

*Tool 5*

JV#, Child first and last name

**Choose an agency**

*If Other, specify:* **Enter agency**

**Protective Capacities Family Assessment (PCFA)**

*Completed by the Case Manager. Refer to Tool 5A &* [*607-05-70-60*](http://www.nd.gov/dhs/policymanuals/60705/60705.htm#607_05_70_60.htm%3FTocPath%3DChild%2520Welfare%2520Practice%2520Model%7CAppendices%2520607-05-70%7CChild%2520Welfare%2520Practice%2520Appendix%252013%253A%2520PCFA%2520Instructional%2520Guidelines%2520607-05-70-60%7C_____1) *when completing this form.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| *The Protective Capacities Family Assessment (PCFA) is a collaborative process between the case manager and the parent/caregiver to examine and understand the behaviors, conditions, or circumstances that resulted in a child being unsafe. The collaborative process identifies enhanced protective capacities that can be employed to promote and reinforce change, and diminished protective capacities that must change in order for the parent/caregiver to regain full responsibility for the safety of the child. The Case Plan is developed with the family based on information gathered and documented within this assessment.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DEMOGRAPHIC INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FRAME#** | | | | Enter FRAME # | | | | | | | | | | **CPS Assessment #** | | | | | | | | | | Enter Assessment # | | | |
| **Case Manager** | | | | First and last name | | | | | | | | | | **Supervisor** | | | | | | | | | | First and last name | | | |
| **Case Name** | | | | Enter case name | | | | | | | | | | **FRAME Program Type** | | | | | | | | | |  | In-Home | | |
|  | Foster Care | | |
| **Legal Status** | | | |  | | Parent/Caregiver Custody | | | | | | | | **Current Safety Plan Type** | | | | | | | | | |  | In-Home | | |
|  | | Agency Custody | | | | | | | |  | Foster Care | | |
| **Date of Warm Handoff 2** | | | | | | | | | | | | | | Select date | | | | | | | | | | | | | |
| **Date of Most Recent Child & Family Team Meeting** | | | | | | | | | | | | | | Select date | | | | | | | | | | | | | |
| **Date of Next Child & Family Team Meeting** | | | | | | | | | | | | | | Select date | | | | | | | | | | | | | |
| **CHILDREN** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child’s Name** | | | First, Middle, Last | | | | | | | | | | Age | | | **years old** | | | **DOB** | | | | MM/DD/YY | | | | |
| **Biological Mother** | | | First, Middle, (Maiden), Last | | | | | | | | | | **Biological Father** | | | | | First, Middle, Last | | | | | | | | | |
| **Aliases** | | | | | | | | | | | | | **Aliases** | | | | | | | | | | | | | | |
| N/A*No known aliases for this person.* | | | | | | | | | | | | | N/A*No known aliases for this person.* | | | | | | | | | | | | | | |
| List all known aliases for biological mother | | | | | | | | | | | | | List all known aliases for biological father | | | | | | | | | | | | | | |
| **Does the child have Native American heritage?** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Yes | Enter Tribe | | | | | | | | | | |  | | No | | | | | | |  | Unknown | | | | |
| *When “Yes”:*   * *Refer to ICWA policy requirements AND complete the* [*ND ICWA Inquiry form*](https://und.edu/cfstc/_files/docs/2020-nd-icwa-inquiry-form-fillable.pdf) *AND Date Inquiry Form Sent* * *Send to the designated Tribe(s) when ICWA applies (if not already completed)* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date Enrollment Inquiry Sent** | | | | | Select date | | | | | | | | **Date Enrollment Application Sent** | | | | | | | | | Select date | | | | | |
|  | | N/A *This child is not ICWA eligible.* | | | | | |  | N/A *This child is not ICWA eligible.* | | | | |
| **Enrollment Number** | | | | | Enter number | | | | | | | | N/A *This child is not ICWA eligible.* | | | | | | | | | | | | | | |
| **Child’s race**  *Check all that apply.* | | | | |  | | White | | | | | |  | | American Indian/Alaskan Native | | | | | | | | | | | | |
|  | | Black | | | | | |  | | Asian/Pacific Islander | | | | | | | | | | | | |
| **Is the child Hispanic?** | | | | |  | | Yes | | | |  | No |  | | Unable to Determine | | | | | | | | | | | | |
| **Is the child in a Nexus-PATH placement?** | | | | | | | | | | | | |  | | Yes | |  | | | No | | | | | | | |
| **If yes, what level of care?** | | | | | | | |  | Treatment Foster Care (TFC) | | | | | | | |  | | | Regular Foster Care (RFC) | | | | | |  | N/A |
| **Nexus-PATH Case Manager** | | | | | | | | | | First and last name | | | | | | | | | | | Contact information | | | | | | |

