



Section 5 – Court Procedures

Form 5.3.1

Case Plan Report

LAST NAME, First Name

Born: month, day, year

Apprehended on: month, day, year

(Presented in Court after a child(ren)/youth is declared to be in need of protection.)

Respectfully Submitted By:

(Name of Worker)

Child Protection Worker

(Appointment Number)

(Date that the Report is written)



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Child or Youth's Information *Please ensure you note answers for each child/youth involved in the Case Plan*

Name:	Gender:
Date of Birth/Age:	Birthplace:
CFS Status:	Home Community:
Ethnic Identity:	MatrixNT#:
Health Care #:	Language(s):
Indigenous Organization Membership(s) , if applicable:	First Nation Status Card: Nunavut Inuit Enrolment Card (NTI): Inuvialuit Enrollment Card: Métis Citizenship Card: *If applicable
Parent(s)/Care Provider(s)/Caregiver(s) Name: Address: Telephone Number: Indigenous Organization Membership(s) , if applicable: *Add more rows as required*	
Placement Name (if applicable): Address: Telephone Number:	
Sibling(s) Name: Age(s): Placement(s), if not together: *Add more rows as required*	

Ensure the following is up to date:

- ☐ Immunization Record
- ☐ Dental Exam
- ☐ Medical Appointments (including well-child appointments,

Are there any medical concerns or has the child/youth received any diagnoses in the past? If yes, please provide details below:

Does the child/youth have any allergies? If yes, please provide details below:



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Has the child/youth received any assessments (i.e. educational, psychological, behavioral, etc.)? If yes, please provide details below:

FAMILY'S PREVIOUS CHILD/YOUTH PROTECTION INVOLVEMENT (if applicable)

CURRENT CHILD/YOUTH PROTECTION CONCERNS

SERVICES CURRENTLY BEING OFFERED TO THE PARENT(S)/CARE PROVIDER(S)/CAREGIVER(S) AND THE CHILD(REN)/YOUTH

PARENT/CARE PROVIDER(S)/CAREGIVER(S) STRENGTHS AND NEEDS

What does the parent/care provider/caregiver(s) identify as their priority strengths? Document responses in the chart below? Think of when the parent/care provider/caregiver(s) have overcome a similar or stressful situation in the past, what strengths did they use to overcome and get through it? (Add additional rows as required)

STRENGTHS

Priority Areas of Strength	Strength Applies to:



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What does the parent/care provider/caregiver(s) identify as their priority needs? Document responses in the chart below. Consider possible triggers for stress and how these could be related to their needs (add additional rows as required)

NEEDS

Priority Areas of Need	Need Applies to:

What does the parent/care provider/caregiver(s) identify as their goals for the future?

*What does the **parent/care provider/caregiver(s)** identify as their **child/youth's immediate needs**, as well as their goals for the future?*



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If the child/youth is not placed with family or family members, what is the plan for on-going reassessment for family reunification or placement with extended family?

CHILD/YOUTH STRENGTHS AND NEEDS *Please ensure you note answers for each child/youth involved in the Agreement

*What does the **child/youth** identify as **their immediate needs**, as well as their goals for the future?*

Describe the child/youth's physical and mental health?

Describe the child/youth's education, if applicable (e.g. grade level, educational plans, academic successes and challenges, feelings about attending school etc.).

How is the child/youth adjusting to their current placement, if applicable?

What kind of social and recreational activities is the child/youth involved in, and how are these activities being maintained?

*What type of relationship does the child/youth have with their **parent/care provider/caregiver(s)**?*



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*If the child/youth is out of the home, what is the level of contact with their **parent/care provider/caregiver(s)** and how will this be supported?*

*What type of relationship does the child/youth have with their **sibling(s)**?*

*If the child/youth is out of the home, what is the level of contact with their **sibling(s)** and how will this be supported?*

*What type of relationship does the child/youth have with their **extended family**?*

*If the child/youth is out of the home, what is the level of contact with their **extended family** and how will this be supported?*

How can the applicable Aboriginal organization or Indigenous Governing Body or other cultural organization support the success of the family unit and/or the safe return of the child/youth to their parent/care provider(s)/caregiver(s) (if applicable)?

How can the Child Protection Worker/Designate support the safe return of the child/youth to their parent/care provider(s)/caregiver(s) care?



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CASE PLAN

A Case Plan should be written with behaviourally specific goals and objectives that consider and incorporate the parent/care provider/caregiver(s)' priority strengths in addressing their own priority needs. It also includes consideration of child characteristics and how they impact family functioning. Once completed, the initial assessment and the Case Plan can be used as a foundation for ongoing conversations. This ongoing assessment process, documented in case notes, informs case reviews and helps measure progress toward achieving household service plan objectives.

Ensure the Household Strengths and Needs Guide is completed to help inform the case plan.

Goals to help the family to address the need(s) and concern(s) (*provide clear statements describing expected behaviour of a child, youth, parent, care provider or caregiver; make specific, clear and observable*):

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

CONSENT AND SIGNATURES

I understand that I have the right to consult with a lawyer and to take this matter to court for resolution.



