KC Name: _____
POC #: _____
CW Name: _____
Referral Date: _____
PAT Level: _____

CERTIFICATION PACKET WEEK-3:

- ☐ Collect paperwork/Answer questions
- ☐ Complete Foster Parent Registry
- ☐ Complete Medical/Surgical Authorization form
- ☐ Complete Sub-CG checklist
- ☐ Complete KSA A, B, C, and D – print age appropriate KSA B from Z drive
- ☐ Training/Medical/FBI follow up

RESOURCE FAMILY APPLICANT REGISTRATION / UPDATE FORM (CY 131)

Mail to:
PENNSYLVANIA ADOPTION EXCHANGE
P.O. Box 4469
Harrisburg, PA 17111-0469
800-227-0225

☐ SWAN ID #		☐ PAE ID #		For updates: Complete Agency Information section, shaded entry blocks and all information that has changed

FAMILY DEMOGRAPHICS

All fields must be filled out unless noted

PARTNER #1

LAST NAME	FIRST NAME	MI	GENDER ☐ MALE ☐ FEMALE

DATE OF BIRTH	SOCIAL SECURITY # (Requested)	TELEPHONE (Daylight)
		( )

RACE AND ETHNICITY - Check all that apply

RACE: ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White
ETHNICITY HISPANIC: ☐ YES ☐ NO

PARTNER #2

LAST NAME	FIRST NAME	MI	GENDER ☐ MALE ☐ FEMALE

DATE OF BIRTH	SOCIAL SECURITY # (Requested)	TELEPHONE (Daylight)
		( )

RACE AND ETHNICITY - Check all that apply

RACE: ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White
ETHNICITY HISPANIC: ☐ YES ☐ NO

STREET ADDRESS	E-MAIL

CITY	STATE	ZIP	COUNTY

APPLICANT(S) MARITAL STATUS
☐ Married ☐ Single ☐ Alternative Lifestyle ☐ Other _____

PREVIOUS FAMILY ADDRESSES

List all home addresses for the previous 10 years (attach additional page, if needed) OR ☐ Not Applicable

STREET	CITY	STATE	ZIP	COUNTY
STREET	CITY	STATE	ZIP	COUNTY
STREET	CITY	STATE	ZIP	COUNTY
STREET	CITY	STATE	ZIP	COUNTY
STREET	CITY	STATE	ZIP	COUNTY

ALL OTHER MEMBERS OF HOUSEHOLD

Attach additional page, if necessary, OR ☐ Not Applicable
For families already registered ONLY: If adding or removing a member of the household, check New or Delete as appropriate

NAME	DATE OF BIRTH	GENDER	RELATIONSHIP TO APPLICANTS	SOCIAL SECURITY # (Requested)	New	Delete

FAMILY INFORMATION

Please answer the following questions.

1. List the occupations of the applicants, including a stay-at-home parent.
   - ☐ Partner 1 _____
   - ☐ Partner 2 _____
2. List any special needs training applicants have.
3. Select the type of neighborhood where applicants live. ☐ Rural ☐ Urban ☐ Suburban

FAMILY DISPOSITION

Disposition: ☐ APPROVED ☐ DISAPPROVED ☐ CLOSED
For type of care: ☐ ADOPTIVE ☐ FOSTER CARE ☐ KINSHIP

DATE of DISPOSITION

Please choose type of foster care approval or reason for any disapproval or closure below.

APPROVED - For foster care, choose type of approval

- ☐ FULL
- ☐ REGULATION WAIVER GRANTED

DISAPPROVED - Choose reason

- ☐ CHILD ABUSE HISTORY
- ☐ CRIMINAL HISTORY
- ☐ FAILURE TO COMPLETE TRAINING
- ☐ FAILURE TO FOLLOW AGENCY POLICY
- ☐ FALSIFICATION / MISREPRESENTATION OF INFORMATION
- ☐ UNFAVORABLE FAMILY PROFILE
- ☐ OTHER Explain: _____

CLOSED - Choose reason

- ☐ Adopted child from PA child welfare system
- ☐ Adopted child from another state (CW)
- ☐ Adopted privately / domestically
- ☐ Adopted internationally
- ☐ Kinship adoption
- ☐ Kinship care – not adoption
- ☐ Kinship home-child no longer in home
- ☐ Permanent Legal Custodian
- ☐ Family unresponsive
- ☐ Moved to other agency
- ☐ Moved away
- ☐ No longer interested / personal reasons
- ☐ Other reason: _____

If closing a previously registered, approved family, complete all shaded areas of the form and the Agency Information section. Sign and date below. I certify that the information provided is accurate and complete.