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| **RESIDENT OR PRESENT PARENTS/CAREGIVERS** | | | |
| **Parent** | **Relationship to Child(ren)** | **Phone #** | **Address** |
| First and last name | Relationship | Enter phone # | Enter address |
| **Aliases** | | | |
| N/A*No known aliases for this person.* | | | |
| List all known aliases | | | |
| **NONRESIDENT OR ABSENT PARENTS/CAREGIVERS** | | | |
| **Parent** | **Relationship to Child(ren)** | **Phone #** | **Address** |
| First and last name | Relationship | Enter phone # | Enter address |
| **Aliases** | | | |
| N/A*No known aliases for this person.* | | | |
| List all known aliases | | | |
| **OTHER ADULTS** | | | |
| **Name** | **Relationship to Child(ren)** | **Phone #** | **Address** |
| First and last name | Relationship | Enter phone # | Enter address |
| **Aliases** | | | |
| N/A*No known aliases for this person.* | | | |
| List all known aliases | | | |

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| **SECTION I**  ***PCFA Introduction Stage Summary*** |
| 1. **Document efforts to engage parents/caregivers – both present and absent – in the PCFA process and their responsiveness; include the current status of engagement.**   *This is information learned from Warm Handoff 3 – Initial Contact With the Family (introduction meeting). Document a summary of the conversation.* |
| Describe efforts to engage all parents/caregivers |
| 1. **Roles, Expectations, and the PCFA Process**   *Document your conclusions about the parents’/caregivers’ understanding of role, acceptance of, and expectation for agency involvement; document the extent to which parents/caregivers understand the PCFA process. This is information learned from Warm Handoff 3 – Initial Contact With the Family (introduction meeting).* |
| Describe conclusions about parent/caregiver understanding of roles, expectations, and PCFA process |
| 1. **Reason for Agency Involvement**   *Document discussion about Impending Danger, parent/caregiver response, parent/caregiver current understanding and acceptance. This is information learned from Warm Handoff 3 – Initial Contact With the Family (introduction meeting).* |
| Describe discussion with parent/caregiver about impending danger |
| 1. **Commitment to Participate**   *Identify your conclusion about parent/caregiver willingness and capacity to participate in the PCFA process. This is information learned from Warm Handoff 3 – Initial Contact With the Family (introduction meeting).* |
| Describe your conclusion about parent/caregiver willingness to participate |
| 1. **Safety Management Status**   *Describe the status of the safety plan at the onset of the PCFA process. This is information learned from Warm Handoff 3 – Initial Contact With the Family (introduction meeting).* |
| Describe status of the safety plan |