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I understand that either party may cancel this Agreement at any time provided they give the other party **ten (10) days** written notice and have this matter brought before the court for resolution.

We, the members listed below, understand that:

By signing our name below, we are stating that we have reviewed the Agreement and the Case Plan in its entirety.

I, _____
(Parent/Care Provider/Caregiver)

☐ Agree with the POCA and Case Plan
☐ Disagree with the POCA and Case Plan

(day/month/year)

I, _____
(Parent/Care Provider/Caregiver)

☐ Agree with the POCA and Case Plan
☐ Disagree with the POCA and Case Plan

(day/month/year)

I, _____
(Child Protection Worker/Designate)

☐ Agree with the POCA and Case Plan
☐ Disagree with the POCA and Case Plan

(day/month/year)

I, _____
(Supervisor/Manager)

☐ Agree with the POCA and Case Plan
☐ Disagree with the POCA and Case Plan

(day/month/year)



Section 6 – Case Management

Form 6.1.1

Case Notes

Case Note

Purpose:

1. Client Contact

Case Note Date/Time:



Method of Contact:

Select

Contact Location:

Select

Contact With: ☐ Other

Interviewed or Observed:

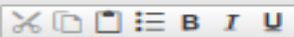
Interviewed

Private/Not In Private:

Select

Add

Note:



Note Entered: 2020-03-02 03:03 PM

Spell Check

Cancel

Save

Save and Continue



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Case Note

Select

- 1. Client Contact
- 2. General - No Client Contact
- 3. Supervisory Consultation
- 4. Legal Consultation
- 5. Case Transfer

Case Note Date/Time:



Contact Location:

Select

Contact With: ☐ Other

Interviewed or Observed:


Interviewed

Private/Not In Private:

Select

Add

Note:



Note Entered: 2020-03-02 03:03 PM

Spell Check

Cancel

Save

Save and Continue



Form 6.1.1

CFS STANDARDS AND PROCEDURE MANUAL



Section 6 – Case Management

Form 6.1.1

Case Note

Purpose:

1. Client Contact

Case Note Date/Time:



Method of Contact:

Select

Contact Location:

Select

- 1. Home (Household)
- 2. Placement Resource
- 3. Community
- 4. Worker's Office
- 5. School
- 6. Hospital/Medical Setting
- 7. Police Station
- 8. Court
- 9. Other Setting

Private/Not In Private:

Select

Add

Note:



Note Entered: 2020-03-02 03:03 PM

Spell Check

Cancel

Save

Save and Continue



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Case Note

Purpose:

1. Client Contact

Case Note Date/Time:



Method of Contact:

Select

Contact Location:

Select

Contact With: ☐ Other

☐ Check All



Private/Not In Private:

Select

Add



Note Entered: 2020-03-02 03:03 PM

Spell Check

Cancel

Save

Save and Continue



Section 6 – Case Management

Form 6.1.1

Case Note

Purpose:

1. Client Contact

Case Note Date/Time:

Method of Contact:

Select

Contact Location:

Select

Contact With: ☐ Other

Select

Interviewed

Observed

Private/Not In Private:

Select

Add

Note:

B *I* U

Note Entered: 2020-03-02 03:03 PM

Spell Check

Cancel

Save

Save and Continue



Section 6 – Case Management

Form 6.1.1

Case Note

Purpose:
1. Client Contact

Case Note Date/Time:

Method of Contact:
Select

Contact Location:
Select

Contact With: ☐ Other

Interviewed or Observed:
Interviewed

Private/Not In Private:

Select
In Private
Not In Private

Add

Note:

✂️ 📄 📌 ☰ B I U

Note Entered: 2020-03-02 03:03 PM

Spell Check

Cancel

Save

Save and Continue

After you select “Contact With”, “Interviewed or Observed” and “Private/Not in Private”, you will need to click on “ADD” to add the client to the case note. Also, all other types of case notes appear the same.



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Form 6.1.1

Case Note

Purpose:

2. General - No Client Contact ▼

Case Note Date/Time:

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Note:

Note Entered: 2020-03-02 03:03 PM

Spell Check

Cancel

Save

Save and Continue

NORTHWEST TERRITORIES
SDM® HOUSEHOLD STRENGTHS AND NEEDS ASSESSMENT/REASSESSMENT

r: 1-17

Case Name: (Last) _____ (First) _____ **Assessment Date:** _____

Case Number: _____

Primary Caregiver: (Last) _____ (First) _____ **Primary Caregiver DOB:** _____

Secondary Caregiver: (Last) _____ (First) _____ **Secondary Caregiver DOB:** _____

Assessment Type: ☐ Initial ☐ Reassessment #: ☐ 1 ☐ 2 ☐ 3 ☐ ____

Child 1: (Last) _____ (First) _____ **Child 1 DOB:** _____

Child 2: (Last) _____ (First) _____ **Child 2 DOB:** _____

Child 3: (Last) _____ (First) _____ **Child 3 DOB:** _____

Child 4: (Last) _____ (First) _____ **Child 4 DOB:** _____

Child 5: (Last) _____ (First) _____ **Child 5 DOB:** _____

Child 6: (Last) _____ (First) _____ **Child 6 DOB:** _____

Office: _____

Score each item taking into account the family's perspective, child's perspective (where appropriate), CPW observations, collateral contacts, and available records. Refer to accompanying definitions to determine the most appropriate response. Enter the score for each item.

