formal training (e.g. oral medications). Child may not be current on immunizations or routine medical appointments, but this has not impacted the child's health.
3. Minor health/disability needs. The child has health care or disability needs and the child is at an age or developmental level that requires routine interventions to be provided by someone else; or the child is at an age or developmental level at which he/she could take responsibility for his/her own care, but has not yet demonstrated a willingness to do so.
4. Serious health/disability needs. The child has serious health problems or a disability that requires interventions that are typically provided by professionals or caregivers who have received substantial instruction (e.g., central line feeding,

paralegic care, or wound dressing changes); or child has a medical condition and child's own behavior causes condition to worsen or health to deteriorate (child refuses to participate in medical care, monitoring of health care, taking medication, and/or altering behavior as prescribed).

T. CSN4. Education

1. Does child have a specialized educational plan? (Specialized educational plan includes individualized educational program [IEP], study team, 504 plan, etc.)
2. Outstanding academic achievement. The child is working above grade level and/or is exceeding the expectations of the specific educational plan.
3. Satisfactory academic achievement or child not of school age. The child is working at grade level and/or is meeting the expectations of the specific educational plan, or the child is not of school age. The child is meeting and following the expectations of an alternative educational program (e.g., GED).
4. Academic difficulty. The child is working below grade level in at least one but not more than half of academic subject areas, and/or child is struggling to meet the goals of the existing educational plan. The existing educational plan may need modification or the child may need to be assessed for an educational plan.
5. Severe academic difficulty. The child is working below grade level in more than half of academic subject areas and/or child is not meeting the goals of the existing educational plan. The existing educational plan needs modification. Also score "d" for a child who is required by law to attend school but is not attending.
6. If the child has a need in this domain, the CFS Specialist will indicate if truancy is a significant contributing factor by indicating 1) Yes; 2) No or 3) Not Applicable.

U. CSN5. Family Relationships

1. For children in out-of-home placement, the CFS Specialist will score the child's family, not his/her placement family.
2. Nurturing/supportive relationships. The child experiences positive interactions with family members. The child has a sense of belonging within the family. The family defines roles, has clear boundaries, and supports the child's growth and development.
3. Adequate relationships. The child experiences positive interactions with family members and feels safe and secure in the family, despite some minor family conflicts. The family may struggle to define roles and clarify boundaries, but the child's growth and development are supported.
4. Strained relationships. Stress/discord within the family interferes with the child's sense of safety and security. The family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own. The family may have ill-defined roles or lack of boundaries; as a result, the child's development is not well-supported.
5. Harmful relationships. Chronic family stress, conflict, or violence severely impedes the child's sense of safety and security. The family is unable to resolve stress, conflict, or violence on their own and is not able or willing to obtain outside assistance. The family may not define roles or boundaries within the household, or may define roles in ways that are harmful to household members.

V. CSN6. Child Physical and Cognitive Development

1. For this item, the CFS Specialist will base the assessment on developmental milestones. These milestones are further described in References section of this document.ⁱ

2. Advanced development. The child's physical and cognitive skills are above his/her chronological age level.
3. Age-appropriate development. The child's physical and cognitive skills are consistent with his/her chronological age level.
4. Limited development. The child does not exhibit most physical and cognitive skills expected for his/her chronological age level.
5. Severely limited development. Most of the child's physical and cognitive skills are two or more age levels behind chronological age expectations.

W. **CSN7. Substance Abuse**

1. Chooses drug-free lifestyle. The child does not use alcohol or other drugs and is aware of consequences of use. The child avoids peer relations/social activities involving alcohol and other drugs, and/or chooses not to use substances despite peer pressure/opportunities to do so.
2. No use/experimentation. The child does not use alcohol or other drugs. The child may have experimented with alcohol or other drugs, but there is no indication of sustained use. When considering indicators of sustained use, evaluate the impact of use on the child's functioning in school, family, and community (e.g., increase in conflict with parents or care providers, decline in school performance). If impact is not apparent, consider use to be experimentation.
3. Alcohol or other drug use. The child's alcohol or other drug use results in disruptive behavior and discord in school/community/family/work relationships. Negative impacts or alcohol/drug use have not progressed to the point that relationships with individuals or institutions (school, employment) have broken down. Use may have broadened to include multiple drugs.
4. Chronic alcohol or other drug use. The child's chronic alcohol or other drug use results in severe disruption of functioning, such as loss of relationships, job, school suspensions/expulsion/drop-out, problems with the law, and/or physical harm to self or others. The child may require intensive structure and support or medical intervention to achieve and maintain sobriety.

X. **CSN8. Cultural Identity**

1. For this item, cultural identity may refer to an **ethnic, religious, or social identity (community norms); sexual orientation; or gender identification** that reflects the unique characteristics of the caregiver. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict and/or generational norms. Consider norms to be patterns of behavior that are accepted as appropriate within family or community.
2. Cultural component is supportive and no conflict is present. The child identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.
3. No cultural component that supports or causes conflict. The child identifies with a culture and its community; however, that cultural identity is not serving as a resource to him/her. He/she experiences no conflict related to cultural identity; **or** the child has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.
4. Cultural component that causes some conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *some* conflict related to cultural identity; **or** the child

has no particular identification with a culture and the absence of cultural identity is resulting in *some* conflict with family or community.

5. Cultural component that causes significant conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *significant* conflict related to cultural identity; **or** the child has no particular identification with a culture and the absence of cultural identity is resulting in *significant* conflict with family or community.

Y. **CSN9. Peer/Adult Social Relationships**

1. Strong social relationships. The child enjoys and participates in a variety of constructive, age-appropriate social activities. The child enjoys reciprocal, positive relationships with others.
2. Adequate social relationships. The child demonstrates adequate social skills. The child maintains stable relationships with others; occasional conflicts are minor and easily resolved.
3. Limited social relationships. The child demonstrates inconsistent social skills; the child has limited positive interactions with others. Conflicts are more frequent and serious, and the child may be unable to resolve them.
4. Poor social relationships. The child has poor social skills, as demonstrated by frequent conflictual relationships or exclusive interactions with negative or exploitive peers, or the child is isolated and lacks a support system.

Z. **CSN10. Delinquent Behavior**

1. Delinquent behavior includes any action that, if committed by an adult, would constitute a crime. Also include crimes that are youth-specific (e.g., consuming alcohol).
2. Preventive activities. The child is involved in community service, other prosocial community activities, and/or crime prevention programs and takes a stance against crime. The child has no arrest history and there is no other indication of criminal behavior.
3. No current delinquent behavior. The child has no current indication of criminal behavior, **or** the child has successfully completed probation, OJS, or diversion, and there has been no criminal behavior in the past two years.
4. Occasional delinquent behavior. The child is engaging or has engaged in occasional, nonviolent delinquent behavior and may have been arrested or placed on probation or OJS. Also include children who have completed diversion within the past two years or are currently involved in a diversion program. Examples include but are not limited to children who have purchased or had possession of illegal drugs but have not yet been arrested.
5. Significant delinquent behavior. The child is involved or has been involved in any violent or repeated nonviolent delinquent behavior that has or may have resulted in consequences such as arrests, incarcerations, probation, diversion or OJS. Include children who have failed to complete probation or diversion.

AA. **CSN11. Life Skills.** Life Skills are assessed using the Ansell-Casey Life Skills Assessment. The Ansell-Casey Assessment has eight topic areas. Each topic has a score maximum of 5 points. To determine the child's needs using the Ansell-Casey assessment, add the scores of all eight topic areas. The total score of all eight topics provides the rating for this item.

1. No needs. The Ansell-Casey Life Skills Assessment Mastery score is between 30 and 40 for this child.

2. Low Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 20 and 29 for this child.
 3. Moderate Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 12 and 19 for this child.
 4. Significant Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 0 and 11 for this child.
- BB. **CSN12. Identified Caregiver Strength/Need (not covered in CSN1-CSN11)**
1. Significant strength. A child has an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.
 2. Not applicable. A child has no area of strength or need relevant for case planning that is not included in CSN1-CSN11.
 3. Minor need. A child has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.
 4. Significant need. A child has a serious need that has a significant impact on family functioning. The family perceives they would benefit from services and support that address the need.
- CC. As part of the FSNA the CFS Specialist will:
1. Continue to verify the sufficiency of the Safety Plan;
 2. Continue to elicit parent/caregiver perceptions regarding identified safety threats;
 3. Reinforce the reduction and elimination of the safety threats;
 4. Engage the parents/caregiver in a collaborative partnership for change;
 5. Facilitate communication and interaction with parents/caregivers;
 6. Recognize parent/caregiver readiness for change related to acknowledging safety threats and need to improve ability to protect their child;
 7. Identify safety related needs;
 8. Identify family/parent/caregiver strengths around which the case plan can be built; and
 9. Identify potential Family Team members and informal resources.

IX. SDM@ RISK REASSESSMENT OF IN-HOME CASES:

- A. The Risk Reassessment combines items from the original risk assessment with additional items that evaluate a family's progress toward case plan goals.
- B. Research has demonstrated that for the reassessment, a single index best categorizes risk for future maltreatment. Unlike the initial risk assessment, which contains separate indices for risk of neglect and risk of abuse, the risk reassessment is composed of a single index.
- C. All in-home services cases, including child abuse/neglect, dependency and 3 (c) cases will be assessed by the CFS Specialist using the Risk Reassessment tool.
 1. Cases in which any child remains in out-of-home placement with a goal of reunification should be assessed using the Reunification Assessment.
- D. These cases will be assessed minimally every 90 days from the initial case plan OR every 90 days from the reunification of all the children to the family home. The reassessment should be completed sooner if there are new circumstances or new information that would affect risk or if a recommendation for case closure is being considered.
- E. The Risk Reassessment guides the decision to keep a family preservation case (children

placed at home) open or to recommend case closure.

- F. The Risk Reassessment will be documented on N-FOCUS within 7 calendar days of completion. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the answers in the risk reassessment regardless of the risk level. The CFS Specialist will utilize the narrative sections within the SDM assessment.