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| **SECTION II**  ***PCFA Discovery Stage Summary*** |
| 1. **Enhanced Parent/Caregiver Protective Capacities**   *Refer to Tool 5A. Identify the* ***key*** *parent/caregiver protective capacities that you and parents/caregivers believe are enhanced; include rationale and basis; indicate differences in opinions.* |
| Identify the KEY enhanced parent/caregiver protective capacities including rationale and basis |
| 1. **Diminished Parent/Caregiver Protective Capacities**   *Refer to Tool 5A. Identify the* ***key*** *diminished protective capacities of each parent/caregiver that you and parents/caregivers believe are diminished; include rationale and basis; indicate differences in opinions.* |
| Identify the KEY diminished parent/caregiver protective capacities including rationale and basis |
| 1. **Parent/Caregiver Self-Awareness Regarding What Must Change**   *Describe your attempts [including use of clinical measures as appropriate] to raise parent/caregiver awareness; identify the current degree of their self-awareness related to the key diminished parent/caregiver protective capacities.* |
| Describe parent/caregiver self-awareness of what must change |
| 1. **Areas of Agreement Regarding What Must Change**   *Document what you and the parent/caregiver agreed upon related to enhancing the key diminished parent/caregiver protective capacities.* |
| Document areas of agreement |
| 1. **Areas of Disagreement Regarding What Must Change**   *Document what you and the parent/caregiver do not agree upon related to enhancing the key diminished parent/caregiver protective capacities.* |
| Document areas of disagreement |
| 1. **Children’s Needs**   *Indicate the extent to which needs are being met for each child.* |
| ***Foster Care Requirements***  *When the agency has custody, the following are ALWAYS required for initial and ongoing assessment of the child:*   * *Health Tracks screening* * *Ongoing maternal and paternal relative search* * *Important connections to parents, siblings, relatives, friends, culture, faith, community, school, etc.* * *Physical/dental/vision health needs and oversight of medications (includes over the counter and prescription)* * *Mental/behavioral health needs and oversight of psychotropic medications (includes over the counter and prescription)* * *Developmental needs (e.g., physical, learning, language, and/or behavior areas)* * *Educational needs and services*   ***In-Home Requirements***  *Based upon case circumstances, the following may be necessary for initial and ongoing assessment of the child:*   * *Health Tracks screening* * *Ongoing maternal/paternal relative search (if child is at high risk of removal and/or an alternate caregiver is needed per the safety plan)* * *Important connections to parents, siblings, relatives, friends, culture, faith, community, school, etc.* * *Physical/dental/vision health needs* * *Mental/behavioral health needs* * *Developmental needs (e.g., physical, learning, language, and/or behavior areas)* * *Educational needs and services* |