Signature_____ Date _____

FOSTER FAMILY APPEAL ACTIVITY

☐ FAMILY FILED APPEAL	☐ APPEAL UPHELD ☐ APPEAL DENIED	DATE
LIST ANY RESTRICTIONS TO APPROVAL		
BASIS FOR APPEAL		

AGENCY INFORMATION

REGISTERING AGENCY

REGISTERING AGENCY			CASEWORKER (Full name)
MAILING ADDRESS			E-MAIL
CITY	STATE	ZIP	COUNTY
TELEPHONE # ( )			FAX #

ALL PREVIOUS FOSTER CARE / ADOPTION AGENCY AFFILIATIONS or ☐ Not Applicable

Attach additional page, if needed

PREVIOUS AGENCY			CASEWORKER (Full name)
MAILING ADDRESS			E-MAIL
CITY	STATE	ZIP	COUNTY
TELEPHONE # ( )			FAX #

ALL PREVIOUS FOSTER CARE / ADOPTION AGENCY AFFILIATIONS (continued)

PREVIOUS AGENCY			CASEWORKER (Full name)
MAILING ADDRESS			E-MAIL
CITY	STATE	ZIP	COUNTY
TELEPHONE # ( )			FAX #

TYPE OF CHILD APPROVED FOR FAMILY

WHAT IS THE MAXIMUM NUMBER OF CHILDREN APPROVED FOR THIS FAMILY'S HOME? _____

SPECIAL NEEDS

CHECK ALL SPECIAL NEEDS FAMILY IS APPROVED TO PROVIDE. ☐ NOT APPLICABLE

- ☐ ABUSE HISTORY
- ☐ ALCOHOL EXPOSED
- ☐ DRUG EXPOSED INFANT
- ☐ EMOTIONAL DISABILITY
- ☐ HIV
- ☐ MH DIAGNOSIS
- ☐ MR DIAGNOSIS
- ☐ MULTIPLE PLACEMENT HISTORY
- ☐ NEGLECT HISTORY
- ☐ PHYSICAL DISABILITY
- ☐ RUNAWAY HISTORY
- ☐ SEXUAL ABUSE HISTORY
- ☐ SIBLINGS: # _____
- ☐ SPECIAL EDUCATION STUDENT
- ☐ SPECIAL MEDICAL CARE
- ☐ OTHER: _____

TYPE OF CHILD FAMILY PREFERS - If family is disapproved, check Not Applicable ☐

RACE / ETHNICITY - Check all family will accept	GENDER	NUMBER OF CHILDREN & AGE RANGE
RACE: ☐ AMERICAN INDIAN / ALASKAN NATIVE ☐ ASIAN ☐ BLACK / AFRICAN AMERICAN ☐ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ☐ WHITE **ETHNICITY HISPANIC:** ☐ YES ☐ NO	☐ MALE ☐ FEMALE ☐ EITHER	**AGE RANGE:** BETWEEN _____ and _____ YEARS **NUMBER OF CHILDREN:** ☐ SINGLE CHILD ☐ SIBLINGS MAXIMUM NUMBER _____

STOP STOP HERE if match suggestions are not needed

CHARACTERISTICS OF CHILD

For adoptive families only: Please choose from the characteristics listed to tell us the type of child the family wants to adopt. Place an X in the most appropriate box for each characteristic.

HEALTH

Characteristic	Acceptable	Will Consider	Unacceptable
1. No significant health problems			
2. Allergies or asthma (may require treatment)			
3. Hyperactivity (may require treatment)			
4. Speech problems (may require treatment)			
5. Hearing problems (may require treatment)			
6. Legally deaf			
7. Vision problems (may require treatment)			
8. Legally blind			
9. Dental problems (may require treatment)			
10. Orthopedic problems (special shoes, brace, etc.)			
11. Seizure disorder			