X. COMPLETION OF THE RISK REASSESSMENT:

A. Items R1-R5:

1. The CFS Specialist will use the definitions to determine the appropriate response for each item and enter the corresponding score.
2. Items R1 and R2 refer to the time period prior to the current referral. Scores for these items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

- B. **R1 – Number of prior neglect or abuse investigations of any household adult.** The CFS Specialist will score the item based on the count of all investigations, substantiated or not, that were assigned for DHHS investigation for any type of abuse or neglect prior to the investigation resulting in the current case. Where possible, history from other county or state jurisdictions should be included. Exclude dependency intakes and investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

- C. **R2 - Household previously had an open ongoing service case (voluntary or court-ordered) due to child abuse or neglect.** The CFS Specialist will mark “yes” if this household previously had an open family preservation or foster care case as a result of a prior investigation prior to the current referral. Include voluntary or court-ordered family services or foster care services; do not include delinquency services or dependency cases (e.g., 3B cases).

D. **R3 - Primary caregiver has a history of abuse or neglect as a child.**

1. The CFS Specialist will mark “yes” if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. Include disclosure of incidents that would be screened in now.
2. R3 and R5 may change if new information is available or if there has been a change in the identified primary caregiver.

- E. **R4 - Characteristics of children in the household.** The CFS Specialist will score this item based on credible statements by caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records. The CFS Specialist will mark each characteristic that is present and score 1 if any characteristic is present.

1. Score 0 if no child in the household exhibits characteristics listed below.
2. Score 1 if any child has any of the characteristics below.
 - a) **Developmental disability**, as evidenced by intellectual disability or other developmental problem, including ADHD that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
 - b) **Learning disability**. Child has an IEP to address a learning problem such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not

have one, who is in preschool, or who is not enrolled in school.

- c) **Physical disability** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include only credible information about disabilities of long duration).
 - d) **Medically fragile or diagnosed with failure to thrive:** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention (include also infants under six months of age with physical conditions requiring medical intervention if the condition is likely to persist for six months or more), or has a diagnosis of failure to thrive by a physician.
3. R4 may change if a child's condition has changed, or if a child with a described condition is no longer part of the household (children in out-of-home placement with a plan to return home are considered part of the household, and the family should be reassessed using the reunification reassessment).

F. **R5 - Primary caregiver has a past or current mental health problem. The CFS Specialist will score the following based on the definitions below.**

- 1. Score 0 if the primary caregiver does not have a current or past mental health problem.
- 2. Score 1 if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
 - a) Diagnosis of a DSM condition resulting from formal assessment by a mental health clinician;
 - b) Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; or
 - c) Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.
- 3. Indicate if the problem existed within the previous 12 months and/or prior to the previous 12 months. Also indicate if the primary caregiver is currently receiving treatment and what that treatment entails. Do not include diagnoses of ADHD or learning disabilities (e.g. dyslexia).
- 4. R3 and R5 may change if new information is available or if there has been a change in the identified primary caregiver.

G. **Items R6-R8:** These items are scored based only on observations, since the most recent assessment or reassessment. Using the definitions determine the appropriate response for each item and enter the corresponding score. Both the primary and secondary caregivers are assessed in these items.

H. **Item R6 - In the period since the last assessment, the caregiver has addressed an alcohol or drug problem.**

- 1. The CFS Specialist will assess each caregiver separately; the item is scored based on the caregiver demonstrating the more severe behavior. The CFS Specialist will indicate whether or not the caregiver has a current alcohol/drug abuse problem that interferes with the caregiver's or the family's functioning and he/she is not addressing the problem. Not addressing the problem may be evidenced by the following:
 - a) Substance use that currently affects the caregiver's employment; criminal involvement; marital or family relationships; or his/her ability to provide

protection, supervision and care for the child.

- b) An arrest or citation since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing; possession charges for drugs or drug paraphernalia;
 - c) Self-report of a current problem;
 - d) Positive toxicology screen during assessment period, or refusal to comply with toxicology screens; or
 - e) Health/medical problems resulting from current substance use.
2. The CFS Specialist will score the following:
- a) Score 0 if there is no history of an alcohol or drug abuse problem or is there is no current alcohol or drug abuse problem that requires intervention.
 - b) Score 0 if there is an alcohol or drug abuse problem and the caregiver has addressed the problem.
 - c) Score 1 if there is an alcohol or drug abuse problem and the caregiver has not addressed the problem.
3. Legal, non-abusive prescription drug use and responsible, non-abusive use of alcohol should be scored as an "a".

I. Item R7 – Problems with relationships among adults within the household.

1. The CFS Specialist will score this item based on current status of adult relationships in the household.
- a) Score 0 if not applicable or there are no relationship problems observed.
 - b) Score 1 if there are harmful/tumultuous adult relationships or domestic violence.
 - (1) Adult relationships that are significantly conflictual or harmful to domestic functioning or to the care the child receives (but not at the level of domestic violence). Consider adult relationships in which basic household decisions (e.g., regarding chores, division of child care responsibilities) cannot be settled without conflict.
 - (2) The household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult.

J. Item R8 – Primary caregiver provides physical care consistent with each child's needs.

1. The CFS Specialist will mark "yes" if the caregiver is providing age-appropriate physical care for all children in the household. Examples may include the following:
- a) Obtaining standard immunizations (do not consider children who have not been immunized due to religious or philosophical objection);
 - b) Obtaining medical care for severe, chronic, or recurrent illness;
 - c) Providing the child with adequate food;
 - d) Providing the child with adequately clean, weather-appropriate clothing;
 - e) Preventing or addressing rodent or insect infestations;
 - f) Providing adequate housing with operative plumbing and electricity (heating and cooling);
 - g) Ensuring that poisonous substances or dangerous objects are not within reach of a small child; or
 - h) Supporting or providing age/developmentally appropriate hygiene (bathing,

brushing teeth, changing diapers).

K. **Item R9 - Caregiver's progress with case plan outcomes and addressing critical needs.**

1. The CFS Specialist will score this item on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with case plan outcomes. If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of participation/progress.
 - a) Demonstrates new skills consistent with case plan outcomes and addressing critical needs OR is actively engaged in services and activities to gain new skills consistent with case plan outcomes. The caregiver is demonstrating behavioral change consistent with the outcomes in the case plan (e.g., is able to manage substance use/abuse to provide for ongoing safety of children; is able to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary-setting; develops a mutually supportive relationship with partner to provide a safe home for children; provides emotional support for the child, etc.). This may include participation in activities identified on the case plan toward achievement of new skills and caregivers who successfully achieve desired behavior change through activities not specifically identified on the plan. Engagement in services and activities means that the caregiver's participation suggests acquisition and application of new skills, not just compliance with attendance. Compliance with services and activities without demonstration of acquisition of new skills consistent with case plan outcomes is not sufficient for scoring.
 - b) Does not demonstrate new skills consistent with case plan outcomes or addressing critical needs and/or participation is minimal and insufficient to contribute to achieving case plan outcomes or addressing critical needs. This may include complete refusal to participate in services or activities, or participation that has failed to result in behavior change. Caregivers who are demonstrating some progress toward case plan objectives but insufficient progress overall should be scored here.
2. The most difficult part of reassessing risk is completing the case plan progress item (R9). The CFS Specialist can make this easier for yourself and the family by
 - a) Using concrete, behavior-based goals.
 - b) Using the Family Strengths and Needs Assessment (FSNA) to see if there has been a reduction in, or elimination of needs.
 - c) Using the safety assessment to determine if safety threats been resolved
 - d) Documenting each contact with the family quickly, focusing on recording observations that directly relate to case plan goals

L. **Scored Risk Level.** After entering the score for each individual item, enter the total score and indicate the corresponding risk level.

Score	Risk Level
0-1	<input type="checkbox"/> Low
2-4	<input type="checkbox"/> Moderate
5-7	<input type="checkbox"/> High
8+	<input type="checkbox"/> Very High

M. **Policy Overrides:**

1. There are certain conditions that are so serious that a risk level of very high should be assigned regardless of the risk reassessment score. The policy overrides refer to

incidents or conditions that occurred since the risk assessment or last reassessment. If one or more policy override conditions exist, mark “yes” for each reason for the override and mark “very high” for the final risk level.

2. Policy overrides require supervisory review.
 - a) Sexual abuse case and perpetrator is likely to have access to the child. One or more of the children in this household are to have been victims of sexual abuse and actions or inaction by the caregivers indicate that there is a safety threat to the child because the perpetrator is likely to have unsupervised access.
 - b) Non-accidental injury to a child under 2 years old. Any child under 2 years of age in the household has any physical injury resulting from the actions or inactions of a caregiver.
 - c) Severe non-accidental injury. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; and the child requires medical treatment.
 - d) Caregiver action or inaction resulted in death of a child due to abuse or neglect. Any child in the household has died as a result of actions or inactions by the caregiver.

N. Discretionary Override:

1. A discretionary override is used whenever the CFS Specialist believes that the risk score does not accurately portray the family’s actual risk level. The risk reassessment permits the CFS Specialist to increase or *decrease* the risk level by one step. The reason a CFS Specialist may now decrease the risk level is that after working with the family for a period of time, the CFS Specialist has acquired significant knowledge of the family.
2. If a discretionary override applies, mark yes, indicate the reason, and mark the override risk level. Discretionary overrides require CFS Supervisory approval. The CFS Specialist then indicates the final risk level.