A. ASSESSMENT OF STRENGTHS AND NEEDS

CAREGIVER SCORE
Primary Secondary

SN1. Substance Abuse/Sobriety

- ☐ a. Demonstrates a healthy understanding of alcohol and drugs..... +3
- ☐ b. Alcohol or prescribed drug use/no use0
- ☐ c. Alcohol or drug misuse/abuse-3

SN2. Household Relationships/Domestic Violence

- ☐ a. Supportive..... +3
- ☐ b. Minor or occasional household conflict.....0
- ☐ c. Significant household conflict or domestic violence.....-3

SN3. Social Support System

- ☐ a. Strong support system..... +3
- ☐ b. Adequate support system0
- ☐ c. Limited or no support system-3

SN4. Parenting Approach

- ☐ a. Strong parenting approach..... +2
- ☐ b. Adequate parenting approach0
- ☐ c. Inadequate or harmful parenting approach-2

		CAREGIVER SCORE	
		Primary	Secondary
SN5. Coping Skills	<input type="radio"/> a. Strong coping skills +2 <input type="radio"/> b. Adequate coping skills 0 <input type="radio"/> c. Inadequate coping skills -2	_____	_____
SN6. Basic Needs	<input type="radio"/> a. Strong ability to meet basic needs +1 <input type="radio"/> b. Adequate ability to meet basic needs 0 <input type="radio"/> c. Insufficient ability to meet basic needs -1	_____	_____
SN7. Cultural Support	<input type="radio"/> a. Strong cultural support +2 <input type="radio"/> b. Culture neither supports nor causes conflict 0 <input type="radio"/> c. Culture causes conflict -2	_____	_____
SN8. Health and Wellness	<input type="radio"/> a. Strong health and wellness practices +1 <input type="radio"/> b. Adequate health and wellness practices 0 <input type="radio"/> c. Inadequate health and wellness practices -1	_____	_____
SN9. Other Identified Family Strength/Need (not addressed in SN1 – SN8)	<input type="radio"/> a. A family member has a significant strength not addressed in SN1 – SN8 +1 <input type="radio"/> b. Not applicable—no additional strength/need other than identified in SN1 – SN8 ... 0 <input type="radio"/> c. A family member has a need not addressed in SN1 – SN8 -1	_____	_____

Description

B. PRIORITY NEEDS AND STRENGTHS

Enter item number and description of up to three most serious needs (lowest scores) and greatest strengths (highest scores) from Section A (items SN1 – SN9) and indicate to whom each need/strength applies.

Priority Areas of Need		Need Applies to:	Priority Areas of Strength		Strength Applies to:

C. CHILD CHARACTERISTICS

Child Functioning	Confirmed	Suspected	No/Unknown
ADD/ADHD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Criminal behaviour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression/anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developmental delay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug/solvent abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequently unresponsive to caregiver discipline and direction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inappropriate sexual behaviour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irregular school attendance/suspension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learning disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Negative peer involvement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive toxicology at birth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatric disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Running (one or more incidents)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-harming behaviour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Special education services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance abuse-related birth defect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violence toward others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Section 6 – Placement Services

Form 6.12.1

Case Review (to be completed every 3 months)

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

Parent(s)/Care Provider(s)/Caregiver(s) Name:
Address:
Telephone Number:

Add more rows as required

Placement Name (if applicable):
Address:
Telephone Number:

Sibling(s) Name:
Age(s):
Placement, if not together:

Add more rows as required

Reporting Period (mm-dd-yyyy):

Child Protection Worker/Designate:

WHAT GOALS HAVE BEEN ACHIEVED SINCE SIGNING THE AGREEMENT (VSA, SSA, ESSA, POCA) OR CASE PLAN REPORT FROM THE LAST REVIEW?



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Form 6.12.1

WHAT GOALS ARE IN PROGRESS?

What steps have the child/youth and their parent(s)/care provider(s)/caregiver(s) taken to achieve their outstanding goals or needs?

What goals or needs have not been addressed?

What supports and services do the child/youth and their parent(s)/care provider(s)/caregiver(s) need to achieve their goals and/or address their needs?

WHAT IS THE CURRENT SITUATION WITH THE CHILD/YOUTH, THEIR PARENT(S)/CARE PROVIDER(S)/CAREGIVER(S), SIBLING(S), AND/OR EXTENDED FAMILY?

What is the current situation with the child/youth and their parent(s)/care provider(s)/caregiver(s)?