EDUCATION			
Characteristic	Acceptable	Will Consider	Unacceptable
12. High achiever			
13. Achieves on grade level in regular classes			
14. Achieves below grade level in regular classes			
15. Needs special education classes			
16. Needs learning disability classes (LD)			
17. Needs classes for the emotionally or behaviorally handicapped			
18. Needs tutoring in one or more subjects			
19. Has serious behavior problems at school			
CHARACTERISTICS AND BEHAVIORS			
Characteristic	Acceptable	Will Consider	Unacceptable
20. Generally quiet and shy			
21. Generally outgoing and noisy			
22. Emotional issues require ongoing therapy			
23. Tends to reject father figures			
24. Tends to reject mother figures			
25. Difficulty making friends and relating to other children.			
26. Frequently wets the bed.			
27. Frequently wets during the day			
28. Frequently soils him/herself			
29. Masturbates frequently or openly			
30. Poor social skills			
31. Problem with lying			
32. Problem with stealing			
33. Frequently starts physical fights with other children			
34. Tends to abuse animals			
35. Tends to be destructive of clothing, toys. etc.			
36. Frequently uses foul or bad language			
37. Frequent temper tantrums			
38. Difficulty accepting and obeying rules			
39. History of inappropriate sexual behavior			
40. History of running away			
41. History of playing with matches, setting fires			
FAMILY CONNECTEDNESS & HISTORY			
Characteristic	Acceptable	Will Consider	Unacceptable
42. Strong ties to birth family			
43. Strong ties to foster family			
44. Needs continued contact with siblings			
45. Previous adoptive disruption			
46. Sexually abused			
47. Exposed to promiscuous sexual behavior			
48. Conceived by rape			
49. Conceived as a result of prostitution			

50. One or both parents addicted to alcohol			
FAMILY CONNECTEDNESS & HISTORY			
Characteristic	Acceptable	Will Consider	Unacceptable
51. One or both parents chemically dependent, other than alcohol			
52. One or both parents has criminal record			
53. One or both parents mentally retarded			
54. One or both parents has mental illness			
55. No information available about one or more parent			
RESOURCE FAMILY'S FEELINGS ABOUT OPENNESS WITH BIRTH FAMILY			
Characteristic	Acceptable	Will Consider	Unacceptable
56. Meet with birth parents			
57. Contact with birth parents through agency or intermediary			
58. Send letters to birth parents			
59. Receive letters from birth parents			
60. Send videos to birth parents			
61. Receive videos from birth parents			
62. Have phone contact between adults			
63. Child continues visits with siblings			
64. Child continues visits with extended relatives in birth family			
65. Child continues visits with birth parents			
66. Receive birth parents' name, address, phone number, etc.			
67. Adoptive parents willing to give first name to birth parents			
68. Adoptive parents willing to give identifying information to birth parents			

SIGNATURE OF AGENCY WORKER REQUIRED

I verify that this information is accurate and complete to the best of my knowledge or information and belief. The information is submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code).

_____ _____

AGENCY WORKER **DATE**

A SECOND CHANCE INC.
Kinship Care

KINSHIP STRENGTH ASSESSMENT: FOCUS A
KINSHIP CAREGIVER

Date of referral:	Date of Placement:	Date of Focus A Interview:
Primary Caregiver:	Secondary Caregiver:	
Caregiver's relationship to child(ren):	Permanency Plan (if known):	
POC caseworker:	POC case number: ACCYF case number:	ACCYF caseworker & Regional office:
Person(s) present during the Focus A interview:		

A. Household Composition/Physical Condition

(Ask the following questions to the Primary Caregiver and his/her spouse/partner.)

1) Does anyone in your household, or family, currently have a special need or any physical, emotional, or mental health problems for which they receive ongoing or frequent medical care, counseling or therapy? **Yes** **No**
If yes, please describe who in the household has the condition, the diagnosis/name of the condition, any medication being used, any special equipment or instructions pertinent to the condition, how often they receive care, and complete the checklist below.
(Interviewer complete ROI's, if applicable.)

_____
_____
_____
_____
_____

Does this illness/condition limit your ability to:	Yes	No
a. Move about the house?		
b. Work at a job?		
c. Do daily chores/errands?		
d. Provide ongoing care and supervision to child(ren)?		
e. Drive a car?		

2) Has anyone in this household, or in your family, been seen in the past by a physician, therapist, or counselor for any special need such as emotional, physical, and/or mental problems? **Yes** **No**
If yes, please give the name of the professional, when & where they received treatment, what the condition was, do they still experience the condition, and were they on any medication, etc.
(Interviewer - fill out ROI's, if applicable.)