O. Recommended Decision

Risk Reassessment Case Status Recommendation	
Risk Level	Recommendation
Low	Recommended Closure*
Moderate	Recommended Closure*
High	Recommend the case remain open
Very High	Recommend the case remain open
<p>*Low and moderate risk cases must be recommended for closure <u>only</u> if the case closure SDM® safety assessment finding is safe.</p> <p>For cases that remain open following Risk Reassessment, the new risk level guides minimum contact standards that will be in effect until the next Risk Reassessment is completed.</p>	

XI. SDM® REUNIFICATION ASSESSMENT:

- A. The Reunification Assessment consists of four parts where the results are used to reach a permanency plan goal and to guide decisions about whether or not to return a child home.
 - 1. Risk Reassessment
 - 2. Parenting Time Evaluation
 - 3. Safety Reassessment and
 - 4. Permanency Plan Recommendation.
- B. The CFS Specialist will conduct the Reunification Assessment on any ongoing case in which at least one child is in out-of-home placement with a goal of reunification. [Does not apply for OJS cases].
- C. The CFS Specialist will not complete this assessment if a court determination has been made that reasonable efforts to reunify the child and parent are not required or for a child with a goal other than reunification. The CFS Specialist will proceed with updating the FSNA.
- D. The CFS Specialist will conduct the Reunification Assessment at a minimum, every 90 days from the initial case plan. When possible (e.g., at 6 months, 12 months, etc.), the CFS Specialist will coordinate the reunification assessment with the FSNA and the new case plan.
- E. If a Reunification Assessment is completed for purposes outside of the case planning time frame (e.g., court hearing), and the next case plan is due within 30 days, a new Reunification Assessment is not required with the new case plan. After the new case plan, the reunification assessment schedule should resume every 90 days from the case plan.
- F. If critical incidents have occurred in the 30 days between the completion of a Reunification Assessment and a recommendation regarding reunification, the CFS Specialist will revise the previous Reunification Assessment if the assessment is not final; a new assessment is not required. If the Reunification Assessment is final, a new assessment is required.
- G. The Reunification Assessment results inform the decision of whether a child is recommended for reunification or if a change to the permanency plan goal should be recommended. If families have effectively reduced risk, have achieved at least acceptable parenting time, and the home is safe or conditionally safe, reunification can be recommended by the CFS Specialist. The permanency plan guidelines and recommendation sections guide recommendations to return a child home, continue reunification efforts with this household, or recommend a change to the permanency goal.
- H. The Reunification Assessment will be documented on N-FOCUS within 7 calendar days of completion. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the Reunification Assessment regardless of the final determination. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding decisions on each of the items.

XII. COMPLETION OF THE REUNIFICATION ASSESSMENT:

- A. **Section 1: Reunification Risk Reassessment:** The CFS Specialist will complete the reunification risk reassessment and indicate the final risk level. The final risk level from Section 1 of the reunification assessment also determines the contact guidelines that will apply to the assessed household for the next review period.

- B. **R1. Initial risk level or prevention level (after overrides)** – The initial risk level or prevention level for the referral is used to score this item. If there is no initial risk assessment or prevention assessment (for 3B cases) for this family, mark “e” and score as 4.
1. Low – 0
 2. Moderate –
 3. High – 4
 4. Very high – 5 or
 5. No initial risk level – 4
- C. **R2. Has there been a new substantiation (in this household) since the last assessment/reassessment?** The CFS Specialist will rate this item based on whether new allegations of maltreatment have been received (for this household) since the last assessment (if completed at case opening) or reassessment.
1. Score 0 if no new allegation of maltreatment was substantiated by DHHS, or if DHHS made the agency aware of a concern in the household but did not investigate that concern.
 2. Score 6 if a new allegation of maltreatment was received and substantiated by DHHS.
- D. **R3. Caregiver(s) progress with case plan.** The CFS Specialist will rate both caregivers based on whether each has mastered or is mastering skills learned from participation in programs and/or services. Indicate the progress for each caregiver in the home, but enter the score based on the caregiver with the least progress. The CFS Specialist will indicate if there is no secondary caregiver.
1. Score minus 2 (-2) if the caregiver: Demonstrates new skills consistent with case plan outcomes and has successfully addressed identified critical needs. Has successfully changed behavior to improve ability to protect and care for children.
 - a) Is demonstrating behavioral change consistent with case plan outcomes and addressing critical needs (e.g., is able to manage substance use/abuse to provide for ongoing safety of children; is able to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary-setting; develops a mutually supportive relationship with partner to provide a safe home for children); and
 - b) Has successfully completed all recommended services, is actively participating in services, OR is pursuing objectives detailed in case plan.
 2. The caregiver’s compliance with services and activities without demonstration of acquisition of new skills consistent with case plan objectives and addressing critical needs is not sufficient for scoring.
 3. Demonstrates few new skills consistent with case plan outcomes and addressing critical needs. Minimal participation in pursuing outcomes. The CFS Specialist will score 0 if the caregiver has demonstrated some behavioral change consistent with case plan outcomes and addressing critical needs. The caregiver is minimally participating in services or has made progress but is not fully complying with activities in the plan.
 4. Does not demonstrate new skills consistent with case plan outcomes or addressing critical needs. May have participated in activities but is not meeting objectives; refuses involvement in services or failed to comply/participate as required. The CFS Specialist will score 4 if the caregiver has demonstrated minimal or no behavioral change consistent with case plan outcomes or addressing critical needs. The

caregiver refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills due to a failure or inability to participate.

E. **Scored Risk Level. The CFS Specialist will assign the family’s risk level based on the following chart:**

Score	Risk Level
<input type="checkbox"/> -2 to 1	<input type="checkbox"/> Low
<input type="checkbox"/> 2 to 3	<input type="checkbox"/> Moderate
<input type="checkbox"/> 4 to 5	<input type="checkbox"/> High
<input type="checkbox"/> 6 and above	<input type="checkbox"/> Very High

F. **Policy Overrides:** There are certain conditions so serious that a risk level of very high should be assigned regardless of the risk reassessment score. The policy overrides refer to incidents or conditions that occurred only during the current review period (i.e., since the initial risk assessment or last reassessment). If one or more policy override conditions exist, the CFS Specialist will select “yes” for each reason for the override and select “very high” for the final risk level. Policy overrides require supervisory review.

1. **Sexual abuse case and perpetrator is likely to have access to the child.** One or more of the children in this household are to have been victims of sexual abuse AND actions or inaction by the caregivers indicate that there is a safety threat to the child because the perpetrator is likely to have unsupervised access.
2. **Non-accidental injury to a child under 2 years old.** Any child under 2 years of age in the household has any physical injury resulting from the actions or inactions of a caregiver.
3. **Severe non-accidental injury.** Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; AND the child requires medical treatment.
4. **Caregiver action or inaction resulted in death of a child due to abuse or neglect.** Any child in the household has died as a result of actions or inactions by the caregiver.

G. **Discretionary Override:** The CFS Specialist may request a discretionary override that would move the final score up or down one risk level. This request must be approved by a supervisor.

1. When a judge orders a child to be placed in out-of-home care, an override should be considered but should not be the reason sole reason to override the CFS Specialists assessment.

H. **Section 2: Parenting Time Evaluation:**

1. For each child, the CFS Specialist will indicate the level at which the caregiver demonstrating the least progress has participated in the parenting time plan.
2. Only combinations of frequency and quality that fall into the shaded section of the grid may be considered acceptable.
3. The parenting time evaluation considers the caregivers parenting time separately for each child. When assessing parenting time, the CFS Specialist will consider the

caregiver making the least progress.

Parenting Time Frequency	Quality of Face-to Face Visit			
	Strong	Adequate	Limited	Destructive
Totally				
Routinely				
Sporadically				
Rarely or never				

Note: Shaded cells indicate acceptable parenting time. Unshaded cells indicate unacceptable parenting time.

4. The CFS Specialist will utilize the following guidelines to determine the quality and frequency of parenting time visits.
5. Parenting time frequency will be evaluated by looking at the following:
 - a) Visits that are appreciably shortened by late arrival/early departure are considered missed.
 - b) Do not consider as missed visits those that were missed due to child unavailability.
 - c) Do not consider as missed visits missed due to illness of a child living with the caregiver, or severe weather.
 - d) When a legitimate reason to miss a visit (e.g., caregiver illness or caregiver work schedule) is used with unusual frequency, consider asking the caregiver to provide documentation.
6. To calculate the parenting time percentage, divide the number of visits the caregiver successfully attended by the number of visits scheduled in the review period.
 - a) **Totally:** Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).
 - b) **Routinely:** Caregiver may miss visits occasionally and rarely requests to reschedule visits in advance (65-89% compliance)
 - c) **Sporadically:** Caregiver misses or cancels visits, or reschedules many scheduled visits at the last minute (i.e. less than 24 hours prior to visit: 26-64% compliance).
 - d) **Rarely or never:** Caregiver does not visit or attends 25% or fewer of the allowed visits (0-25% compliance). Also select "rarely or never" if any of the following conditions are present:
 - (1) Caregiver has failed to visit, or visits have been suspended due to parental behavior. The caregiver has attended none of the scheduled visits during the review period and has not provided a reasonable explanation or attempted to reschedule; or there were no scheduled visits during the review period or visits were cancelled by the agency due to the parent's behavior (e.g., repeated problems with substance abuse during parenting time, therapist's recommendation that parenting time be discontinued, parents threatening to abscond with the children).
 - (2) Visitation is not required. The court has ordered that no visits occur, due to safety concerns for the child; or parental rights are no longer intact.
 - (3) Caregiver has been unable to visit child. The caregiver has not visited the child during the review period because he/she is unable due to physical

incapacity (e.g., hospitalization), incarceration, or because the caregiver could not be located.

7. The quality of the visit is based on the CFS Specialist’s direct observation whenever possible, supplemented by observation of the child, reports from foster parents, etc. When parenting time is not supervised, the CFS Specialist may rely on other information, such as child or therapist reports, the physical condition of children when they return from parenting time, observation of caregiver preparation for parenting time (e.g., purchase of snacks or diapers, provision of age-appropriate toys), reports of caregiver timeliness in picking up or returning children, and contact by caregivers subsequent to unforeseen events (e.g., caregiver contacting worker promptly if a child is accidentally injured during a visit or to report unintended contact with a person who is not permitted access to the child).