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| **Child Being Assessed** | | | | | | | | | | First and last name | | | | | | | | | | | | | | | | | | | | | | | | |
| **Describe Child Functioning** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe child functioning | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RELATIVE SEARCH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | N/A because *(select one of the following)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | This is an in-home case and relative search is not necessary (due to case circumstances). | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | This is a foster care case and relative placement is not appropriate due to child’s specialized needs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | This is a foster care case and identity of both parents and relatives remains unknown. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | This is an 18+ foster care case. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***= = = Go to IMPORTANT CONNECTIONS = = =*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Maternal relative search has been completed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Dates completed:** List dates of all maternal relative searches completed for this child | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Paternal relative search has been completed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Dates completed:** List dates of all paternal relative searches completed for this child | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Efforts to identify, locate, inform, and evaluate maternal and paternal relatives as potential placement options AND results of the search.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Document relative search efforts. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Relative search efforts are the same for all children. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IMPORTANT CONNECTIONS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | N/A*This is an in-home case and the safety plan does not include placement with alternate caregivers.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***= = = Go to PHYSICAL HEALTH = = =*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Important connections have been maintained. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | List child’s important connections and describe how they are being maintained. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHYSICAL HEALTH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | N/A *This is an in-home case and physical health needs are not present or parent/caregiver is willing and able to manage child’s needs.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***= = = Go to MENTAL/BEHAVIORAL HEALTH = = =*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Physical, dental, and vision health needs have been assessed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physician/Facility** | | | | | | | | | | Physician name/facility name | | | | | | | | | | | | | | **Date of Last Appointment** | | | | | | | | | | Select date |
|  | | | | | N/A *No physician.* | | | | | | | | |
| **Concerns, diagnosis, and/or follow-up needed** | | | | | | | | | | Document additional physical health information | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | N/A *No additional information.* | | | | | | | | | | | | | | | | | | | |
| **Dentist/Facility** | | | | | | | | | | Dentist name/facility name | | | | | | | | | | | | | | **Date of Last Appointment** | | | | | | | | | | Select date |
|  | | | | | N/A *No dentist.* | | | | | | | | |
| **Concerns, diagnosis, and/or follow-up needed** | | | | | | | | | | Document additional dental health information | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | N/A *No additional information.* | | | | | | | | | | | | | | | | | | | | |
| **Ophthalmologist/Facility** | | | | | | | | | | Ophthalmologist name/facility | | | | | | | | | | | | | | **Date of Last Appointment** | | | | | | | | | | Select date |
|  | | | N/A *No ophthalmologist.* | | | | | | | | | | |
| **Concerns, diagnosis, and/or follow-up needed** | | | | | | | | | | Document additional ophthalmology information | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | N/A *No additional information.* | | | | | | | | | | | | | | | | | | | | | |
| **Additional needs/services/information for physical health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List additional physical health needs and services provided. If none, enter “None identified.” | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | **Health Tracks screening has been scheduled or completed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date:** | | | | | | | | Select Date | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | N/A *This is an in-home case and Health Tracks screening isn’t necessary based on the circumstances.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Child takes medication for physical health needs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications:** | | | | | | | | | | List type(s) and dosage(s) | | | | | | | | | | | | | | | | | | | | | | | | |
| **CHECK ONE:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Physical health needs are met | | | | | | | | | | | | | |  | | | Physical health needs are partially met | | | | | | | |  | | | | Physical health needs are not met | | | | |
|  | Dental health needs are met | | | | | | | | | | | | | |  | | | Dental health needs are partially met | | | | | | | |  | | | | Dental health needs are not met | | | | |
| **MENTAL/BEHAVIORAL HEALTH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | N/A *This is an in-home case and mental/behavioral health needs are not present or parent/caregiver is willing and able to manage child’s needs.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***= = = Go to DEVELOPMENT = = =*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Mental/behavioral health needs have been assessed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mental Health Therapist/Facility** | | | | | | | | | | Therapist name/facility name | | | | | | | | | | | | | | **Appointment Frequency** | | | | | | | | | | Describe frequency |
|  | | N/A *No mental health therapist.* | | | | | | | | | | | |
| **Concerns, diagnosis, additional information** | | | | | | | | | | Document additional therapy information | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | N/A *No additional information.* | | | | | | | | | | | | | | | | | | | | | | |
| **Psychologist/Facility** | | | | | | | | | | Psychologist name/facility name | | | | | | | | | | | | | | **Date of Last Appointment** | | | | | | | | | | Select date |
|  | | N/A *No psychologist.* | | | | | | | | | | | |
| **Concerns, diagnosis, additional information**  *(if different than above)* | | | | | | | | | | Document additional psychological information | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | N/A *No additional information.* | | | | | | | | | | | | | | | | | | | | | | |
| **Psychiatrist/Facility** | | | | | | | | | | Psychiatrist name/facility | | | | | | | | | | | | | | **Date of Last Appointment** | | | | | | | | | | Select date |
|  | | N/A *No psychiatrist.* | | | | | | | | | | | |
| **Concerns, diagnosis, additional information**  *(if different than above)* | | | | | | | | | | Document additional psychological information | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | N/A *No additional information.* | | | | | | | | | | | | | | | | | | | | | | |
| **Additional needs/services/information for mental/behavioral health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List additional mental/behavioral health needs and services provided. If none, enter “None identified.” | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Child takes medication for mental/behavioral health needs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications:** | | | | | | | | | | List type(s) and dosage(s) | | | | | | | | | | | | | | | | | | | | | | | | |
| **CHECK ONE:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Mental/behavioral health needs are met | | | | | | | | | | | | | | | |  | | | Mental/Behavioral health needs are partially met | | | | |  | | | Mental/behavioral health needs are not met | | | | | | |
| **DEVELOPMENT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | N/A *This is an in-home case and developmental needs are not present or parent/caregiver is willing and able to manage child’s needs.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **= = = *Go to EDUCATION* = = =** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Developmental needs have been assessed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Provider/Facility** | | | | | | | | | | Provider name/facility | | | | | | | | | | | | | | **Date of Last Appointment** | | | | | | | | | | Select date |
|  | | N/A *No provider.* | | | | | | | | | | | |
| **Concerns, diagnosis, and/or follow-up needed** | | | | | | | | | | Document additional developmental information | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | N/A *No additional information.* | | | | | | | | | | | | | | | | | | | | | | |
| **CHECK ONE:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Developmental needs are met | | | | | | | | | | | | | | |  | | | Developmental needs are partially met | | | | | | | |  | | | | Developmental needs are not met | | | |
| **EDUCATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | N/A *This is an in-home case and educational needs are not present or parent/caregiver is willing and able to manage child’s needs OR this is an out-of-home (foster care) case and the child is age or younger and there are no apparent developmental delays requiring educational services.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **= = = *Go to OTHER* = = =** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Educational needs have been assessed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **School/Location** | | | | | | | | | School name/location | | | | | | | | | | | | | | | **Grade** | | | | | | | | | | Enter grade |
| **Educational Supports** | | | | | | | | |  | | 504 Plan | | | | | | | | | | |  | Individual Education Plan | | |  | | | | Other: | | | Specify | |
| **Additional needs/services/information for education** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List child’s educational information. If none, enter “None identified”. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CHECK ONE:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Educational needs are met | | | | | | | | | | | | | | | |  | | | | Educational needs are partially met | | | | | |  | | | | Educational needs are not met | | | |
| **OTHER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | N/A*No other needs have been identified.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **= = = *Go to SECTION III* = = =** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Other needs have been assessed that are not identified above | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | List child’s other needs and services provided. If none identified, enter “None identified”. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CHECK ONE:** | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | |
|  | All other needs are met | | | | | | | | | | | | | | | |  | | | | All other needs are partially met | | | | | | | |  | | | All other needs are not met | | |

