

*Tool 7*

JV#, Child first and last name

**Choose an agency**

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

**Protective Capacities Progress Assessment (PCPA)**

*Completed by the Case Manager. Refer to tool 5A &* [*607-05-35-45*](https://www.nd.gov/dhs/policymanuals/60705/60705.htm#607_05_35_45.htm%3FTocPath%3DChild%2520Welfare%2520Practice%2520Model%7CSafety%2520Framework%2520Practice%2520Model%2520607-05-35%7CProtective%2520Capacities%2520Progress%2520Assessment%2520607-05-35-45%7C_____1) *when completing this form.*

|  |
| --- |
| *The Protective Capacities Progress Assessment (PCPA) is completed after the Case Plan is in effect and continues until case closure. The PCPA documents the quality of the helping relationship between the parents/caregivers and the agency, and the degree to which specific behaviors or conditions are changing in the intended direction.* |

|  |
| --- |
| **In-Home Case Plan**  ***Absent effective preventative services, out of home care is the planned arrangement for the child.***  **Out-of-Home Case Plan**  ***If sufficient progress is not made, the case plan is used to help achieve a permanent plan other than return home.*** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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  Agency Custody | **Current Safety Plan Type** | In-Home  Out-of-Home | |
| **Date of Warm Handoff 2** | Select date | **Date of Child & Family Team Meeting** | Select date | |
| **CHILDREN** | | | | |
| First and last name | | Age **years old** | **DOB:** MM/DD/YY | |
| **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* * *Send to the designated Tribe(s) when ICWA applies (if not already completed)* | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **RESIDENT OR PRESENT PARENTS/CAREGIVERS** | | | |
| **Name**  First and last name | **Relationship to Child(ren)**  Relationship | **Phone #**  Enter phone # | **Address**  Enter address |

|  |  |  |  |
| --- | --- | --- | --- |
| **NONRESIDENT OR ABSENT PARENTS/CAREGIVERS** | | | |
| **Name**  First and last name | **Relationship to Child(ren)**  Relationship | **Phone #**  Phone number | **Address**  Address |

|  |
| --- |
| **OTHER ADULTS**  *Safety Service providers, alternate caregivers, foster parents, kinship caregivers, child and family team members, etc.* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  First and last name | **Relationship to Child(ren)**  Relationship | **Phone #**  Phone number | **Address**  Address |

|  |
| --- |
| **SECTION I**  ***Assessing Parent/Caregiver Progress*** |
| **N/A** *This case is post-TPR or 18+*  **= = = *Go to SECTION II* = = =** |
| *Identify what progress has been made toward enhancing the KEY protective capacities of all parents/caregivers (present or absent) based on the Case Plan goals.* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PARENT/CAREGIVER** | First and last name | | | |
| **GOAL** | | | | |
| Enter the parent’s/caregiver’s goal. | | | | |
| **Status of Goal:** | **Goal remains the same**  **Goal has been revised**  **Goal has been achieved and no new goal identified** | | | |
| **Measurement Criteria:**  *(Progress made toward goal achievement)* | | **No progress** | **Progress** | **Goal achieved** |
| Describe progress made (or lack of progress made) since last assessment including rationale for goal revision. | | | | |

