Voluntary Services Agreement & Case Plan

Last Name, First Name (List adults who will be signatories to this Agreement)

LAST NAME, First Name (list names and birthdates of children or youth to whom this Agreement pertains)
Born: month, day, year

___ INITIAL VOLUNTARY SERVICES AGREEMENT
__RENEWAL VOLUNTARY SERVICES AGREEMENT

Prepared By:
(Name of Worker)
Child Protection Worker
(*Name of Authority/Region)*
(Appointment Number)
(Date that the Report is written)

Child or Youth's Information (complete this section for each child/youth who is part of VSA)	
Name:	**Gender:**
Date of Birth/Age:	**Birthplace:**
CFS Status:	**Home Community:**
Ethnic Identity:	**MatrixNT#:**
Health Care #:	**Language:**
Indigenous or Cultural Organization Membership(s), if applicable:	**First Nation Status Card:** **Nunavut Inuit Enrolment Card (NTI):** **Inuvialuit Enrolment Card:** **Métis Citizenship Card:** ***If applicable**

Child or Youth's Information (complete this section for each child/youth who is part of VSA)	
Name:	**Gender:**
Date of Birth/Age:	**Birthplace:**
CFS Status:	**Home Community:**
Ethnic Identity:	**MatrixNT#:**
Health Care #:	**Language:**
Indigenous or Cultural Organization Membership(s), if applicable:	**First Nation Status Card:** **Nunavut Inuit Enrolment Card (NTI):** **Inuvialuit Enrolment Card:** **Métis Citizenship Card:** ***If applicable**

Parent/Care Provider/Caregiver/Expectant Parent Information (complete this section for each person who is part of VSA)	
Name:	**Gender:**
Date of Birth/Age:	**Birthplace:**
CFS Status:	**Home Community:**
Ethnic Identity:	**MatrixNT#:**
Health Care #:	**Language:**
Indigenous or Cultural Organization Membership(s), if applicable:	**First Nation Status Card:** **Nunavut Inuit Enrolment Card (NTI):** **Inuvialuit Enrolment Card:** **Métis Citizenship Card:** ***If applicable**

Parent/Care Provider/Caregiver/Expectant Parent Information (complete this section for each person who is part of VSA)

Name:	**Gender:**
Date of Birth/Age:	**Birthplace:**
CFS Status:	**Home Community:**
Ethnic Identity:	**MatrixNT#:**
Health Care #:	**Language:**
Indigenous or Cultural Organization Membership(s), if applicable:	**First Nation Status Card:** **Nunavut Inuit Enrolment Card (NTI):** **Inuvialuit Enrolment Card:** **Métis Citizenship Card:** ***If applicable**

Child or Youth's Information for Siblings NOT Part of the VSA (complete this section for each sibling who is not part of VSA)

Name:	**Date of Birth/Age:**
Address (if applicable)	
Telephone Number:	

DATE THE VOLUNTARYT SERVICES AGREEMENT AND CASE PLAN BEGINS AND ENDS (dd/mm/yyyy)

DATE THE VOLUNTARY AGREEMENT WILL BE REVIEWED (dd/mm/yyyy)

IF THE VOLUNTARY SERVICES AGREEMENT AND CASE PLAN IS BEING RENEWED, PROVIDE THE DATE THE INITIAL VOLUNTARY SERVICES AGREEMENT AND CASE PLAN STARTED (dd/mm/yyyy)

WAS AN INDIGENOUS GOVERNING BODY(S) (IGB), APPLICABLE ABORIGINAL (AAO) OR CULTURAL ORGANIZATION(S) INVOLVED IN THE DEVELOPMENT OF THE CASE PLAN? (If yes, what is the name of the IGB, AAO or Cultural Organization and the representative(s) involved in development of the Case Plan?

CHILDREN/YOUTH'S FAMILY BACKGROUND (where they lived, their childhood/upbringing, culture and traditions, their relationships with other family members, etc.)

FAMILY'S STRENGTHS AND NEEDS

What do the children/youth, parent(s)/care provider(s)/caregiver(s) or expecting parent(s) identify as strengths about their family? (List the needs for the children and adults)

Strengths	Strength Applies to

What do the children/youth, parent(s)/care provider(s)/caregiver(s) or expecting parent(s) identify as the priority needs for their family? *(*List the needs for the children and adults*)*

Priority Areas of Need	Need Applies to

CASE PLAN

RECOMMENDATIONS

Discuss the needs with the parent(s)/care provider(s)/caregiver(s) and child 12 years of age or older (if developmentally appropriate) or expecting parent(s). If a child/youth is placed out of the parental home (as part of this VSA), include a reunification plan.