Quality of Caregiver Child Interaction	
Strong	<ul style="list-style-type: none"> • Consistently demonstrates protective and supportive behaviors toward the child that are consistent with case plan outcomes throughout the entire review period. • Responds in an engaging and nurturing manner to the child’s cues and behaviors. • Identifies and responds appropriately to the child’s emotional and physical care needs. • Demonstrates effective behavior management strategies. • Puts child’s needs ahead of his/her own needs. • Demonstrates a focus on the child during visits; shows empathy to child. • Engages the child in age-appropriate activities at own initiative. • Conducts himself/herself appropriately during visits. • Initiates participation in school, other child activities, and medical appointments. • Visitation has progressed to include extended visits.
Adequate	<ul style="list-style-type: none"> • Consistently demonstrates protective and supportive behaviors toward the child that are consistent with case plan outcomes. • Demonstrates an ability to recognize child’s behaviors and cues; generally responds appropriately to behavior and cues. • Identifies the child’s physical and emotional needs; responds adequately to these needs. • Demonstrates effective behavior management strategies. • Generally puts child’s needs ahead of his/her own. • Demonstrates a focus on the child during visits; shows empathy to child. • Conducts himself/herself appropriately during visits. • Participates in school, other child activities, and medical appointments.
Limited	<ul style="list-style-type: none"> • Demonstrates an ability to recognize child’s cues and behaviors, but needs guidance in establishing an appropriate response to these cues and behaviors. • Recognizes a need to set limits with child, but enforces limits or behavior management in an inconsistent or detrimental manner. • Demonstrates an ability to identify child’s physical and/or emotional needs, but may need assistance in consistently responding to the child in an appropriate manner. • Occasionally puts the child’s needs ahead of his/her own. • Conducts him/herself appropriately during visits.
Destructive	<ul style="list-style-type: none"> • Demonstrates lack of understanding for child’s cues and behaviors or an inability to respond appropriately to the child’s cues and behaviors. • Demonstrates limited or no ability to establish effective behavior management

	<p>strategies.</p> <ul style="list-style-type: none"> • Has not demonstrated an ability to identify or respond to the child’s physical or emotional care needs. • Rarely puts child’s needs ahead of his/her own. • May have persisted in maltreatment during visitation. • May not be focused on child during parenting time and/or conducts himself/herself inappropriately during visit (examples of inappropriate conduct include but are not limited to arriving for parenting time while substance-affected, or cursing at/violently arguing with worker in presence of child).
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I. **Parenting Time Overrides:** The CFS Specialist will indicate if any condition exists that should override the parenting time evaluation to **unacceptable**.

1. Policy: Parenting time is supervised for safety. This override must always be selected by the CFS Specialist whenever parenting time is supervised, regardless of whether or not it is court ordered. This includes all instances even when the CFS Specialist may disagree with the court order or determines that there is no safety issue requiring supervision. The court has ordered supervised visitation and the policy override would be marked as unacceptable. Drop-In monitoring of parent/child contact is not considered for an override.
2. Policy: No visits have occurred in the family home.
3. Policy: Visitation has not progressed to include extended visits.
4. Discretionary: The CFS Specialist must document a reason for this override and must have supervisory approval.

J. **Section 3: Reunification Safety Reassessment:**

1. **Section A. Safety Threat Assessment:** The CFS Specialist will begin by identifying and describing the safety threats that were present at the time the children were taken into protective placement.
 - a) If the household currently being considered for reunification was not the removal household, indicate that this is a non-removal household when explaining why safety threats that brought the child into care no longer apply.
 - b) For non-removal households, there may not be any past safety threats to document in the first part of Section A.
2. In the second part of Section A, the CFS Specialist will identify any safety threats that are currently present in the household being considered for reunification. During the safety assessment the CFS Specialist must consider the characteristics and behaviors of all adults who will have access to the children if they are reunified into the household, as well as the physical safety of the home itself.
3. It is important that the CFS Specialist carefully considers and assesses for each safety threat and works with the family to identify strategies to immediately contain each threat. In some situations, it may not be possible to contain identified safety threats. If it is not possible to mitigate the safety threat through a safety plan, the CFS Specialist should consider adding efforts to resolve the threat to the case plan.

K. **Safety Threats:** The following threats are behaviors or conditions that may place a child in immediate danger of serious harm if returned home. The CFS Specialist will identify the presence of each threat by endorsing the item.

1. Caregiver made a plausible threat to cause serious physical harm, as indicated by any of the following:
 - a) Caregiver fears he/she will maltreat the child and/or requests that placement

continue.

- b) Current threat to cause serious harm or retaliate against the child. Threat of action that would result in serious harm, or household member plans to retaliate against the child for DHHS investigation or intervention. This threat may be verbal or may be indicated by physical behavior towards the child. Include credible reports of caregiver statements by others.
2. Caregiver does not protect/is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
- a) Caregiver does not protect or is unable to protect the child from serious harm or threatened harm by other family members, other household members, or others having access to the child. Caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age, emotional or physical disability, or developmental stage.
 - b) An individual with known violent criminal behavior/history resided in the home or caregiver allows access to the child. Caregiver may or may not know about individual's history. Include homes where gang activity occurs or where there is violent illegal activity in the home.
Examples include but are not limited to the following:
 - (1) Mother and grandfather both reside in the household. Grandfather has a history of using inappropriate physical discipline. Mother believes that grandfather will not change his behavior and does not think that she can stop him.
 - (2) Father is aware that a cousin has sexually abused one of the children being considered for reunification, but will not restrict cousin's access to the home.
3. Caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. Needs may be basic or exceptional.
- a) Caregiver does not or cannot provide appropriate supervision for the child, considering the child's age and developmental level, e.g., allowing a toddler to play unsupervised in front of a busy street.
 - b) Caregiver does not or cannot make appropriate child care arrangements, e.g., leaving children with a babysitter who has significant substance abuse problems.
 - c) Caregiver does not have the ability to provide or the capacity to keep (refrigerate or heat) food or drink for the child.
 - d) Caregiver does not or cannot provide the child with clothing that would protect him/her from severe weather.
 - e) Caregiver does not have the resources necessary to safely transport child to necessary medical or mental health appointments due to lack of transportation (public or private vehicle) or lack of nearby facilities.
 - f) Child has significant medical or mental health needs, and credible concerns exist regarding caregiver's ability to maintain child's safety or the safety of other vulnerable children in the home.
 - g) Caregiver has no housing or is currently residing in a temporary or short-term emergency shelter. If the child were returned to the caregiver, the child's needs for minimally safe conditions (water, structurally safe environment, protection

from severe weather elements) would not be met.

- h) Caregiver does not or cannot ensure safe sleeping arrangements for children, taking into consideration age and vulnerabilities of children, e.g., infant sleeping arrangements that include soft surfaces that present suffocation risk.

4. **The physical conditions are hazardous and immediately threatening to the health and/or safety of the child.** Based on the child's age, emotional or physical disability, and developmental status, the child's physical living conditions (including but not limited to the following) are hazardous and immediately threatening:

- a) Leaking gas from stove or heating unit;
- b) Substance or objects accessible to the child that may endanger his/her health and/or safety (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities; unsecured weapons);
- c) Lack of water or utilities (heat, plumbing, electricity), and no alternate, safe provisions are made;
- d) Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows;
- e) Exposed electrical wires;
- f) Excessive garbage or rotted or spoiled food that threatens health;
- g) Serious illness or significant injury is likely to occur due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites, severe infestations);
- h) Evidence of human or animal waste throughout living quarters;
- i) Housing that does not meet minimal community safety standards, e.g., buildings that have been condemned or determined to be unsound by housing authority or other professional inspection.

5. **The severity of previous maltreatment and current circumstances suggest that the child's safety may be of immediate concern.** To endorse this item, there must be either a previous incident or pattern of incidents **and** concern about current circumstances.

<p>Previous maltreatment includes any of the following:</p> <ul style="list-style-type: none">• Prior death of a child as a result of maltreatment.• Prior serious injury to the child other than accidental: Caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impaired the health or well-being of the child <i>and required medical treatment</i>. Include any sexual abuse that required medical treatment.	<p>AND Previous maltreatment includes any of the following:</p> <ul style="list-style-type: none">• Caregiver has limited resources for parenting support.• Caregiver has had limited opportunity to demonstrate improved parenting for more than 48 hours at a time and/or under significant stress.• Caregiver continues to show no remorse or responsibility for previous behavior that resulted in harm to a child.• Case manager and/or others involved in the case have credible concerns regarding the child's safety if he/she returned home.
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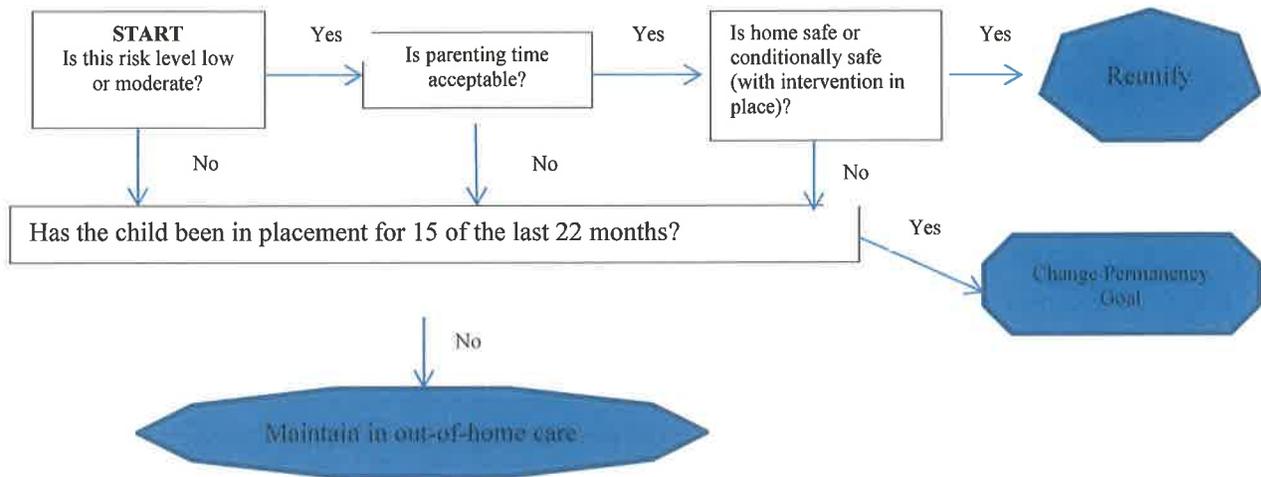
<ul style="list-style-type: none"> • Drug-exposed infant. Prior to the current case, a child was born drug-exposed, meaning having a positive toxicology screen at birth for mother or child, and a current caregiver considered for reunification was the birth parent. • Prior termination of parental rights or permanent placement of another child: The caregiver had parental rights terminated as a result of CA/N, or has had a child permanently placed outside his/her custody (i.e., guardianship or other planned permanent placement). • Prior removal of a child or failed reunification: Removal/placement of a child by DHHS or other responsible agency or concerned party was necessary for the child's safety, or child has reentered foster care after prior reunification attempts. 	
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6. **Child behaviors place or would place the child at imminent threat of serious harm, in spite of appropriate response by caregiver.** To mark this threat, **three** conditions **must** be present:

<p>The child is currently engaging in or habitually engages in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from home and place themselves in unsafe living/sleeping situations, children who engage in prostitution, children who engage in self-harming behaviors if returned to the home (e.g., prior reunifications have failed due to child behaviors or child has stated an intent to</p>	<p>AND The child's caregiver(s) have responded or are currently responding appropriately and making reasonable efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child and increasing direct supervision and monitoring of the child.</p>	<p>AND The caregiver's current or prior efforts, although appropriate, are/were insufficient to prevent the child from engaging in the behavior in the future.</p>
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return to such behaviors).		
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7. **Other (specify).** The CFS Specialist will select this safety threat if no other threat applies and the CFS Specialist can describe the situation and the threat.
- L. **Safety Decision:** After the CFS Specialist has identified the past and current safety threats, the CFS Specialist will base the safety decision on whether or not the family has made **sustainable change** to resolve the safety threats identified at the time of removal and/or whether or not safety interventions are available to develop a safety plan to **contain or mitigate** current safety threats.
1. The CFS Specialist will determine the following:
 - a) The child is **SAFE**. No safety concerns are present. **Safety threats that resulted in the child's removal** (as documented on the initial safety assessment) **are no longer present**, and no current safety threats were identified. The CFS Specialist will **document how initial safety issues were resolved**.
 - b) The child is **CONDITIONALLY SAFE**. One or more safety threats are present. The CFS Specialist will **briefly describe the specific safety plan** that has been written with the family **to immediately** address the safety threats(s).
 - c) The child is **UNSAFE**. One or more safety threats are present. **The only intervention to ensure safety is continued out-of-home placement**. The CFS Specialist will document why other interventions could not be implemented to reunify the child at the present time.
 2. The CFS Specialist will also document in the Reunification Safety Assessment the following:
 - a) Evidence and observations of caregiver behaviors used to answer safety assessment items; and
 - b) The supports provided by the CFS Specialist to the family during the review period to help address safety threats.
- M. **Section 4: Permanency Plan Recommendation Summary:**
1. The CFS Specialist will complete the decision tree for each child being considered for reunification and document the results.
 2. Reunification is recommended when:
 - a) Risk is low or moderate, parenting time for the child is acceptable, and the home is safe or conditionally safe, reunification is recommended. If any of these three conditions is not met, the CFS Specialist should indicate if the child has been in care for 15 of the previous 22 months. If so, a new permanency goal should be recommended. If not, efforts toward reunification should be continued.
 - b) The recommendation of the assessment will be evaluated by the CFS Specialist. The CFS Specialist will determine if the outcome of the permanency plan recommendations summary decision tree is the appropriate action for this case. If there are unique circumstances in this family that justify a different recommendation, the CFS Specialist may exercise a discretionary override. If the CFS Specialist chooses to override the tool recommendation, he or she should indicate a reason for this override and seek supervisor approval.
 - (1) The CFS Specialist, may, for example, override a tool recommendation to change the permanency goals if the family has made good progress on case plan goals and the CFS Specialist believes reunification may be achieved in the next review period. The CFS Specialist should carefully document the evidence that supports this view.



The CFS Specialist will utilize the Reunification Assessment tool in N-FOCUS to document the following recommendations for each child.

3. The CFS Specialist will utilize the Reunification Assessment tool in N-FOCUS to document the following recommendations for each child.

Child Name	Parenting Time	In care for 15 of 22 months?	Permanency Plan Recommendation Summary Outcome	Discretionary Override	New Goal Recommendation
	<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Reunify <input type="checkbox"/> Maintain in care <input type="checkbox"/> Change permanency goal	<input type="checkbox"/> No override <input type="checkbox"/> Reunify <input type="checkbox"/> Maintain in care <input type="checkbox"/> Change permanency goal	<input type="checkbox"/> Reunification <input type="checkbox"/> Adoption <input type="checkbox"/> Permanent Guardianship <input type="checkbox"/> I.L. <input type="checkbox"/> Self-sufficiency with support

4. The CFS Specialist will summarize in N-FOCUS Narrative the following:
 - a) Briefly describe the permanency plan recommendation for each child and why this recommendation was selected for the child; and
 - b) Explain why a discretionary override was needed for the child (if applicable).
5. The Reunification Assessment can be completed at any time the situation changes. **NOTE:** Reports of concern of abuse or neglect or other care concerns regarding a licensed or approved foster or relative foster care provider will be assessed using the Assessment for Safety and Suitability.

XIII. CASE PLANNING: *Refer to Program Guidance Memo "Permanency and Case Planning."*

- A. **Case Plans for Wards who are 16 Years of Age or Older:** *Refer to Program Guidance Memo #30-2015 – Transitional Living Planning.*

XIV. GENOGRAMS AND ECO-MAPS: All CFS Specialists are required to develop a genogram and eco-map with each family receiving ongoing services, whether court or non-court involved. The genogram and eco-map will be started at the assessment stage for any family whose child has been determined to be conditionally safe or unsafe, or for whom the risk of future maltreatment is high or very high. Documentation will be completed using the standardized format. ⁱⁱ Genograms and eco-maps are reviewed and updated by the CFS Specialist throughout the family's involvement with DHHS. Genograms and eco-maps will be documented and placed in the most current volume of the case file. The genogram and ecomap should be a part of every team meeting and updated as new information is obtained.

XV. SDM CASE REVIEWS: At a minimum, the CFS Supervisor will conduct the following reviews of SDM Assessments. The CFS Supervisor will utilize discretion and the work performance of individual CFS Specialists to determine the frequency of additional SDM Reviews.

- A. The CFS Supervisor will review every SDM Assessment in which an Override is utilized;
- B. The CFS Supervisor will review every SDM Assessment for CFS Trainees for the first 6 months or until the CFS Trainee has been promoted to CFS Specialist;
- C. The CFS Supervisor will conduct a random sample of SDM Assessments. One SDM Assessment will be selected each month for each CFS Specialist. The CFS Supervisor will conduct an in-depth review of one SDM Assessment for each CFS Specialist.

XVI. CASE CLOSURE

- A. The decision on recommending case closure in abuse, neglect, dependency, and 3 (c) cases is based on information gathered for the SDM® Risk Reassessment and the Safety Assessment.
- B. The child, parent/caregiver (when parental rights are intact), family, and family team members are all involved when considering making a recommendation to the court to close a case. In all court involved cases, in addition to the family team members, all legal parties including the Guardian ad Litem, CASA and county attorney will provide input in the decision to recommend case closure.
- C. Building Support Systems. Stabilizing the changes which have been made by the family is important. The CFS Specialist and the Family Team must identify changes and develop a plan that will enable the family to be successful without DHHS involvement. This process may be completed with case plans prior to requesting discharge. The use of informal supports is a key to stabilizing and maintaining change after DCFS involvement.
- D. If referrals for services have not been made for children and families prior to discharge, the CFS Specialist will assist the ward and family by making referrals to DHHS programs such as AABD, medical assistance, Developmental Disabilities or other programs such as Social Security.
- E. The CFS Specialist will inform the parent, guardian, or young adult to apply for a change in payee with the Social Security Administration, Veterans Administration or Railroad Retirement Board, as appropriate.
- F. Safety Plan in Place: The CFS Specialist cannot close a case with a safety plan in place. If a safety plan is still needed, the child is not safe and the case cannot be closed. If the safety plan depends on the case monitoring or resources of agencies DCFS contracts with, the case cannot be closed. The CFS Specialist must ensure the family has developed and/or implemented strategies to keep the child safe over the long term.
- G. In order to recommend discharge one of the following must be in place:

1. Non-Court Involved Cases: The CFS Specialist will take action to close a case when:
 - a) All children in the family are determined to be safe **and** the determination of risk is low or moderate;
 - b) All children in the family are determined to be safe **and** a high or very high risk family refused services **and** the supervisor have determined that the county attorney should not be contacted **or** the County Attorney has determined that there will be no court intervention; or
 - c) The child, parent/caregiver, or family in a non-court case cannot be located after all reasonable efforts have been made.
2. Court Cases: The CFS Specialist will take action to close a court case when:
 - a) A Court of competent jurisdiction has dismissed the involvement of the Department in the case;
 - b) Reunification has occurred and the child is determined to be safe;
 - c) The child's adoption is finalized;
 - d) The child's guardianship is finalized (court appoints a guardian and terminated Department custody);
 - e) The sending state through the Interstate Compact for the Protection of Children closes the case;
 - f) The child has reached the age of majority. See guidance on the Transitional Living Plan Program;
 - g) The child enlists in the armed services and completes basic training;
 - h) The child marries;
 - i) The child has been a runaway for 12 consecutive months and cannot be located;
 - j) The child dies; or
 - k) The child is convicted and sentenced as an adult.

XVII. CLOSED CASE FILES: Files that are closed must contain the following information, as applicable. All information except for the following, will be in N-FOCUS:

- A. Original certified documents containing a raised seal or certified documents;
- B. Signed relinquishment of Parental Rights;
- C. Original documents necessary for an adoption or evidence in the court room;
- D. Any document that is not readily and easily readable once imaged;
- E. Photographs, cards or other keepsakes that may be valuable to the family should be given to the appropriate person when appropriate to do so, or if not appropriate, they should be maintained in the hard file.