3) Many families today have family members who are battling drug and/or alcohol abuse issues. Does anyone in your household, or family, have one or both of these issues?
Yes **No**
If yes, please describe who is experiencing the problem and indicate if they sought and completed a treatment program, support group, etc. to overcome it. *(Interviewer - complete ROI's, if applicable)*

4) Please comment on the current overall health of caregivers and household members over the age of 18.
Interviewer – Remind the primary caregiver that everyone over age 18 in the household must complete a physical exam before certification can occur.

	Excellent	Good	Fair	Poor
Primary Caregiver				
Secondary Caregiver				
Household member over age 18 (name):				
Household member over age 18 (name):				
Household member over age 18 (name):				

5) Has anyone in this household, including yourself, ever been arrested, charged with a crime, or spent time in prison, or a detention center? **Yes** **No**
If yes, please describe the incident that caused this arrest/incarceration including who, when, where, time served, the incident itself, and the result of any charges.

B. Social Support

1) Are you receiving any help from people in your home or friends/family from outside the home in the following areas?
(Interviewer - follow-up with substitute caregiver policy, transportation policy, discipline policy, and clearances for any or all of the named people, if necessary.)

Help with…	Yes	No	Name	How Often?
Baby-sitting or child care?				
Transportation?				
Work around the home?				
Disciplining the children?				
Emotional or moral support?				

2) How often are you and/or your spouse/partner at home when the child(ren) arrive home from school (if of school age)? Always Usually Sometimes Rarely
If the answer is sometimes or rarely, please describe where you are during these hours.

Who, if anyone, meets the child(ren) at home after school when you are not available? Please be specific as to their relationship to you and the child(ren), and how often

3) When you are not available, who cares for the child(ren) (i.e. the summertime, when you vacation, or if the child is not of school age)? Please be specific as to names, relationship to you and the child(ren), how often this occurs, and for how long a period of time.

C. Information on referred children

Ask the following questions about the child(ren) being referred by ACCYF.

1) To the best of your ability, describe the placement history of each child. Placements include: other foster homes, shelters, group homes, extended hospital stays for mental evaluation, and return to the birth parents after the initial removal. Please try to give dates, names of the institutions, and time periods for each placement.
(Interviewer - complete ROI's, if applicable)

2) How did the child(ren) come to live with you?

___ I/my spouse brought the child(ren) from their parents to live with me/us
___ The child(ren) and the birth parent(s) moved in with me/us
___ The birth parents and I agreed I/we should take care of the child(ren)
___ Birth parents dropped off the children and never returned
___ Child(ren) were removed from birth parents by CYF and brought to me/us
___ Child(ren) were removed from another home by CYF and placed with me/us
___ Other (describe) _____

3) Occasionally, some children are more challenging to parent than others. Would you say that any of the children in your care are challenging to parent? **Yes** **No**
If yes, why is he/she/they difficult to parent? Please describe behaviors. (*Interviewer - record answer verbatim.)*

_____
_____
_____
_____

4) Compared to other children his or her age, do you feel that the child(ren) are slow, fast, or average in his/her physical and mental development?
(Indicate for each child opinions on both physical and mental development. Circle 'P' for physical and 'M' for mental.)

Name _____:	___ Slow (P/M)	___ Fast (P/M)	___ Average (P/M)
Name _____:	___ Slow (P/M)	___ Fast (P/M)	___ Average (P/M)
Name _____:	___ Slow (P/M)	___ Fast (P/M)	___ Average (P/M)
Name _____:	___ Slow (P/M)	___ Fast (P/M)	___ Average (P/M)
Name _____:	___ Slow (P/M)	___ Fast (P/M)	___ Average (P/M)

If slow, please explain in detail why you feel this way.

_____
_____

5) Has the child(ren), either presently or in the past, need to be taken to a therapist/counselor/doctor about any emotional, behavioral, or developmental problems?
Yes **No**
If yes, please give the reason why he/she was seen by this person, the doctor's name, when he/she was seen, and if the problems still exist. *(Interviewer - try to record verbatim. Complete ROI's if necessary.)*

_____
_____

6) Does the child(ren) currently have any physical, emotional, or mental conditions that requires:

- o ongoing or frequent treatment from a doctor/therapist?
- o prescribed use of a medication?
- o use of special equipment?

If yes to any of the above, please list the problem, give the name of the condition, name of the medication, frequency and dosage, and name of the doctor/therapist.
(Interviewer – Complete ROI's if necessary.)