What has changed for the child/youth and their parent(s)/care provider(s)/caregiver(s), i.e., work, school, friends, housing, medical, dental, optical, counseling, treatment, recreational, family relationships, emotional and social development?

How is the child/youth adjusting to their placement, if applicable? What supports and services do the foster caregiver(s) need to help the child/youth adjust to their placement?



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How does the parent(s)/care provider(s)/caregiver(s) feel about the child/youth's out of home placement, if applicable?

How is the child/youth's relationship with their parent(s)/care provider(s)/caregiver(s), sibling(s) and/or extended family being maintained? What is the type and frequency of access, and how is it progressing?

What service providers are involved in joint service planning for the child/youth and their parent(s)/care provider(s)/cargiver(s), (i.e., IGB, cultural organization, Mental Health Counsellor, etc.)? How are they supporting the child/youth and their parent(s)/care provider(s)/caregiver(s) to achieve their goals?

WHAT IS THE REUNIFICATION PLAN? (If child/youth is placed out of the home)

What needs to occur for the safe return of the child/ youth to their parent(s)/care provider(s)/caregiver(s) care?

How can the Child Protection Worker/Designate support the safe return of the child/youth to their parent(s)/care provider(s)/caregiver(s) care?

How can the applicable Aboriginal organization, Indigenous Government or cultural organization support the safe return of the child/youth to their parent(s)/care provider(s)/caregiver(s) care?



Section 6 – Placement Services

Form 6.12.1

WHAT IS THE ALTERNATIVE LONG-TERM PLACEMENT PLAN?

What is the alternative long-term placement plan for the child/youth if they cannot be safely returned to the care of their parent/care provider(s)/caregiver(s) within the timelines set out in their POCA out of the Home or Temporary Custody Order?

- ☐ Placement with another parent/care provider/caregiver (by consent or court order)
- ☐ Placement with Extended Family or Significant Other(s)
- ☐ Custom Adoption
- ☐ Continuing Placement with Foster Caregiver(s)
- ☐ Care Providership Agreement or Order

If the child/youth is not placed with the other parent/care provider/caregiver (by consent or court order), extended family, adults from the child/youth's Indigenous/cultural community or adults from another Indigenous community, what is the plan for ongoing reassessment for family reunification OR placement with the other parent/care provider/caregiver, extended family or adults significant to the child/youth?

What does the child/youth identify as their goals for the future?

What does the parent(s)/care provider(s)/caregiver(s) identify as their child's goals for the future?

What does the parent(s)/care provider(s)/caregiver(s) identify as their goals for the future, if applicable?

What needs to occur for the child/youth to achieve their long-term plan, if applicable?



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Date Review Completed (mm-dd-yyyy):

Date for next Review (mm-dd-yyyy):

- ☐ The child/youth’s needs have been re-assessed and the Specialized Needs Assessment has been updated as required.
- ☐ The SDM® Household Strengths and Needs Assessment (HSNA) has been re-assessed and updated as required.

Signatures reflect agreement with the information contained with this Case Review (if a signature is unavailable, state why).

Child Protection Worker/Designate

Child Protection Worker/Designate Signature

(mm-dd-yyyy)

Supervisor/Manager

Supervisor/Manager Signature

(mm-dd-yyyy)

Closing Summary

Name: _____ Date of Birth: _____
(day/month/year)

File Number: _____ Legal Status: _____

Completed by: _____ Date: _____
(worker) (day/month/year)

Period Covered: _____ To: _____

1. Goals Achieved:

2. Goals Not Achieved:

3. Current Situation: *Factual summary of what has changed for the child and/or family, e.g. work, school, friends, housing, appointments, adjustment to placement, counselling, treatment, recreational and social interests, family relationships, emotional and social development.*

4. Reassessment: *Your thoughts on what is happening in the family, progress in the child and/or family, areas that have improved significantly or require improvement, emerging issues, long term goals.*

5. Reason for Closure:

6. Date of Written Notice: _____

PARENT/LEGAL GUARDIAN

DATE

PARENT/LEGAL GUARDIAN

DATE

CHILD (IF 12 YEARS OR OLDER)

DATE

DISCUSSED WITH FOSTER PARENT ON _____ (date)

CHILD PROTECTION WORKER

DATE

SUPERVISOR

DATE

DATE CLOSED

NOTE: Everything in italics is to be used as a guide, and is not part of the Closing Summary