XVIII. CLOSED CASE RETENTION: For information on maintenance of closed child welfare files, see the Children and Family Services retention and disposal schedule which can be accessed at www.sos.state.ne.us/records-management.

XIX. PERSONAL PROPERTY AND INFORMATION AT CASE CLOSURE: The following information and documents will be provided to the legal custodian of the child at the time of case closure or the child if they have reached the age of majority upon discharge and case closure for children who were in out of home care.

- A. The original birth certificate: a copy must be retained in the case record;
- B. The original Social Security card: a copy must be retained in the case file;
- C. A written summary of medical history or a copy of medical records to include:
 - 1. Immunizations; and
 - 2. Names, addresses, and phone numbers of primary medical providers;
- D. Copies of report cards or transcript of grades;
- E. A written summary of the family background including
 - 1. Relatives and Kin;
 - 2. Birthdates; and
 - 3. Medical history
- F. A written summary of the child's out-of-home placement history;
- G. Photo(s) of the child and family;
- H. Any personal records such as baptism or confirmation certificate;
- I. Information regarding trust accounts and amounts; and
- J. Any records of tribal affiliations, including tribal identification cards or Certificates of Degree of Indian Blood. (Copies must be maintained in the case record.)

XX. DISPOSITION OF GUARDIANSHIP FUNDS AT DISCHARGE: When a ward is discharged from the Department, all of the funds that are held by the Department in a guardianship "trust fund" account must be transferred immediately to the most appropriate individual or agency. The CFS Specialist will complete a "Request and Authorization for use of State Ward Guardianship Funds" on N-FOCUS. Finance and Accounting will ensure correct distribution of funds. The CFS Specialist should contact their local Income Maintenance Foster Care Worker if they have specific questions.

GLOSSARY

Abandonment means a parent's intentionally withholding from a child, without just cause or excuse, the parent's presence, care, love, protection and maintenance and the opportunity for the display of parental affection for the child.

Abandoned Child means a child who is without an appropriate caregiver due to the intentional act and conscious decision of the parent not to care for the child.

Active efforts means and includes and includes, but is not limited to:

1. A concerted level of casework, both prior to and after the removal of an Indian child, exceeding the level that is required under reasonable efforts to preserve and reunify the family described in section 43-283.01 in a manner consistent with the prevailing social and cultural conditions and way of life of the Indian child's tribe or tribes to the extent possible under the circumstances;
2. A request to the Indian child's tribe or tribes and extended family known to the department or the state to convene traditional and customary support and services;
3. Actively engaging, assisting, and monitoring the family's access to and progress in culturally appropriate and available resources of the Indian child's extended family members, tribal service area, Indian tribe or tribes, and individual Indian caregivers;
4. Identification of and provision of information to the Indian child's extended family members known to the department or the state concerning appropriate community, state, and federal resources that may be able to offer housing, financial, and transportation assistance and actively assisting the family in accessing such community, state, and federal resources;
5. Identification of and attempts to engage tribally designated Nebraska Indian Child Welfare Act representatives;
6. Consultation with extended family members known to the department or the state, or a tribally designated Nebraska Indian Child Welfare Act representative if an extended family member cannot be located, to identify family or tribal support services that could be provided by extended family members or other tribal members if extended family members cannot be located; and
7. Exhaustion of all available tribally appropriate family preservation alternatives.

Adjudication means the process of rendering a judicial decision as to whether the facts alleged in a petition or other pleadings are true.

Administrative Hearing is a due process hearing held to appeal a decision made by a state agency.

Adoption means the method provided by law to establish the legal relationship of parent and child with the same mutual rights and obligations that exist between children and their birth parents.

Adoption Disruption means termination of an adoptive placement prior to finalization of the adoption.

Adoption Dissolution means legal termination of an adoption that has been finalized, including legal termination of the adoptive parent(s)' rights.

Adoption Exchange means a listing of children with special needs for whom an adoptive family is being sought, and of families approved for adoption of special needs for children. Some exchanges also list children needing a legal risk placement.

Adoption Registry means a central repository of profiles for all families approved for adoption or foster-adopt by the Department and available for such a placement.

Adoptive Placement means a type of placement that has not been finalized by a Decree of Adoption issued by a county or juvenile court.

Adult means an individual 19 years or older.

Affidavit is a written statement of facts signed under penalty of perjury, often before a court clerk or notary public who administers the oath to the signing party, who is called the affiant or declarant. Affidavits are routinely required for the procurement of warrants and are used in some jurisdictions to initiate juvenile court proceedings. They may be admitted into evidence.

Aftercare means the control, supervision, and care exercised over youth who have been paroled. It also means the outpatient treatment program for persons who have completed inpatient substance abuse treatment.

Age of Majority means the age at which, by statute, an individual is considered an adult and responsible for his/her own care, support and actions.

Agency Substantiated means that the Department's determination of child abuse or neglect against the subject of the report of child abuse or neglect was supported by a preponderance of the evidence and based upon an investigation pursuant to Neb. Rev. Stat. 28-713.

Allegation means a charge or claim of fact in a petition or other pleading which must be proven if the petition or other pleading is to be found true.

Approval study means a process which includes results of a home visit, a Child Protective Services check, a law enforcement check, and responses from references completed by the Department of a relative or person known to a child prior to placement occurring.

Beginning of foster care means the first 60 days after a placement in out-of-home care is made.

Beyond a reasonable doubt means the highest standard of proof, most often used in criminal cases. The evidence must, by virtue of their probative force, prove guilt. This standard of proof is applied when a court terminates the parental rights of Indian and non-Indian parents to an Indian child.

Caregiver means a parent or guardian, or in some cases, other adult in the household who provides care and supervision for the child. The primary caregiver provides the most child care. The primary caregiver is considered to provide at least 51% of care. The secondary caregiver is the other legal parent or another adult in the household who cares for the children.

Case Closure

Case closure means the 1) safety and risk does not rise to the need for court intervention; or the children are safe and the risk is low to moderate; or the family is unable to be located or 2) decision and process on the successful achievement of goals and outcomes of a child/family that eliminate the need for services and supervision.

Case Plan means a written agreement developed by the CFS Specialist with input from the family

members and other team members that identifies the agreed upon goals and objectives. Case Plans are developed for both court involved and non-court involved families.

Case Planning means the family-centered strengths-based process of engaging family members to ensure services are tailored to best address the family's strengths and needs. For Indian children/youth, case planning includes contacting and involving the tribe at the earliest opportunity.

Central Registry means the list of records maintained by the Department containing records of all reports of child abuse or neglect opened for investigation which have been classified as Court Substantiated or Agency Substantiated.

Child means an individual who by reason of minority, is legally subject to parental, guardianship, or similar control. In the state of Nebraska child means an individual less than 19 years of age.

Child and Families Services Specialist means the case manager, initial assessment or ongoing case manager assigned to work with a child or their family who is employed by the Department of Health and Human Services.

Child Caring Agency means an agency incorporated to provide care for children in residential settings maintained by the organization for that purpose.

Child custody proceeding for an Indian child means and includes:

1. "Foster care placement" means any action removing an Indian child from its parent or Indian custodian for temporary or emergency placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, but where parental rights have not been terminated;
2. "Termination of parental rights" means any action resulting in the termination of the parent-child relationship;
3. "Preadoptive placement" means the temporary placement of an Indian child in a foster home or institution after the termination of parental rights, but prior to or in lieu of adoptive placement;
4. "Adoptive placement" means the permanent placement of an Indian child for adoption, including any action resulting in a final decree of adoption; and
5. "Voluntary foster care placement" means a non-court-involved proceeding in which the department or the state is facilitating a voluntary foster care placement or in-home services to families at risk of entering the foster care system. **This includes cases that are identified as non-court involved and Alternative Response.** An Indian child, parent, or tribe involved in a voluntary foster care placement shall only be provided protections as provided in Neb. Rev. Statute 43-1505(4) and sections 43-1506 and 43-1508

Child Placing Agency means an organization authorized by its articles of incorporation to place children with a foster family or in adoptive homes.

Child Pornography means any visual depiction (live performance or photographic representation) and includes undeveloped film or video tape or data stored on a computer disk or by other electronic means which is capable of conversion into a visual image and also includes any photograph, film, video, picture, digital image or computer-displayed image, video or picture, whether made or produced by electronic, mechanical, or other means of an individual under 18 years of age of sexually

explicit conduct.

Clear and convincing evidence means the amount of evidence needed to convince ordinarily prudent minded people that the evidence is strongly in favor of one of the parties. It is more than a preponderance of evidence. Clear and convincing evidence is the standard of proof needed to place an Indian child in foster care.

Closed Adoption means an adoptive situation in which there is no contact or exchange of information between birth relatives(s) and adoptive parent(s) after a decree of adoption.

Commitment means an order by the court committing a child to the care and custody of the Department of Health and Human Services.

Commitment Date means the date that a child is made a Department ward via court order or voluntary relinquishment.

Concurrent Planning means the process of developing and implementing plans simultaneously to reach the primary permanency objective and an alternative objective. Concurrent planning may occur at any time in a case regardless of adjudication, including status offense and delinquency.

Conditionally Safe means that one or more safety threats are present, and protective safety interventions have been identified and agreed to by caregiver(s). An in-home safety plan is required.

Continuance means the postponement of a hearing, trial or other scheduled court proceeding, at the request of one or both parties, or by the judge without consulting them.

Conviction means the finding that an individual is guilty beyond a reasonable doubt of committing a crime.

Court Appointed Special Advocate (CASA) means a lay volunteer appointed by the court to assist in representing the child's interest in a juvenile court proceeding.

Court Involved Case means a case in which the County Attorney has filed a petition in the interest of the child and the court has assigned responsibility of the child to DHHS or the court has taken jurisdiction of the child and family to address identified safety threats, risk of harm to the child or community safety.

Court Pending means that a criminal complaint, indictment, or information or a juvenile petition under Neb. Rev. Stat. § 43-247(3)(a) has been filed in District Court, County Court, or separate Juvenile Court, and that the allegations of the complaint, indictment, information, or juvenile petition relate or pertain to the same subject matter as the report of abuse or neglect.