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| **SECTION III**  ***PCFA Safety Management Conclusion*** | | | | |
| **DANGER THRESHOLD CRITERIA**  *Impending danger is a foreseeable state of danger in which a family behavior, attitude, motive, emotion, or situation can be anticipated to have severe effects on a child at any time in the near future and requires safety intervention. The Danger Threshold is crossed and becomes and Impending Danger when the safety threat meets* ***ALL*** *of the following five criteria.* | | | | |
|  | **Observable** | *Family behaviors, conditions, or situations representing a danger to a child that are specific, definite, real, can be seen, identified and understood, and are subject to being reported, named, and justified. The criterion “observable” does not include suspicion, intuitive feelings, difficulties in worker- family interaction, lack of cooperation, or difficulties in obtaining information.* | | |
|  | **Vulnerable Child** | *A child who is dependent on others for protection and is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age; physical and emotional development; ability to communicate needs; mobility; size and dependence and susceptibility. This definition also includes all young children from 0 – 6 and older children who, for whatever reason, are not able to protect themselves or seek help from others.* | | |
|  | **Out of Control** | *Family behaviors, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment not subject to the influence, manipulation, or ability within the family’s control. Such out-of-control family conditions pose a danger and are not being managed by anybody or anything internal to the family system. The family cannot or will not control these dangerous behaviors, conditions, or situations.* | | |
|  | **Imminent** | *The belief that dangerous family behaviors, conditions, or situations will remain active or become active within the next several days to a couple of weeks and will have an impact on the child within that timeframe. This is consistent with a degree of certainty or inevitability that danger and harm are possible, even likely, outcomes without intervention.* | | |
|  | **Severity** | *The degree of harm that is possible or likely without intervention. As far as danger is concerned, the danger threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment, and death. The danger threshold is also in line with family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child. In judging whether a behavior or condition is a threat to safety, consider if the harm that is possible or likely within the next few weeks has potential for severe harm, even if it has not resulted in such harm in the past. In addition to this application in the threshold, the concept of severity can also be used to describe maltreatment that has occurred in the past.* | | |
| **Is there Impending Danger?**  *Determine whether circumstances within the family cross the Danger Threshold; reference the most recent safety plan.* | | |  | Yes |
|  | No |
| **STATUS OF IMPENDING DANGER**  *Document whether the Impending Danger identified during the CPS Assessment remains the same at the conclusion of the PCFA. If the status of Impending Danger has changed, identify how the danger is currently manifested.* | | | | |
| Document information regarding the status of Impending Danger. | | | | |
|  | **N/A** *No Impending Danger was identified during the PCFA process.* | | | |