Child and Family Services Face Sheet

Child/Youth's Information	
Name (Alias):	Gender/Sex:
Date of Birth/Age (mm/dd/yyyy):	Place of Birth:
CFS Status & Expiry Date (mm/dd/yyyy):	MatrixNT/CFIS#:
Ethnic Identity:	Language:
Health Care #:	First Nation Status Card: Nunavut Inuit Enrolment Card (NTI): Inuvialuit Enrollment Card: Métis Citizenship Card: *If applicable
Alerts/Allergies:	
Indigenous Organization Membership (if applicable):	
Foster Care Resource: Physical/Mailing Address: Email: Telephone Number:	
Primary Caregiver's Name (i.e., parent, legal guardian, grandparent, aunt, uncle, etc.): Physical/Mailing Address: Email: Telephone Number:	
Secondary Caregiver's Name (i.e., parent, legal guardian, grandparent, aunt, uncle, etc.): Physical/Mailing Address: Email: Telephone Number:	
Sibling(s) Name: Age(s): Placement, if not together:	
Extended Family and/or Significant Person(s): Physical/Mailing Address: Email: Telephone Number:	
Significant Person(s)" Physical/Mailing Address: Email: Telephone Number:	
Special Needs of the Child/Youth/Young Adult:	
Medications:	
Immunization Records:	



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<div>Family Doctor/Clinic Name: Telephone Number: Email:</div> <div>Pediatrician Name: Telephone Number: Email:</div> <div>Dentist: Telephone Number: Email:</div> <div>Counsellor: Telephone Number: Email:</div> <div>Optometrist: Telephone Number: Email:</div> <div>Psychologist: Telephone Number: Email:</div> <div>Psychiatrist: Telephone Number: Email:</div> <div>Occupational Therapist: Telephone Number: Email:</div> <div>Speech Language Pathologist: Telephone Number: Email:</div> <div>Other Specialist(s): Telephone Number: Email:</div>
<div>School: Address: Email: Telephone Number: Teacher Name(s): Principal Name:</div>
<div>First Nation Status Card, Nunavut Inuit Enrolment Card (NTI), Métis Citizenship Card Number: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</div> <div>Cultural Support Plan on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____</div> <div>Concurrent Permanency on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____ Date the Concurrent Permanency is to be updated (mm/dd/yyyy): _____</div> <div>Social History on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____ Date the Social History is to be updated (mm/dd/yyyy): _____</div> <div>Child Assessment for Adoption Placement on file, if applicable: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____</div>



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Date the Child Assessment for Adoption Placement is to be updated (mm/dd/yyyy): _____

Genogram on file: ☐ Yes ☐ No ☐ N/A Date Completed (mm/dd/yyyy): _____

Date the Genogram is to be updated (mm/dd/yyyy): _____

Transition Plan on file, if applicable: ☐ Yes ☐ No ☐ N/A Date Completed (mm/dd/yyyy): _____

Date the Transition Plan is to be updated (mm/dd/yyyy): _____

Voluntary Services Agreement and Case Plan on file: ☐ Yes ☐ No ☐ N/A Date Completed (mm/dd/yyyy): _____

Date the Voluntary Services Agreement and Case Plan are to be updated (mm/dd/yyyy): _____

Support Services Agreement and Case Plan on file: ☐ Yes ☐ No ☐ N/A Date Completed (mm/dd/yyyy): _____

Date the Support Services Agreement and Case Plan are to be updated (mm/dd/yyyy): _____

Plan of Care Agreement and Case Plan on file: ☐ Yes ☐ No ☐ N/A Date Completed (mm/dd/yyyy): _____

Date the Plan of Care Agreement and Case Plan are to be updated (mm/dd/yyyy): _____

Certified Apprehension and/or Child Protection Order(s) on file: ☐ Yes ☐ No ☐ N/A

Court Documents on file: ☐ Yes ☐ No ☐ N/A

Live Birth Registration on file: ☐ Yes ☐ No

Immunization Record(s) on file: ☐ Yes ☐ No

Birth Certificate on file: ☐ Yes ☐ No

Medical and Reports etc. on file: ☐ Yes ☐ No ☐ N/A

Educational Records on file: ☐ Yes ☐ No ☐ N/A

Children’s Special Allowance Application on file (only for TCO and PCO children/youth): ☐ Yes ☐ No ☐ N/A

Date Sent to the DHSS (mm/dd/yyyy): _____

Children’s Special Allowance Cancellation on file (only for TCO and PCO children/youth): ☐ Yes ☐ No ☐ N/A

Date Sent to the DHSS (mm/dd/yyyy): _____

Latest Photo of Child/Youth on file: ☐ Yes ☐ No Date Completed (mm/dd/yyyy): _____

Passport on file: ☐ Yes ☐ No ☐ N/A Date Completed (mm/dd/yyyy): _____

Completed by: _____ Date (mm/dd/yyyy): _____

Note:
Move all documents to current volume



Extended Support Services Agreement Face Sheet

Child/Youth’s Information	
Name (Alias):	Gender/Sex:
Date of Birth/Age (mm/dd/yyyy):	Place of Birth:
CFS Status & Expiry Date (mm/dd/yyyy):	MatrixNT/CFIS#:
Ethnic Identity:	Language:
Health Care #:	First Nation Status Card: Nunavut Inuit Enrolment Card (NTI): Inuvialuit Enrollment Card: Métis Citizenship Card: *If applicable
Alerts/Allergies:	
Indigenous Organization Membership (if applicable):	
Residence: Physical/Mailing Address: Telephone Number: Email:	
Caregiver’s Name, if applicable: Physical/Mailing Address: Telephone Number: Email:	
Legal Guardian’s Name, if under Public or Private Guardianship: Physical/Mailing Address: Telephone Number: Email:	
Extended Family: Physical/Mailing Address: Telephone Number: Email:	
Significant Person(s): Physical/Mailing Address: Telephone Number: Email:	
Special Needs:	
Medications:	
Adult Services Worker: Telephone Number: Email: Counsellor: Telephone Number: Email:	