Court Report means a written document that contains information about the child and the family and the progress towards achieving the goals in the case plan.

Court-Substantiated means that a district court, county court, or separate juvenile court has entered a judgment of guilty on a criminal complaint, indictment, or information, or an adjudication of jurisdiction on a juvenile petition pursuant to Neb. Rev. Stat. § 43-247(3) (a), and the judgment or adjudication relates or pertains to the same subject matter as the report of abuse or neglect.

Courtesy Assessment means an assessment completed at the request of another state jurisdiction without continuing involvement of DHHS.

Courtesy Supervision means a cooperative arrangement between two or more counties, states or tribes to provide, or continue to provide, services to children and their families who are the subject of a dispositional order.

Criminal History means a county, state, or federal criminal history of conviction or pending indictment of a misdemeanor or felony.

Cruel Punishment means any type of discipline that results in injury, cuts, extreme bruising; withholding food, water, or required care, or requiring child to consume non-food items or inappropriate amounts of food, water or non-food items; a parent/caregivers' use of sadistic measures or weapons.

Cultural Plan means a written plan to ensure a life-long process of encouraging and fostering the Indian child's awareness and understanding of their Native American and tribal heritage and the development of a positive cultural identity. Key components of this plan include, but are not limited to, educating the child about his/her tribal history; initiating and maintaining connections and contact with extended family and other tribal members; exposing the child to positive Native American role models, literature, music, and art; recognizing and addressing racism at the child's current age and in the future, planning for the child to be a part of tribal events and ceremonies, etc.

Custody means the right to or responsibility for a child's care and control, carrying with it the duty of providing food, shelter, medical care, education and discipline.

Dependent Child means a child whose parent is or will be unable to care for the child through no fault of the parent, when no maltreatment has been identified. The parent may be incapacitated or absent due to illness, death, incarceration, or otherwise unavoidably unable to provide care, the child has extraordinary mental health, emotional, or physical needs which the parent does not have the ability or capacity to meet.

Discharge means the termination of Department guardianship or custody of the child.

Disposition means the court's determination of a case in which there is an issuance of a final order or opinion.

Dispositional Hearing means the hearing used for the purpose of determining what will occur with or by a child and/or parents who have been adjudicated within the juvenile court's jurisdiction. A dispositional hearing is when the juvenile court judge will order implementation of a treatment plan.

Domestic Violence means the establishment of control and fear in a relationship through the use of violence and other forms of abuse between spouses, persons living as spouses or adult members of the same household. The offender may use physical abuse, emotional abuse, sexual abuse, economic oppression, isolation, threats, intimidation, and maltreatment of the children to control the other person. Relationships involving domestic violence may differ in terms of the severity of the abuse, but control is the primary goal of all offenders.

Emotional Abuse means the parent/caregiver demonstrates a pattern of criticizing, rejecting,

insulting, isolating, terrorizing, or humiliating the child, resulting in serious emotional or behavioral issues.

Emotional Neglect means a parent/caregiver's pattern of failure to seek ongoing or emergency mental health services for a child who has suicidal, homicidal, or severe self-harming behaviors. Severe self-harming behaviors include cutting, burning, or other self-mutilation that requires medical treatment OR risk-taking behaviors likely to result in serious physical harm.

Escapee means a youth who has made an unauthorized flight from a facility to which he/she has been committed by the court or placed by lawful authority.

Evidence means any sort of proof submitted to the court for the purpose of influencing the court's decision on a case.

Expungement Review means the process for an individual, whose name has been entered on the Child and/or Adult Abuse Central Registry, to request that their name be removed.

Failure to Thrive means a serious medical condition in which a child's weight and motor development are significantly below average for his/her age. Usually, though, not always, found in children less than one year old, the syndrome may have an organic cause or it may be caused by severe emotional or physical neglect.

Family means a biological, adoptive or self-created unit of people residing together consisting of adult(s) and child(ren) with the adults(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, cultural practices and a significant relationship. Biological parents, siblings, and others with significant attachments to a child living outside of the home are included in the definition of a family.

Family/Person Centered Practice means a process that is based on a core set of values, beliefs, and principles that recognize that families can and should contribute to all aspects of services through their active participation.

Family Preservation means the efforts being made to safely keep the family together. Family Preservation is also the permanency objective whenever a decision is made that indicates the child can be safely maintained in the home

Family Strength means areas of a family's life where they exhibit power and decision making that is an asset to the family. Identified family strengths are used when developing safety interventions and strategies to achieve case plan goals.

Family Team means a group comprised of individuals selected by the family (including children), including, but not limited to family, friends, relatives, peers, providers, teachers, etc. who come together both formally and informally to form a circle of support around a person and/or family. Children must be involved in all family team meetings unless they are younger than age 9 or not developmentally appropriate to participate.

Family Team Meeting: A meeting that is convened for the purpose of creating, implementing, evaluating, and updating a Safety Plan and/or Case Plan that furthers an individual's/family's achievement of their goals and the child safety concerns. The team meeting must include the family (unless reunification is not the permanency goal), the Case Manager, and may include other formal

and informal supports selected by the family (or others if the family is no longer involved).

Formal Resource People/Participants/Supports means individuals who participate as members of the Family Team due to their paid relationship with the child and family. Examples of this include foster parents, teachers, therapists, community treatment aides, family organization advocates (mentors paid to provide support who are not chosen by the family), and agency staff.

Foster Care means engaged in the service of exercising 24-hour daily care, supervision, custody, or control over children, for compensations or hire, in lieu of the care of supervision normally exercised by parents in their own home. Foster care will not include casual care at irregular intervals or programs as defined in Neb. Rev. Stat. §71-1910. The Indian Child Welfare Act expands the definition of foster care to include guardianships and placements in which the parent or Indian custodian cannot have the child returned upon demand.

Foster Care Placement means (a) all types of placements of juveniles described in Neb. Rev. Stat. 43-245 and 43-247, (b) all types of placements of neglected, dependent, or delinquent children, including those made by the Department of Health and Human Services, by the court, by parents, or by third parties, (c) all types of placements of children who have been voluntarily relinquished pursuant to Neb. Rev. Stat. 43-106.01 to the department or any child-placing agency as defined in Neb. Rev. Stat. 71-1926 licensed by the department, and (d) all types of placements that are considered to be a trial home visit, including those made directly by the department or office.

Foster family means the placement in which a child is residing other than with their biological parent(s) or legal guardians.

Foster Home means a private single-family living unit, under one roof, housing no more than nine children/youth under the age of 19 including foster children and children of the provider that provides 24-hour parenting to all of the children. No more than six children can be under the age of 12.

Group Home means a home operated under the auspices of an organization that is responsible for providing social services, administration, direction, and control for the home and that is designed to provide 24-hour care for twelve or fewer foster children in a residential setting.

Guardian means an individual appointed by a court who has the powers and responsibilities of a parent. The guardian is empowered to facilitate education, authorize medical care, consent to marriage or adoption of the ward. Under Nebraska law a guardian is not legally required to provide financial support for the ward and is not liable for acts of the ward.

Guardian ad Litem means an attorney appointed by the court to act in the minor's or an incompetent adult's behalf in a lawsuit and protect the minor's or adult's best interests in court.

Guardianship means that the court has appointed an individual to become a child's guardian. Guardianship is one of the permanency objectives available to children if reunification or adoption cannot occur.

Household means all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. A person considered as a member of the household if he/she spends 50% or more of his/her time in the home OR if the home is his/her only permanent residence (e.g., deployed members of the military, temporarily

incarcerated individuals).

Household Violence means violence within the household which can include child to child; child and parent; parent to parent; or other caretakers or relatives in the home.

Independent Living means the establishment of a residence for a foster youth to reside outside of a foster placement or his/her family. The youth would reside in an apartment, house, dorm or other type of living arrangement and is responsible for taking care of their needs i.e., paying rent, buying and preparing food, managing a budget). It is also a term used as a permanency objective or concurrent plan for a youth 16 years of age or older when it appears reunification may not occur and adoption or legal guardianship are not appropriate and the youth's best interest is served by self-sufficiency.

Indian Child Welfare Act means the federal and state law that provides direction in working with Indian Children and their families. Refer to the Indian Child Welfare Act Operations Manual for specific direction in working with children and families that may be Indian. __

Informal Living Arrangement means that the parent has made arrangements prior to or after DCFS involvement for a temporary and alternative place for their child to reside until child safety can be managed in the parental home.

Informal Resource People/Participants/Supports means individuals who participate as members of the Family Team and do not receive payment for their responsibility with respect to the family. Examples of this may be relatives, neighbors, spiritual leaders, volunteer mentors, friends, etc.

Initial Assessment means the process the Department utilizes to assess for child safety, risk and to determine if maltreatment occurred.

Injury means tissue damage such as welts, bruises, or lacerations that last more than 24 hours, resulting from trauma.

Intake means the stage of the CPS case process where the CPS caseworker screens and accepts reports of child maltreatment.

Interstate Compact on Juveniles (ICJ) means the law which provides (1) for the return from one state to another of delinquent juveniles who have absconded; (2) for the return of non-delinquent juveniles who have run away from home; (3) for the cooperative supervision of delinquent juveniles on probation or parole; and, (4) for additional cooperative measures to the protection of juveniles and of the public.

ICJ Compact Administrator means the individual in each compacting state appointed by the appropriate state authority for the administration and management of the state's supervision and transfer of juvenile delinquents.

Interstate Compact on the Placement of Children (ICPC) means the law which controls the movement of children from one state to another for the purposes of placement.

ICPC Administrator or designee means a person designated by the executive head of each jurisdiction that is party to this compact who shall be general coordinator of activities under this compact in his/her jurisdiction and who, acting jointly with like persons of other party

jurisdictions, shall have the power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact. In Nebraska this person is located in the Policy Unit of the Division of Children and Family Services. Interstate Compact on ICPC and ICPC Administrator designee definitions are out of alphabetical order and should be moved to where Interstate Compact on Juveniles definition is located.