Need(s) and concern(s) impacting the child/youth.

Goals to help the family or expectant parent(s) address the need(s) and concern(s) they identify.

ACTIONS (How the goals are going to be met)	RESPONSIBILITY (Who is going to do the task)	WHY ARE WE IMPLEMENTING THIS ACTION? (I.e., safety, reunification etc.)	TIMEFRAMES	MEASUREMENT OF ACHIEVEMENT

SIGNATURES

I am aware this **Voluntary Services Agreement and Case Plan** may be cancelled or modified by myself and/or Child and Family Services if I am unable to fulfill my responsibilities.

I also understand this **Voluntary Services Agreement and Case Plan** can be cancelled by me if I no longer wish to have services from Child and Family Services. I will notify the Child Protection Worker/Designate if I am no longer interested in services.

By signing my name below, I am stating that I have reviewed the **Voluntary Services Agreement and Case Plan** in its entirety, and I am in agreement with the services to be provided as well as my rights and responsibilities in achieving the goals of this **Voluntary Services Agreement and Case Plan**.

_____	_____	_____
Parent/Care Provider/Caregiver	Parent/Care Provider/Caregiver Signature	(mm-dd-yyyy)
_____	_____	_____
Parent/Care Provider/Caregiver	Parent/Care Provider/Caregiver Signature	(mm-dd-yyyy)
_____	_____	_____
Child Protection Worker/Designate	Child Protection Worker Signature	(mm-dd-yyyy)
_____	_____	_____
Supervisor/Manager	Supervisor/Manager Signature	(mm-dd-yyyy)

FOSTER HOME APPLICATION

Applicant'(s) Information			
Name(s):			
Date and Place of Birth:			
Home Address:			
Mailing address *(if different from above)*:		Telephone Number *(home)*:	
Name of Employer:		Occupation:	
Work Hours:		Phone Number(s):	
Applicant(s)'s health, including any condition(s) impacting ability to care for children/youth:			

Applicants' Relationship Information			
☐ Married	☐ Single	☐ Common Law	Date Relationship began:

Children/youth living in the home:				
Name	Gender	Birth Date	Relationship to Applicants	

Other Adults living in the home:			
Name	Gender	Birth Date	Relationship to Applicants

Type of Housing
☐ House ☐ Duplex ☐ Apartment ☐ Other *(specify)* Number of Bedrooms:

Foster Children/youth:	
We would like to foster a child/youth: Age range: _____ Gender(s): _____	
Interested in providing care for children/youth who may be experiencing: ☐ Medical Condition(s) ☐ Minor Physical Disability ☐ Fetal Alcohol Spectrum Disorder ☐ Significant Physical Disability ☐ Emotional/ Behavioural issues ☐ Developmental Delay(s) ☐ Learning Disability/Delay ☐ History of Trauma	☐ History of Sexual/Physical Abuse/Neglect ☐ Exposure to Family Violence *Willing to Provide:* ☐ Respite Care ☐ Emergency care ☐ Temporary/ Short-term placements ☐ Long-term Foster Care ☐ Care to Transition to Adoptive home ☐ Care for Siblings

Regular Foster Home Applicant(s): I/We, understand that the following forms need to be completed prior to this application being considered for approval:

- Consent for Release/Obtain Information
- Medical Examination Report
- Criminal Record Check including vulnerable sector check *(every adult residing in the home)*
- Interprovincial Child Protection Background check (where applicable),
- 3 References

Once the above documentation is submitted, a Foster Home Study will be completed within 45 days. Written notification of the outcome of this application will be mailed within 14 days of the completion of the home study. If approved, the *Foster Home Agreement, Oath of Confidentiality and Caregiver Discipline Agreement* must be signed prior to children being placed in the foster home.

Extended Family/Provisional Foster Home Applicant(s): Children/youth may be placed with extended family and/or community members in emergency situations with the completion of a Child and Family Services records check and RCMP check. The *Foster Home Agreement, Oath of Confidentiality and Caregiver Discipline Agreement* must be signed within 72 hours of the children's/youth's placement. The following additional documentation must be completed within 14 days of placement:

- Foster Home Agreement
- Criminal Record Check (every adult residing in the home)
- Medical Examination Report
- Extended Family/Provisional Foster Home Study

If all documentation is not submitted, I/we understand that the children/youth placed in our home may be removed.