Section 6 – Case Management

Form 6.19.2

<div>Psychologist: Telephone Number: Email:</div> <div>Psychiatrist: Telephone Number: Email:</div> <div>Other Specialist(s): Telephone Number: Email:</div>
<div>Transition Plan on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____ Date the Transition Plan is to be updated (mm/dd/yyyy): _____</div> <div>Extended Support Services Agreement and Case Plan on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Date the Extended Support Services Agreement and Case Plan are to be updated(mm/dd/yyyy): _____</div> <div>Certified Permanent Custody Order: <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>Live Birth Registration on file: <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>Birth Certificate on file: <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>First Nation Status Card, Nunavut Inuit Enrolment Card (NTI), Métis Citizenship Card Number: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</div> <div>Passport on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed(mm/dd/yyyy): _____</div>
<div>Completed by: _____ Date (mm/dd/yyyy): _____</div>

Note:
Move all documents to current volume



Foster Care Resource Face Sheet

Foster Care Resource Information	
Foster Care Resource (1) Name (Alias):	Foster Care Resource (2) Name (Alias):
Date of Birth (mm/dd/yyyy):	Date of Birth (mm/dd/yyyy):
Ethnic Identity:	Ethnic Identity:
Language:	Language:
Place of Birth:	Place of Birth:
Telephone Number:	Telephone Number:
Email Address:	Email Address:
Home Address:	
Mailing Address (if different from home address):	
Name of Employer:	Name of Employer
Occupation:	Occupation:
Date Home Opened (mm/dd/yyyy):	Date Home Closed (mm/dd/yyyy):
MatrixNT/CFIS#:	
Foster Children/Youth Living in the Home Name(s), Age(s) and Date(s) of Placement:	
Biological Children/Youth Living in the Home Name(s) and Age(s):	
Other Children/Youth Living in the Home Name(s) and Age(s):	
Other Adults Living in the Home Name(s):	
Type of Foster Home: <input type="checkbox"/> Regular <input type="checkbox"/> Extended Family <input type="checkbox"/> Provisional Number of Bedrooms: _____ <i>Note: These homes may provide respite and room and board services but only in emergency situations.</i>	
Foster Home Application on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____	
Foster Home Study on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____	
Child Protection Records Check form(s) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____	



Section 6 – Case Management

Form 6.20.1

Date the Child Protection Records Check is to be updated (mm/dd/yyyy): _____ Consent for Release/Receipt of Information form(s) (Interprovincial CPRC) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____
Consent for Release/Receipt of Verbal Information form(s) (allows CPW to consult RCMP) on file (Extended/Provisional Foster Homes): <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____
Consent for Release of Police Information form(s) on file for Criminal Records Check (every 2 years): <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Consent for Check for a Sexual Offence for which a Record Suspension (Pardon) has been granted or Issued (Vulnerable Sector Verification) form(s) on file (every 2 years): <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Date the Criminal Records Check is to be updated (mm/dd/yyyy): _____ Approval or Rejection Letter from the Director of Child and Family Services on file for those foster care resource provider(s) who have a charge or an outstanding conviction as per the “relevant” offences as outlined in Standard 7.4 – Foster Home Criminal Record Check: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____
Annual Foster Home Agreement form on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Date the Foster Home Agreement is to be updated (mm/dd/yyyy): _____
Annual Foster Parent Oath of Confidentiality form on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Date the Foster Parent Oath of Confidentiality is to be updated (mm/dd/yyyy): _____
Annual Caregiver Discipline Agreement form on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Date the Caregiver Discipline Agreement is to be updated (mm/dd/yyyy): _____
Medical Examination Report form(s) on file (every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Date the Medical Examination is to be updated (mm/dd/yyyy): _____
Three Foster Parent References on file (Regular Foster Home only): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____
Approval Outcome Letter on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____
Quality of Care Review(s) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____
Most recent Foster Home Annual Review(s) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Completed (mm/dd/yyyy): _____ Date the Foster Home Annual Review is to be updated (mm/dd/yyyy): _____
Placement Closure Report on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date Completed (mm/dd/yyyy): _____
Completed by: _____ Date (mm/dd/yyyy): _____

Note:
Move all documents to current volume



Section 6 – Case Management

Form 6.21.1

Foster Care Report

Child/Youth's Information

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 Enrollment Card: Métis Citizenship Card: *If applicable

Foster Caregiver(s) Name:

Address:

Telephone Number:

Add more rows as required

Parent(s)/Care Provider(s)/Caregiver(s) Name:

Address:

Telephone Number:

Add more rows as required

Sibling(s) Name:

Age(s):

Placement, if not together:

Add more rows as required

Name of Assigned Foster Care Worker/Designate:

Name of Assigned Child Protection Worker/Designate:

Reporting Period (mm-dd-yyyy):

Date of Home Visit (mm-dd-yyyy):

DESCRIBE ANY SIGNIFICANT EVENTS THAT HAVE OCCURRED DURING THE PERIOD OF THE FOSTER CARE REPORT (achievements, challenges, changes in household, etc.)