_____

_____

7) To what extent has caring for the child(ren) impacted you and/or your family?

- o Not at all (explain) _____
- o Very Little (explain) _____
- o Moderately(explain)_____

8) How would you describe your relationship with the child(ren)? Would you say that it is:

- o Excellent (explain)_____
- o Very Good (explain) _____
- o Good (explain) _____
- o Fair (explain) _____
- o Poor (explain) _____

9) What do you think is the best future for the child? Would it be

- o Return to birth mother
- o Adoption by you
- o Long term foster care w/you
- o Legal guardianship
- o Other _____
- oReturn to birth father
- oAdoption by another family
- o Foster Care with another family

Why do you feel this way?

_____

_____

10) Would you ever consider adopting the child(ren)? **Yes** **No**
If no, please explain. *(Interviewer - record verbatim)* _____

_____

_____

If yes, would you also consider adopting the child(ren)'s other siblings? **Yes** **No**

_____

Are either the birth mother or birth father using drugs or alcohol or have they ever in the past?

BM - Yes No Do not know
BF - Yes No Do not know

Is he/she/they receiving any treatment for this issue? If yes, where?

_____

_____

12) Do you know of any sexual or physical abuse or neglect by the birth father or mother? If yes, please describe. **Yes** **No**

_____

_____

Is the child(ren) receiving any counseling for this issue? If yes, where? _____

_____

C. Family Dynamics

1) Where are the child(ren)'s birth mother/birth father now living?
Please be specific and give last known address.

_____

_____

2) What is the plan for visitation between child(ren) and the birth mother, birth father, or siblings?
Please be specific as to how often, when, where, etc.

_____

_____

3) How often do you speak with the birth mother and/or father?

	Primary Caregiver		Children	
	BM	BF	BM	BF
About once a week				
Several times a week				
1 to 3 times a month				
Several times a year				
About once a year				
Not at all				
If not at all, when was the last time you spoke with him and/or her?				

4) How much conflict would you say you and the birth mother and birth father have over the following issues?

	Birth Mother			Birth Father		
	Never	Sometimes	Frequently	Never	Sometimes	Frequently
Visits with the children?						
How the children are disciplined?						
Cooperation w/reunification goals?						
His/her lifestyle?						

5) How would you describe your current relationship with the birth mother and birth father?

	Very friendly	Somewhat friendly	Neither bad or good	Somewhat unfriendly	Very unfriendly
Birth Mother					
Birth Father					

Has the relationship changed since you became the caregiver for the children?
If yes, please describe.

_____

_____

6) I'm going to read some statements. Tell me, in your opinion, if these are true of the birth mother, birth father or yourself.
Y = yes, N = no, S = sometimes, DK = do not know

	Birth Mother					Birth Father				
	Y	**N**	**S**	**DK**	**Explain**	**Y**	**N**	**S**	**DK**	**Explain**
Willing to do what is necessary to be reunified w/child(ren).										
Concerned if he/she ever regains custody of the child(ren).										
Capable of parenting or caring for the children.										
Concern about the child(ren).										
Affectionate toward the child(ren).										

A physical danger to the child(ren).										

**Interviewer- using these answers, look at the visitation plan to assess the child's safety and well-being.*

7) How much influence do you allow the birth parents to have in the decisions about the child(ren)? None Very Little Moderate Very Much
explain_____

_____

8) Overall, what would you say are the chances of reunification with the birth mother or birth father?

	Excellent	Very Good	Good	Fair	Poor	Very Poor
Birth Mother						
Birth Father						

Date of Focus B Interview _____
*Child(ren) must be present to interview at this time.

Date of Focus C Interview/ ISP _____
*Children and Birth Parent(s) should be present at this time.

Date of Focus D Interview _____
*If there are two caregivers, both should be present at this time.

Caregiver(s), please sign below. Your signature indicates that you were asked these questions on the date both listed on the front and after your signature. Your signature does not mean that you are to be "held" to your answers or that your opinions cannot change. If you have any further questions, please ask your POC Caseworker.

_____ _____
Primary Caregiver Date Secondary Caregiver Date

_____ _____
POC Caseworker Date Program Supervisor Date

A SECOND CHANCE INC.
Kinship Care

KINSHIP STRENGTH ASSESSMENT: FOCUS C
BIRTH PARENTS

Birth Mother's Full Name:	Date of Birth:	Social Security Number:
Full Address:		Telephone Number:
Birth Father's Full Name:	Date of Birth:	Social Security Number:
Full Address:		Telephone Number:
Date of Focus C Interview:		

A. Questions to be asked of the Birth Parents *(Please record the answer's verbatim)*

1) Please name your children. Include their ages, present living arrangements, and the names of the other birth parent?