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| **SECTION IV**  ***Safety Determination Analysis*** | | | | |
| *Consider the following safety determination analysis questions to determine the least intrusive and most appropriate level of effort for controlling and managing the identified Impending Danger.* | | | | |
|  | | N/A *This case is post-TPR or 18+* | | |
| **= = = *Go to Signatures* = = =** | | | | |
| **Home** | | | | |
| 1. Does/do the child(ren)’s primary parent(s)/caregiver(s) have a suitable place to reside where an in-home safety plan can be considered? | | |  | Yes |
|  | No |
| 1. Given the current location of the family, can this safety plan be carried out? | | |  | Yes |
|  | No |
| **Calm and Consistent Enough** | | | | |
| 1. Is the home environment calm and consistent enough to allow safety services in accordance with the safety plan, and for people participating in the safety plan to be in the home safely without disruption (e.g., reasonable schedules, routine, structure, general predictability of family functioning)? | | |  | Yes |
|  | No |
| **Willing and Able** | | | | |
| 1. Is/are the primary parent(s)/caregiver(s) cooperative with child welfare services and willing to participate in the development of an in-home safety plan? | | |  | Yes |
|  | No |
| 1. Is/are the primary parent(s)/caregiver(s) willing to allow safety services and actions to be provided in accordance with the safety plan? | | |  | Yes |
|  | No |
| 1. Do/does the primary parent(s)/caregiver(s) have the ability to participate in an in-home safety plan and do what they must do as identified in an in-home safety plan? | | |  | Yes |
|  | No |
| **Sufficient Resources** | | | | |
| 1. Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified impending danger threats? | | |  | Yes |
|  | No |
| **JUSTIFY YES AND NO RESPONSES** | | | | |
| Provide justification for “Yes” and “No” responses above. | | | | |
| **SAFETY PLAN TYPE**  *NOTE:*   * *If the answers to any of questions 1-7 are “No,” the use of an out-of-home safety plan is indicated. Promptly establish an out-of-home safety plan or continue to maintain the child in out-of-home placement.* * *If the answers to all questions 1-7 are “Yes,” the use of an in-home safety plan is indicated OR the child is safe and no safety plan is needed.*   *Check the box next to the most accurate safety plan type:* | | | | |
|  | An out-of-home safety plan is indicated. | | | |
|  | An out-of-home safety plan has been in place, but the use of an in-home safety plan is indicated.  *Proceed with the reunification plan; develop and establish an in-home safety plan.* | | | |
|  | In-home safety plan remains sufficient. | | | |
|  | In-home safety plan has been revised, as needed. | | | |
|  | No safety plan is needed; child is safe. | | | |

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| **SIGNATURES** | |
| **Case Manager** | **Date** |
| **Supervisor** | **Date** |