_____ _____

Foster Parent Applicant Date

_____ _____
Foster Parent Applicant (where applicable) Date

Consent for Release/Receipt of Information

I,_____ of,_____
(print full name of person) *(address)*

hereby consent to

_____
(name of agency/department)

- ☐ Receiving
- ☐ Releasing

the following information:_____
(name specific information wanted)

found in the files of, _____ born on:_____
(name of person) *(DD/MM/YEAR)*

to the_____ , the _____office
(Name of Band/Organization) *(Name of community)*

_____ _____
(Signature) *(Witness)*

Dated this _____day of _____, 20____.

_____
(If other than the client, state relationship to the client)

Section 9 – Concurrent and Long-Term Planning **Form 9.1.3**

Genogram

** Refer to Tool 9.1.1 Genogram Code Key when completing or updating the family genogram**

Child /Youth's Information	
Name:	**Gender:**
Date of Birth/Age:	**Birthplace:**
CFS Status:	**Home Community:**
Ethnic Identity:	**MatrixNT#:**
Health Care #:	**Language:**
Indigenous or or Cultural Organization Membership(s), if applicable:	**First Nation Status Card:** **Nunavut Inuit Enrolment Card (NTI):** **Inuvialuit Enrollment Card:** **Métis Citizenship Card:** ***If applicable**
Current Placement (Name and Address):	
Parent/Care Provider/Caregiver(s)' Name: **Address:** **Telephone Number:** **Indigenous or Cultural Organization Membership(s), if applicable:** ***Add more rows as required***	
Parent/Care Provider/Caregiver(s)' Name: **Address:** **Telephone Number:** **Indigenous or Cultural Organization Membership(s), if applicable:** ***Add more rows as required***	
Date Genogram was created (mm-dd-yyyy):	
Date Genogram was updated (mm-dd-yyyy) (if applicable):	
GENOGRAM	

Signatures:

_____	_____	_____
Child Protection Worker/Designate	Foster Care Worker/Designate Signature	(mm-dd-yyyy)
_____	_____	_____
Supervisor/Manager	Supervisor/Manager Signature	(mm-dd-yyyy)

Invitation à participer au processus de planification des dossiers des enfants ou des adolescent (mesure non contraignante)

NOM :

GOUVERNEMENT :

COLLECTIVITÉ :

ADRESSE :

Madame,
Monsieur,

En vertu de la *Loi concernant les enfants, les jeunes et les familles des Premières Nations, des Inuits et des Métis* (fédéral), le directeur des Services à l'enfance et à la famille (SEF) s'est engagé à offrir des programmes et des services destinés aux enfants et aux adolescents en collaboration avec les corps dirigeants ou les organisations autochtones concernés. Cet engagement est conforme aux pratiques exemplaires visant à améliorer la satisfaction des patients et des collectivités, comme mentionné dans le document du ministère de la Santé et des Services sociaux *Votre bien-être, notre priorité : Plan d'action sur le respect de la culture de 2018 à 2020*, ainsi qu'aux principes de l'article 2 de la *Loi sur les services à l'enfance et à la famille* et des articles 9 et 10 de la loi fédérale.

Vous recevez cette lettre parce que les responsables des SEF travaillent avec un enfant ou un adolescent que vous connaissez peut-être, et que cet enfant ou adolescent, ses parents ou ses fournisseurs de soins ont consenti à ce que les SEF vous invitent à participer à son processus de planification des services de prévention ou à devenir membre du comité chargé de son projet de prise en charge.

Votre opinion est importante. L'enfant ou l'adolescent, ses parents ou ses fournisseurs de soins pensent qu'il bénéficierait de votre soutien, et nous sommes d'avis que votre implication et votre participation seraient dans son intérêt. Vous trouverez ci-joint les informations initiales dont vous avez besoin pour participer à la prise de décision et à la planification pour l'enfant ou l'adolescent. Si vous souhaitez participer et lui offrir votre soutien dans le processus de prise en charge, veuillez me contacter ou contacter mon superviseur ou mon gestionnaire à l'aide des coordonnées indiquées ci-dessous avant la réunion initiale de planification (identifié ci-dessous).

Les renseignements personnels contenus dans ce formulaire ont été recueillis en vertu de la *Loi sur les services à l'enfance et à la famille* ou de la *Loi sur l'accès à l'information et la protection des renseignements personnels* et sont utilisés aux fins de l'application de la *Loi sur les services à*

l'enfance et à la famille. Ces renseignements sont divulgués en vertu de la législation fédérale intitulée *Loi concernant les enfants, les jeunes et les familles des Premières Nations, des Inuits et des Métis*. Toute question concernant la collecte, l'utilisation ou la divulgation de renseignements doit être transmise à