Juvenile Offender means (1) any juvenile who has committed an act other than a traffic offense which would constitute a misdemeanor or an infraction under the laws of the state or violation of a city or village ordinance; or (2) any juvenile who has committed an act which would constitute a felony under the laws of this state; or (3) any juvenile who has committed an act which would constitute a traffic offense as defined in Neb. Rev. Stat section 43-245.

Kinship Home means a home where a child or children receive foster care and at least one of the primary caretakers has previously lived with or is a trusted adult that has a pre-existing, significant relationship with the child or children or is a sibling of such child or children pursuant to Neb. Rev. Stat. 43-1311.02.

Law Enforcement means the police department or town marshal in incorporated municipalities, the office of the sheriff in unincorporated areas, the Nebraska State Patrol, or tribal law enforcement.

Law Enforcement Check means a review of computer information or contact with a law enforcement agency to determine all felony or misdemeanor filings, including any charges filed, the dates filed, the level of charges, disposition date and final disposition.

Least restrictive means a child in a placed in a setting that is most comparable to his/her home.

Legal custody means a legal relationship that is established by court order, in which one individual, referred to as the Custodian, is given legal authority over, and the corresponding legal responsibility for, another individual. Physical custody may or may not be simultaneous with legal custody.

Maltreatment means parenting behavior that is harmful or destructive to a child's (age birth through age seventeen (17)) cognitive, social, emotional, and/or physical development.

Medical Neglect means the parent/caregiver's pattern of refusing or failing to seek/obtain medical treatment or rehabilitative care for the child's conditions that have potential life-threatening or long-term health effects, including failure to thrive. This includes appropriate medication, medical or dental care, or speech or physical therapy when there is potential for lifelong negative impact.

Medical Neglect of Handicapped Infant means the withholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from disabled infants with life-threatening conditions. Exceptions include those situations in which:

1. The infant is chronically and irreversibly comatose;
2. The provision of this treatment would merely prolong dying or not be effective in improving or correcting all the life-threatening conditions; or
3. The treatment would be virtually futile in terms of the survival of the infant and the treatment itself in such a situation be inhumane. Food and water must always be provided regardless of the extent of disabilities, and "quality of life" cannot be used as a criterion for deciding upon appropriate medical treatment.

Missing Child/Family Alert means the process whereby CFS agencies can attempt to locate families

who have left their jurisdiction by notifying other parts of the state or other state CFS agencies that the children are under the jurisdiction of the court or may be in danger.

Near Fatality means a case in which an examining physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment (Neb. Rev. Stat. 81-3126).

Non-Court Involved Case means a case in which the family agrees to work with DHHS without involving the juvenile court system, to address the identified safety threats and/or reduce the potential for risk of future maltreatment to children. Non-court involved cases are also described as Voluntary Cases.

Non-custodial Parent means any individual recognized as the parent legally through marriage, adoption, or biology; a man named by the mother or other relative as the father, who agrees he is the father; or in some cases, an individual who has acted in the role of parent for a significant period of time who does not have placement of the child the majority of the time.

Parenting Time means the quality and quantity of time a parent spends with their child who is in out of home care.

Permanency is both a process and a result that includes involvement of the child as a participant or leader in finding a permanent connection with at least one committed adult who provides a safe, stable and secure parenting relationship, love, unconditional commitment and lifelong support in the context of reunification, a legal adoption, or guardianship, where possible, and in which the child/youth has the opportunity to maintain contacts with important persons including brothers and sisters.

Permanency Plan means the systematic process of carrying out (within a brief, time-limited period) a set of goal-directed activities designed to help children live in permanent families. This process has the goal of providing the child continuity of relationships with nurturing parents or caretakers and the opportunity to establish lifetime family relationships.

Permanency Objective means an anticipated result of all efforts and services, which will result in permanency for the child or his/her discharge from Department custody.

Petition means a document filed by a county attorney in a juvenile court at the beginning of a maltreatment, status offense, and/or delinquency case. The petition states the allegations that, if true, form the basis for court intervention.

Physical Abuse means the non-accidental infliction of injury or an act that poses substantial likelihood of inflicting bodily injury.

Physical Custody means the individual with whom the agency places a child for provision of physical care, or in the case of children who are not wards of DHHS, or the individual(s) physically caring for the child.

Physical Neglect means the failure of the caregiver to provide basic needs, for example food, clothing, shelter, medical care, supervision and a safe and sanitary living environment for the child.

Placement means the arrangement for the care of a child in a licensed or approved foster family or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic or any institution primarily education in character, and any hospital or other medical facility. For purposes of the Indian Child Welfare Act, the definition of placement can include an institution caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character, and any hospital or other medical facility.

Prevention Assessment means a process to evaluate the probability (likelihood, chance, potential, prospect) that a family involved with DHHS for Dependency or Status Offense will experience maltreatment in the next 12 to 18 months.

Primary Caregiver means the person in the household who provides the most child care. The primary caregiver is considered to provide at least 51% of the care.

Preponderance of Evidence means that an event is more likely to have occurred than not by a greater weight of the evidence. As the term "preponderance of the evidence" suggests, there must be credible evidence of maltreatment documented in the case record to support a finding of agency substantiated.

Protective Placement means that safety threats are identified and no interventions are possible, the child is unsafe and must be taken into protective placement. Protective placement is defined as: 1) the family voluntarily placing their child out of the home in a residence approved by the Department; or 2) the Department initiating court action.

Putative Father: A person alleged to be the biological father with no legal establishment of paternity. Also referred to as the alleged parent.

Reasonable efforts mean those supports and services both informal and formal that may allow the child to remain in his/her home safely or to be returned home.

Relative means a person connected to the child by blood, marriage, adoption or tribal law or custom. A person related through legal guardianship will be deemed to be a relative for the purpose of these regulations. For Native American children, relative will be defined either by the law or custom of the tribe, or, in the absence of tribal law or custom, as defined by the Indian Child Welfare Act.

Reunification means a permanent plan for the child that involves the return of the child to any individual who retains parental or legal rights to the child after removal for child abuse, neglect, or both, regardless of the custody arrangement prior to the child entering out-of-home care.

Reunification Assessment means a process to assess whether a child(ren) can be safely returned to the family home based on an evaluation of safety, risk and parenting time.

Risk means the probability (likelihood, chance, potential, prospect) that any harm will occur in the next year to two years.

Risk Assessment means an objective appraisal of the likelihood that children in a household will experience abuse or neglect in the future.

Risk Re-assessment means the process of reassessing for risk to determine if change has been made

in the family that has reduced or increased the probability of future harm.

Runaway means there is reasonable evidence to suggest that the child has runaway or has been absent from home for at least 12-14 hours without parent/caregiver consent, and the parent/caregiver does not know where to locate the child.

Safe child means no safety threats were identified at the present time. Based on currently available information, there are no children likely to be in imminent danger of serious harm.

Safety means actions of protection, demonstrated by a caregiver, that mitigate the danger, demonstrated over time.

Safety Assessment means an immediate (here and now) observation and investigation of whether there are serious and imminent threats to a child. Safety is about the short term.

Safety Intervention means involvement to mitigate safety threats which utilizes family strengths whenever possible through the use of family, kin, neighbors or other individuals in the community as safety resources. It may also include direct services by the case manager and community and agency resources. Action to remove a child from the home may be necessary to ensure child safety through court action, a Voluntary Placement Agreement or the family and DHHS agreement to an informal out-of-home placement with relatives.

Safety Plan means there is a written agreement created with the family that describes the safety threats and how those safety threats will be managed to ensure child safety. The plan may remain in effect as long as needed and must be continuously evaluated and modified as long as it is in effect.

Safety Threat means there are circumstances in the family situation that could result in serious harm to the child. "Serious" means that the harm would require medical or mental health attention or emergency services, and that if DHHS staff do not think they could contain the threat, staff could not leave the child in the home. Imminent means that there is a reasonable expectation that the harm will occur in the next week or month.

Secondary Caregiver is a person residing in the household and provides care for children. They are usually a legal parent or another adult that provides less than 50% of care to the child.

Sexual Abuse means any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

Sexual Exploitation means, but is not limited to, causing, allowing, permitting, inflicting or encouraging, or forcing a minor child to solicit for or engage in voyeurism, exhibitionism, or prostitution, or in the production, distribution or acquisition of pornographic photography, films or depictions of the child when the child is unable to give consent due to the child's age or incapacity.

Status Offender means any juvenile who, by reason of being wayward, or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who departs himself or herself so as to injure or endanger seriously the morals or health of himself, or others; or who is habitually truant from home or school.

Torture means the infliction of intense pain to punish, coerce, or afford sadistic pleasure.

Trial Home Visit means a placement of a court-involved juvenile who goes from a foster care placement back to his or her legal parent or parents or guardian but remains as a ward of the state.

Transitional Living Proposal means there is a Transitional Living Proposal/Plan developed by identifying knowledge and skills of a youth related to their ability to live on their own with limited supports and providing them with education, support and training to develop and improve those skills and knowledge. This term has also been referred to as an Independent Living Plan

Unable to Locate means the subjects of the maltreatment report have not been located after a good faith effort on the part of the Department.

Unfounded means all reports not classified as court substantiated, court pending, agency substantiated, or unable to locate.

Unreasonable use of Confinement/Restraints means the use of restraints without a physician's order; the parent/caregiver using confinement to a chair, bed, corner or similar environment for unreasonable periods of time is considered physical abuse.

Unsafe child means a child for whom one or more safety threats are present and placement is the only protective intervention possible. Without placement, the children will likely be in imminent danger of serious harm.

Violence means the exertion of physical force so as to injure, abuse, or control.

Vulnerable Child means a child/youth that does not have sufficient capacity for self-protection.

References:

ⁱ See attached. Physical and Cognitive Developmental Milestones – Adapted from “Developmental Milestones Summary,” Institute for Human Services, (1990); “Developmental Charts” provided by Jeffery Lusko, Orchards Children’s Services, Southfield, MI; “Early Childhood Development from two to six years of age,” Cassie Landers, UNICEF HOUSE, New York.