Child's Name	Date of Birth/Age	Present Living Arrangements	Name of other Birth Parent
1.			
2.			
3.			

2) How did you initially become involved with Allegheny County Children, Youth, and Families?

BM: _____

BF: _____

How long have you been involved with ACCYF?

BM: _____

BF: _____

3) How do you feel about your involvement with ACCYF?
   BM: _____
   BF: _____
   How do you feel about your involvement with A Second Chance, Inc.?
   BM: _____
   BF: _____

4) How do you feel about your children being in their current placement(s)?
   BM: _____
   BF: _____

5) What is the permanency goal for your child(ren) and do you agree? Why or why not?
   BM: _____
   BF: _____

6) If the goal is reunification, are you aware of the actions listed on your Family Service Plan (FSP) which you must take to become reunified with your child(ren)?
   BM: ☐ Yes ☐ No
   BF: ☐ Yes ☐ No
   Do you feel that you are able to accomplish your FSP goals to achieve reunification with your child(ren)?
   BM: ☐ Yes ☐ No
   BF: ☐ Yes ☐ No
   Are you working toward the completion of any of these goals?
   BM: ☐ Yes ☐ No
   BF: ☐ Yes ☐ No
   If yes, what goal(s) and what is your progress?
   BM: _____
   BF: _____
   How long do you think it will take to accomplish your FSP goals?
   BM: _____
   BF: _____
   What additional support do you feel would assist you in accomplishing reunification?
   BM: _____
   BF: _____
   If you cannot meet your FSP goals would you voluntarily terminate your parental rights?
   BM: ☐ Yes ☐ No
   BF: ☐ Yes ☐ No

7) If you cannot be reunified with your child(ren), what permanent arrangements would you prefer for each of your children and why?
   BM: _____
   BF: _____

How would you feel about the child(ren) staying in their current placement permanently.

BM: _____

BF: _____

How would you feel about the other birth parent gaining custody?

BM: _____

BF: _____

8) How do you feel about adoption as a permanency plan?

BM: _____

BF: _____

9) Do you visit with your children?

BM: ☐ Yes ☐ No

BF: ☐ Yes ☐ No

If yes, how often, where are the visits held, what time and day of week?

BM: _____

BF: _____

In your opinion, how are the visits?

BM: _____

BF: _____

How are the visits arranged (by ACCYF, ASCI, other)?

BM: _____

BF: _____

When you visit with your children, what kinds of activities do you do with them?

BM: _____

BF: _____

If you do not visit, why not?

BM: _____

BF: _____

10) Do you have any drug and/or alcohol related issues?

BM: ☐ Yes ☐ No

BF: ☐ Yes ☐ No

If yes, what is the problem substance(s)?

BM: _____

BF: _____

How long have you used this/these substance(s)?

BM: _____

BF: _____

Are you receiving treatment?

BM: ☐ Yes ☐ No

BF: ☐ Yes ☐ No

If yes, where?

BM: _____

BF: _____

If no, why not?

BM: _____

BF: _____

11) Do you have any medical/mental health issues?

BM: ☐ Yes ☐ No

BF: ☐ Yes ☐ No

If yes, please indicate the condition and the treatment you are pursuing (name of therapist/doctor, medication, where you receive treatment, etc.)

BM: _____

BF: _____

12) Birth Mother - Do you have a positive relationship with the birth father(s)? ☐ Yes ☐ No

Are you currently dating/involved with him/them? ☐ Yes ☐ No

Please describe your relationship with the birth father(s). _____

_____

_____

_____

Birth Father - Do you have a positive relationship with the birth mother(s)? ☐ Yes ☐ No

Are you currently dating/involved with her/them? ☐ Yes ☐ No

Please describe your relationship with the birth mother(s). _____

_____

_____

_____

13) Please answer the following questions about each of your children:

Child's name:				
At which month/week did you deliver?				
Does the child have any mental health or medical issues?				
At which hospital was the child born? Was the delivery routine?				
Did you use any drugs or alcohol while pregnant? If so, which substance?				