Coordonnées de l'enfant ou de l'adolescent Remarque : Un formulaire séparé doit être rempli pour chaque enfant ou adolescent.	
Nom de l'enfant ou de l'adolescent :	
Date de naissance (AAAA-MM-JJ)	
Nom du ou des parent(s) (s'il y a lieu) :	
N° de tél. du ou des parent(s) (s'il y a lieu) :	
Nom du ou des fournisseur(s) de soins (s'il y a lieu) :	
N° de tél. du ou des fournisseur(s) de soins (s'il y a lieu) :	
Nom du corps dirigeant autochtone (s'il y a lieu) :	
Nom de l'organisation autochtone (s'il y a lieu) :	
Service proposé :	☐ Accord de services de soutien volontaires ☐ Accord de services de soutien ☐ Accord concernant le projet de prise en charge (à la maison) qui exige un comité chargé du projet de prise en charge ☐ Accords de services de soutien prolongés
Date de la réunion initiale de planification de la gestion de cas (AAAA-MM-JJ) :	
Signature de l'adolescent, si âgé de plus de 16 ans :	

Signature du ou des parent(s) (s'il y a lieu) :	
Signature du ou des fournisseur(s) de soins (s'il y a lieu) :	
Coordonnées des Services à l'enfance et à la famille	
Nom du préposé à la protection de l'enfance ou de la personne autorisée (agissant au nom du directeur statutaire) :	
Téléphone :	
Adresse :	
Numéro de téléphone d'urgence en dehors des heures de bureau :	
Courriel ou numéro de télécopieur :	
Nom du gestionnaire ou superviseur :	
Numéro de téléphone professionnel du gestionnaire ou superviseur :	
Signature du préposé à la protection de l'enfance ou de la personne autorisée :	

Invitation to Participate in Case Planning Process for Children/Youth/Young Person (non-significant measure)

NAME:
GOVERNMENT:
COMMUNITY:
ADDRESS:

Dear:

Under the Federal Act, *An Act respecting First Nations, Inuit, and Metis children, youth and families,* the Director of Child and Family Services (CFS) is committed to collaborating and engaging with Indigenous governing bodies (IGB) and/or applicable Aboriginal organizations on programs and services for children/youth/young persons. This engagement and collaboration is in accordance with best practices to improve Client and Community Experience as referenced in the Department of Health and Social Services Caring for our People: Cultural Safety Action Plan 2018-2020 as well as upholds the principles in section 2 of the Child and Family Services Act and sections 9 and 10 of the Federal *Act.*

You are receiving this letter because CFS is working with a child/youth/young person you may know and they or their parent(s)/care provider(s) have consented to CFS extending an invitation to you to engage in their prevention service planning process or to become a member of their Plan of Care Committee.

Your views matter. The child/youth/young person and/or parent(s)/care provider(s) believe they would benefit from your support and we believe your involvement and participation is in their best interest. Please see the initial information you need to participate in decision-making and planning for the child/youth/young person attached. If you would like to participate and offer support to the child/youth/young person in the case planning process, please contact myself or my Supervisor/Manager at the contact information listed below prior to the initial case planning meeting (identified below).

The personal information on this form has been collected under the authority of the *Child and Family Services Act* (CFS Act) and/or *Access to Information and Protection of Privacy Act*, and is used for the purpose of administering the CFS Act. This information is being disclosed under the federal legislation *An Act respecting First Nations, Inuit, and Métis children, youth and families*. Any questions about the collection, use, or disclosure of information should be directed to:

Identifying Information Note: A separate form is required for each child/youth/young person	
Name of child/youth/young person:	
Date of birth (yyyy-mm-dd):	
Name of Parent(s) (if applicable):	
Phone Number for Parent(s) (if applicable):	
Name of Care Provider(s) (if applicable):	
Phone Number for Care Provider(s) (if applicable):	
Name of Indigenous Governing Body (if applicable):	
Name of Aboriginal Organization (if applicable):	
Proposed Service:	☐ Voluntary Services Agreement (VSA) ☐ Support Services Agreement (SSA) ☐ Plan of Care Agreement (in-the-home) requiring a Plan of Care Committee ☐ Extended Support Services Agreement (ESSA)
Date of Initial Case Planning Meeting (yyyy-mm-dd):	
Signature of youth/young person (16+ years) (if applicable):	
Signature of Parent (s) (if applicable):	
Signature of Care Provider (s) (if applicable):	

Child and Family Services Contact Information	
Name of Child Protection Worker/Designate (acting on behalf of the Statutory Director):	
Business Phone Number:	
Business Address:	
After-Hours Emergency Phone Number:	
Email/Fax Number:	
Name of Supervisor/Manager:	
Business Phone Number of Supervisor/Manager:	
Signature of Child Protection Worker/Designate:	