|  |
| --- |
| **SECTION II**  ***Assessing Child Progress*** |
| *Identify what progress has been made toward meeting the child’s identified needs.*  ***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 and paternal relative search (if child is at high risk of removal and/or an alternate caregiver is needed as part of 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* |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CHILD’S NAME:** | First and last name | | | | |
| **Describe Progress in Child Functioning**  *Refer to* [*607-05-70-25-10*](http://www.nd.gov/dhs/policymanuals/60705/60705.htm#607_05_70_25_10.htm%3FTocPath%3DChild%2520Welfare%2520Practice%2520Model%7CAppendices%2520607-05-70%7CChild%2520Welfare%2520Practice%2520Appendix%25206%253A%2520Information%2520Needed%2520to%2520Support%2520Safety%2520Decisions%2520607-05-70-25%7C_____4) *& Tool 3B – Factor #3 Child Functioning*  Describe overall progress in child functioning per 607-05-70-25-10 (areas not covered below). | | | | | |
| **RELATIVE SEARCH** | | | | | |
| **N/A because** *(choose 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**  **Paternal relative search has been completed**  *Indicate efforts to identify, locate, inform, and evaluate maternal and paternal relatives as potential placement options and results of the search.*  Document relative search efforts.  **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**  **Needs identified and services provided:**  List child’s physical, dental, and/or vision health needs and services provided. If none identified, enter “None identified”.  **Health Tracks screening has been scheduled or completed**  **Date:** Select date of most recent screening  **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**  *No needs or services completed* | | **Physical health needs are partially met**  *Services in place but not completed* | | | **Physical health needs are not met**  *Services not in place or are pending* |
| **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**  **Needs identified and services provided:**  List child’s mental/behavioral health needs and services provided. If none identified, 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**  *No needs or services completed* | | | | **Mental/Behavioral health needs are**  **partially met**  *Services in place but not completed* | **Mental/behavioral health needs**  **are not met**  *Services not in place or are pending* |
| **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**  **Needs identified and services provided:**  List child’s developmental needs and services provided. If none identified, enter “None identified”.  **CHECK ONE:** | | | | | |
| **Developmental needs are met**  *No needs or services completed* | | | **Developmental needs are partially met**  *Services in place but not completed* | | **Developmental needs are not met**  *Services not in place or are pending* |
| **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**  **Needs identified and services provided:**  List child’s educational needs and services provided. If none, enter “None identified”.  **CHECK ONE:** | | | | | |
| **Educational needs are met**  *No needs or services completed* | | | | **Educational needs are partially met**  *Services in place but not completed* | **Educational needs are not met**  *Services not in place or are pending* |
| **OTHER** | | | | | |
| **N/A** *No other needs have been identified.*  **= = = *Go to SECTION III* = = =**  **Other needs have been assessed that are not identified above** *(for example, independent living, social skills,*  *peer relationships, attachment and caregiver relationships, etc.)*  **Needs identified and services provided:**  List child’s other needs and services provided. If none identified, enter “None identified”.  **CHECK ONE:** | | | | | |
| **All other needs are met**  *No needs or services completed* | | | | **All other needs are partially met**  *Services in place but not completed* | **All other needs are not met**  *Services not in place or are pending* |

|  |
| --- |
| **SECTION III**  ***Assessing Implementation of the Case Plan*** |
| **N/A** *This case is post-TPR or 18+*  **= = = *Go to SECTION IV* = = =** |
| *Assess the implementation of the effectiveness of case plan activities, services, and service providers used to meet the goals for parents/caregivers.* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PARENT/CAREGIVER’S NAME** | First and last name | | | |
| **Participation by parent/caregiver**  *Describe the parent’s/caregiver’s participation in the case planning process since the last assessment to include:*   * *Extent to which the parent/caregiver has made progress related to case plan goal achievement (e.g., the enhancement of key protective capacities);* * *Current status of the motivational readiness of parent/caregiver to change and/or participate in change-oriented services;* * *Level of engagement in both the case planning process and with services providers; and* * *Barriers to achieving progress (if any) and how those barriers will be addressed.* | | **Poor** | **Fair** | **Good** |
| Describe participation by the parent/caregiver in case planning. | | |
| **Suitability of service providers**  *Describe whether:*   * *The service provider(s) has/have successfully engaged in a working relationship with the parent/caregiver;* * *The service provider(s) can effectively address the service needs; and* * *Any adjustments in providers that are needed and how this will be accomplished.* | | **Poor** | **Fair** | **Good** |
| Describe suitability of service providers. | | |
| **Services address the goals**  *Document whether the services provided since the last assessment have been effective in supporting progress toward achieving the case goal(s) for this parent/caregiver. If not, describe the barriers as well as any adjustments or changes to be implemented.* | | **Poor** | **Fair** | **Good** |
| Document whether services address the goal(s). | | |
| **Level of effort**  *Document whether the type and intensity of supports and/or services are effective in controlling impending danger and if not, what adjustments must be made to assure child safety.* | | **Poor** | **Fair** | **Good** |
| Document level of effort necessary and whether adjustments are needed. | | |