Section 6 – Case Management

Form 6.21.1

DESCRIBE THE CHILD/YOUTH'S RELATIONSHIP WITH THE FOSTER CARE PROVIDER

DESCRIBE THE CHILD/YOUTH'S NEEDS WITHIN THE PLACEMENT AND HOW THE FOSTER CARE PROVIDER MEETS THE CHILD/YOUTH'S NEEDS AND DEALS WITH CHALLENGING BEHAVIOURS

DESCRIBE THE CHILD/YOUTH'S ACCESS/VISITATION WITH THEIR PARENT(S)/CARE PROVIDER(S), SIBLING(S) AND EXTENDED FAMILY MEMBER(S)

DESCRIBE THE FOSTER CARE PROVIDER'S CONTACT/RELATIONSHIP WITH THE CHILD/YOUTH'S FAMILY AND EXTENDED FAMILY (comment on any foster family involvement in parent-child access/supporting the child/youth in maintaining contact with family/extended family)



Section 6 – Case Management

Form 6.21.1

DESCRIBE THE CHILD PROTECTION WORKER'S LEVEL OF CONTACT WITH THE CHILD/YOUTH AND FOSTER CARE PROVIDER

IDENTIFY ANY STRENGTHS AND CHALLENGES WITH CONCURRENT, LONG-TERM AND/OR TRANSITIONAL PLANNING FOR THE CHILD/YOUTH AND MEETING THEIR NEEDS

EXPLAIN THE REASON AND OUTCOME OF ANY MEDICAL AND OTHER APPOINTMENTS FOR THE CHILD/YOUTH

DESCRIBE THE CHILD/YOUTH'S ATTENDANCE AT SCHOOL/DAYCARE, RECREATIONAL PROGRAMS AND OTHER COMMUNITY ACTIVITIES, IF APPLICABLE



Section 6 – Case Management

Form 6.21.1

DESCRIBE HOW THE FOSTER CARE PROVIDER IS FOLLOWING UP ON RECOMMENDATIONS FROM THE FOSTER CARE WORKER/DESIGNATE, ASSIGNED CHILD PROTECTION WORKER AND/OR OTHER INVOLVED SERVICE PROVIDERS

IDENTIFY WHAT GOALS THE FOSTER CARE PROVIDER WILL BE ASSISTING THE CHILD/YOUTH TO WORK ON IN THE NEXT THREE (3) MONTHS

DESCRIBE ANY CONCERNS RELATED TO THE CHILD/YOUTH'S GOALS AND SERVICES

DESCRIBE THE OUTCOME OF COURT APPEARANCE(S), IF APPLICABLE



Section 6 – Case Management

Form 6.21.1

DESCRIBE THE TYPE OF SUPPORT/TRAINING REQUIRED/REQUESTED BY THE FOSTER CARE PROVIDER, IF APPLICABLE

DESCRIBE HOW THE FOSTER CARE PROVIDER HAS BEEN ADDRESSING QUALITY OF CARE ISSUES, IF APPLICABLE

DESCRIBE ANY GENERAL CONCERNS OR QUESTIONS THAT THE FOSTER CARE PROVIDER HAS ABOUT FOSTERING (i.e. financial processes, working with Child and Family Services or other professionals)

ADDITIONAL INFORMATION



Section 6 – Case Management

Form 6.21.1

Date Report Completed (mm-dd-yyyy):

Date of Next Report (mm-dd-yyyy):

Most up-to-date reports on the child/youth's goals and plans for reunification or transitioning out of care reviewed with the foster care provider?

☐ Yes

☐ No If no, date to be completed by: _____

Date of last Annual Foster Home Review, if applicable: _____

Signatures reflect agreement with the Foster Care Report (if a signature is unavailable, state why).

Foster Care Provider Name

Foster Care Provider Signature

(mm-dd-yyyy)

Foster Care Provider Name

Foster Care Provider Signature

(mm-dd-yyyy)

Foster Care Worker/Designate

Foster Care Worker/Designate Signature

(mm-dd-yyyy)

Supervisor/Manager

Supervisor/Manager Signature

(mm-dd-yyyy)



Section #9 Concurrent and Long-Term Planning

Form 9.2.1

Transition Plan

Complete the Transition Plan for all youth who are PCO status at least six (6) months before a youth reaches the age of 16 years old (and does not require supports and services after the age of 16 years old) OR six (6) months before a young adult reaches the age majority (19 years old).