How much did the child weigh at birth?				
Who was the pediatrician while the child was in your care?				
What are the child's favorite things (i.e. food, activity, toy, etc.)				

14) Are you employed?

BM: ☐ Yes ☐ No

BF: ☐ Yes ☐ No

If yes, please provide the name of your employer

BM: _____

BF: _____

What is your level of income?

BM ☐ 0 – $10, 000 ☐ $10, 001 – $20,000 ☐ $20, 001 – $40, 000 ☐ more

BF: ☐ 0 – $10, 000 ☐ $10, 001 – $20,000 ☐ $20, 001 – $40, 000 ☐ more

What is the source of your income, if other than employment?

BM: _____

BF: _____

15) What is your level of education (grade completed)?

BM: _____

BF: _____

16) How is/was your relationship with your parents? Please describe in detail.

BM: _____

BF: _____

17) What is your religion and are you actively involved?

BM: _____

BF: _____

What are your wishes in regards to your children and religion or religious services?

BM: _____

BF: _____

Thank you for taking the time to speak with me. Please sign and date below. Your signature indicates that you were asked these questions. It does not mean that you are 'held' to your answers or that your opinions cannot change. If you have further questions, please feel free to ask them now.

Birth Mother	Date	Birth Father	Date
POC Caseworker	Date	Program Supervisor	Date

A SECOND CHANCE INC.
Kinship Care

KINSHIP STRENGTH ASSESSMENT: FOCUS D
SUMMARY ASSESSMENT

Primary Caregiver's name:	Secondary Caregiver's name:	
POC caseworker:	POC case number: ACCYF case number:	ACCYF caseworker & regional office:
Person(s) present during the Focus D interview:		
Date of Focus D Interview:		

This focus is to be used as a summary of the previous focuses. Please answer each question in detail. Questions 1-4 to be completed by POC Caseworker.

1. What is the current permanency goal for each child as defined by ACCYF?
   Child name: _____ Goal: _____
   Child name: _____ Goal: _____
   Child name: _____ Goal: _____
   Child name: _____ Goal: _____
   Child name: _____ Goal: _____

2. Please indicate which permanency goal each party of the Kinship Triad desires for the child(ren) in care.
   Kinship Caregiver(s): _____
   _____
   Child (if more than one indicate each child's desire): _____
   _____
   Birth Mother (if more than one indicate each Birth Mother's desire): _____
   _____
   Birth Father (if more than one indicate each Birth Father's desire): _____
   _____

3. In your assessment of the Kinship triad and your discussions with ACCYF, what do you feel will be the most viable permanency goal for each child in care?
   (Please target each child separately.
   Child name: _____ Goal: _____
   Child name: _____ Goal: _____
   Child name: _____ Goal: _____
   Child name: _____ Goal: _____

If the goal you have chosen differs from that of any party in the Kinship Triad, please indicate why you feel this goal is deemed more appropriate for this family.

4. For the permanency plan identified above, list action steps that must be taken in order to achieve the desired outcome. Also, list the barriers you perceive will hinder the accomplishment of the goal.

Questions to be asked of the Kinship Caregiver(s):

5. How long are you willing to provide care for the child(ren)? _____

6. Has the child(ren) expressed any thoughts to you regarding their permanency? Yes No
   If yes, please explain.
   _____
   _____

7. If reunification is not possible, are you willing to adopt the child(ren)? Yes No
   If yes, what services do you feel are needed? _____
   _____
   If no, please explain why. _____
   _____

8. Is there anything that ASCI or ACCYF can do to assist you in caring for the child(ren), or is there anything we can do or should be doing for the child(ren)?
   _____
   _____
   _____
   _____
   _____
   _____

Caregiver(s), please sign and date below. Your signature indicates that you were asked these questions and does not mean that you are 'held' to your answers, or that your opinions cannot change. You will have continuing input regarding the services you receive throughout the time your case is open with ASCI. If you have any further questions, please ask your POC caseworker.