|  |  |
| --- | --- |
| **CASE PLAN ASSESSMENT CONCLUSION** | |
| **No change** | **Revised as documented in SECTION I** |

|  |  |  |
| --- | --- | --- |
| **SECTION IV**  ***Assessing Safety Management*** | | |
| **N/A** *This case is post-TPR or 18+*  **= = = *Go to SECTION V* = = =** | | |
| **DANGER THRESHOLD CRITERIA** | | |
| *Impending Danger is a foreseeable state of danger in which family behaviors, attitudes, motives, emotions, or situations 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 an 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 PCFA remains the same. If the status of Impending Danger has changed, identify how it is currently manifested.*  Describe the status of Impending Danger as currently manifested. If no Impending danger identified, describe what has changed. | | |

|  |  |
| --- | --- |
| **SECTION V**  ***Safety Determination Analysis*** | |
| **N/A** *This case is post-TPR or 18+* | |
| **= = = *Go to SECTION VI* = = =** | |
| **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. Is there confidence in the sustainability of the safety plan in the current location of the parent(s)/caregiver(s)? | **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) possess the necessary 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.** | |

|  |  |
| --- | --- |
| **SECTION VI**  ***Permanency Plan and Process*** | |
| **N/A** *In-Home Safety Plan is in place*  **= = = *Go to SECTION VII* = = =** | |
| **Permanency Goal(s)**  *Check all Permanency Goals in effect at the time of this assessment.* | **Reunification** |
| **Guardianship** |
| **Placement With Relative** |
| **Adoption** |
| **Another Planned Permanent Living Arrangement (APPLA)** |
| **When reunification is an established permanency goal:**  *Describe the step-by-step plan for reunification including timing for implementation of the safety plan and the process for returning the child home.*  Describe the reunification plan. | |
| *Provide a summary of the quality of family contact (per the family interaction plan within the Safety Plan form) and extent to which the experiences contribute, distract, or raise questions about reunification and establishing an in-home safety plan. Quality is judged by appropriate interaction, frequency, nurturing, and appropriate parent/caregiver involvement and participation.*  Summarize the quality of family contact with the child(ren). | |
| **N/A** *No family contact because* Describe reason(s) for no family contact. | |
| **When the established permanency goal(s) do not include reunification:**  *Describe the anticipated timing and process for achieving the child(ren)’s permanency goal(s).*  Describe the permanency plan for all identified permanency goals identified for the child(ren). | |
| **N/A** *Reunification is the only permanency goal.* | |

|  |
| --- |
| **SECTION VII**  ***Case Closure*** |
| **N/A** *Case remains open*  **= = = *Go to SIGNATURES section* = = =** |
| **The child is safe\* and has resided in the family home for**  Enter the number of months |
| **Case is being closed**  *Summarize the status of the case including parent/caregiver protective capacities, family network resources, connections to community services as appropriate, status of the child(ren)’s needs, status of change.*  Summarize the status of the case at closure. |

*\*The determination that the child is safe is based on the ND DHS-CFS definition per* [*607-05-01-01*](http://www.nd.gov/dhs/policymanuals/60705/60705.htm#607_05_01_01.htm%3FTocPath%3DChild%2520Welfare%2520Practice%2520Model%7CIntroduction%2520and%2520Overview%2520607-05-01%7C_____2)

**PCPA Signature Page**

|  |  |
| --- | --- |
| **Case Name:** Enter case name | **CFT Meeting Date:** Select date |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PCPA SIGNATURES** | | | | |
| **Print Name** | **Signature** | **Role** | **Do you agree with the plan?** | **Date** |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |

**For all Child and Family Team participants:** By signing this PCPA you are acknowledging that: 1) You were informed of the action or task you have agreed to perform; 2) You understand and are in agreement with the requirements and will fulfill them to the best of your ability; and 3) You agree to contact the case manager if you are unable to perform your responsibilities. Either you have received a copy of this plan or one will be mailed to you.

**Supervisor’s Approval**

|  |  |  |
| --- | --- | --- |
| **Print Name** | **Signature** | **Date** |