_____	_____	_____	_____
Primary Caregiver	Date	Secondary Caregivers	Date
_____	_____	_____	_____
POC Caseworker	Date	POC Supervisor	Date

A SECOND CHANCE INC.
Kinship Care

MEDICAL AND SURGICAL AUTHORIZATION

Case Name _____ **Case Number** _____

Regarding the following Minor/s:

1. _____ DOB _____
2. _____ DOB _____
3. _____ DOB _____
4. _____ DOB _____
5. _____ DOB _____

1. **Yes** ❑ **No**❑ The provision of routine medical and dental care for said child.
2. **Yes** ❑ **No**❑ The use and administering of such tests and immunizing treatment, to said child, as the attending physician deems to be advisable.
3. **Yes** ❑ **No**❑ The use of all emergency medical and dental procedures necessary to preserve life or prevent permanent impairment, in the case that there is no time to obtain specific parental consent.
4. **Yes** ❑ **No**❑ The admission of said child to a hospital in the event said child develops a condition calling for hospital treatment.
5. **Yes** ❑ **No**❑ The use and administration of an anesthetic and the performance of a surgical operation on said child, if the attending physician deems this to be necessary.

_____

Signature of Parent/Guardian *Address*

_____

Signature of Parent/Guardian *Address*

_____

Witness *Date*

A SECOND CHANCE INC.
Kinship Care

SUBSTITUTE CAREGIVER CHECKLIST

IF AN APPROVED KINSHIP CAREGIVER NEEDS TO USE A SUBSTITUTE CAREGIVER FOR A CHILD, THE FOLLOWING PROCEDURES NEED TO BE IMPLEMENTED. ALSO, THIS CHECKLIST MUST BE COMPLETED FOR EACH CAREGIVER. IF THE KINSHIP FAMILY SUBSEQUENTLY BEGINS TO USE A DIFFERENT CAREGIVER, THIS FORM MUST BE COMPLETED AGAIN AND ATTACHED TO THE NEXT KINSHIP HOME RE-EVALUATION FORM.

☐ OVERNIGHT ☐ BABYSITTING ☐ BOTH

I. DEMOGRAPHIC INFORMATION

KINSHIP FAMILY NAME _____

SUBSTITUTE CAREGIVER'S NAME _____

RELATIONSHIP TO KINSHIP PARENT _____

ADDRESS _____

_____

_____

TELEPHONE _____

BIRTH DATE _____

SUBCAREGIVERS

SOCIAL SECURITY NUMBER _____

II. STUDY WORKER IS TO INTERVIEW THE SUBSTITUTE CAREGIVER TO:

☐ DISCUSS AGENCY POLICIES AND PROCEDURES
☐ ASSESS CAREGIVERS'S ABILITY TO COMPLY WITH POLICIES
☐ ASSESS CAREGIVER'S ABILITY TO MEET FOSTER CHILD'S NEEDS
☐ ASSIST CAREGIVER IN UNDERSTANDING FOSTER CHILD ISSUES AND NEEDS

DATE OF INTERVIEW ___/___/___

III. THE FOLLOWING MUST BE OBTAINED AND FILED IN THE FOSTER HOME RECORD FOR EACH SUBSTITUTE CAREGIVER:

☐ DPW CHECKLIST	DATE COMPLETED	___/___/___
☐ CHILD ABUSE & POLICY CLEARANCES	DATE OBTAINED	___/___/___
☐ SIGNED & WITNESSED DISCIPLINE POLICY	DATE OBTAINED	___/___/___
☐ SIGNED & WITNESSED TRANSPORTATION POLICY	DATE OBTAINED	___/___/___
☐ COPY OF A PHYSICAL EXAM (necessary only if child placed over 30 days)	DATE OBTAINED	___/___/___
☐ IF THE SUBSTITUTE CARE IS TO BE PROVIDED AT THE CAREGIVER'S HOME, A SAFETY CHECKLIST MUST BE COMPLETED BY A WORKER ON SITE	DATE COMPLETED	___/___/___

IV. IF THE SUBSTITUTE CAREGIVER IS GOING TO TRANSPORT THE FOSTER CHILD, THE FOLLOWING INFORMATION MUST BE OBTAINED:

LICENSE NUMBER: _____ EXPIRATION DATE: _____

CAR INSPECTION DATE: _____ CAR SEAT MODEL NUMBER: _____

Visitation Encounter Form

I/ We _____ understand that my signature below verifies a visit with my ASCI caseworker on_____.

Signed:

_____	_____
☐ Kinship Caregiver/ Resource Parent	Date
_____	_____
☐ Secondary Kinship Caregiver/ Resource Parent	Date
_____	_____
☐ Child	Date
_____	_____
☐ Other (please specify relationship to child)	Date
_____	_____
☐ ASCI Caseworker	Date

Z\Forms2008\POC\Visitation Encounter
11/2008