Youth or Young Adult's Information

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

Current Placement:
Address:
Telephone Number:

Parent(s)/Care Provider(s)/Caregiver(s) Name:
Address:
Telephone Number:
Indigenous Organization Membership, if applicable:

add more rows as required

Sibling(s) Name:
Age(s):
Placement, if not together:
Indigenous Organization Membership, if applicable:

add more rows as required

Child Protection Worker/Designate:

WHO ARE THE MEMBERS OF THE TRANSITION PLAN?



Section #9 Concurrent and Long-Term Planning

Form 9.2.1

WHAT DOES THE YOUTH/YOUNG ADULT IDENTIFY AS THEIR LONG-TERM GOAL(S) AND AMBITION(S)?

WHAT DOES THE YOUTH/YOUNG ADULT IDENTIFY AS THEIR EDUCATION AND/OR EMPLOYMENT NEEDS?

WHAT DOES THE YOUTH/YOUNG ADULT IDENTIFY AS THEIR FINANCIAL PLAN (consider how youth/young adult will earn income, application for income support, obtain bank card, etc.)?

WHAT DOES THE YOUTH/YOUNG ADULT IDENTIFY AS THEIR PLACEMENT AND ACCOMMODATION PLAN?

HOW DOES THE YOUTH/YOUNG ADULT PLAN TO MAINTAIN THEIR FAMILIAL RELATIONSHIPS AND/OR CULTURAL CONNECTIONS?



Section #9 Concurrent and Long-Term Planning

Form 9.2.1

WHO DOES THE YOUTH/YOUNG ADULT IDENTIFY AS THEIR SUPPORT NETWORK (who can the youth/young adult contact for assistance or support when needed)?

WHAT LIFE SKILL(S) DOES THE YOUTH/YOUNG ADULT IDENTIFY AS NEEDING SUPPORT WITH (cooking, household maintenance, financial responsibility, job applications, parenting, etc.)?

IDENTIFY THE INDIVIDUALS, SERVICES, AND PROGRAMS AVAILABLE TO SUPPORT THE YOUTH/YOUNG ADULT IN ACHIEVING THEIR GOAL(S)

HOW WILL CHILD AND FAMILY SERVICES SUPPORT THE YOUTH/YOUNG ADULT IN ACHIEVING THEIR GOALS?

HOW WILL THE APPLICABLE ABORIGINAL ORGANIZATION(S), INDIGENOUS GOVERNING BODY(S) OR CULTURAL ORGANIZATION(S) SUPPORT THE YOUTH OR YOUNG ADULT IN ACHIEVING THEIR GOALS?



Section #9 Concurrent and Long-Term Planning

Form 9.2.1

DESCRIBE/DEFINE ANY LEGAL CONSIDERATIONS INCLUDING A PLAN FOR RESOLUTION OF ANY OUTSTANDING LEGAL REQUIREMENT.

SUMMARIZE THE OUTSTANDING STEPS REQUIRED TO IMPLEMENT THE TRANSITION PLAN (making reference to specific timelines, include outstanding referrals/services needed, contact information for other key formal and informal supports and upcoming planning meetings required between them, the Youth and the Child Protection Worker/Designate, financial accountability expectations, etc.)

Date Transition Plan Created(mm-dd-yyyy):

Date Transition Plan will be reviewed (mm-dd-yyyy):

Signatures reflect agreement with the information contained with this Transition Plan (if a signature is unavailable, state why).

Youth/Young Adult Name

Youth/Young Adult Signature

(day/month/year)

Child Protection Worker/Designate

Child Protection Worker/Designate Signature

(day/month/year)

Supervisor/Manager

Supervisor/Manager Signature

(day/month/year)

Access Plan for Parents

DATE: _____ FAMILY NAME: _____

PARENTS: *(indicate only those parents and guardians who will be having access)*

CHILDREN:

1. _____
2. _____
3. _____
4. _____

1. _____
2. _____
3. _____
4. _____

OTHERS: *(indicate any other individuals who will be having access and their relationship to child)*

YOUR CHILD PROTECTION WORKER IS: _____

DETAILS OF VISITS:

FREQUENCY AND DURATION:

Visits will occur _____ times per week for _____ hour(s).

LOCATION:

☐ Authority office ☐ Family Home ☐ Community, Specify: _____

TRANSPORTATION: Do parents and/or guardians require assistance with transportation to Visits?

☐ No ☐ Yes, specify: _____

SPECIAL CONDITIONS *(List specific conditions that are expected by parents ie. confirm attendance, discipline, substance use, condition of home, safety measures etc.)*

- 1.
- 2.
- 3.

STRUCTURE - Specific activities that are expected to occur during visits i.e. mealtimes, naptimes, assistance with homework, medical appointments, school meetings...etc.

- 1.
- 2.
- 3.

LEVEL OF SUPERVISION - indicate where supervising worker will be located during visits

- ☐ Unsupervised
- ☐ Partially Supervised Specify: _____
- ☐ Fully Supervised Specify: _____

TERMINATION/MODIFICATION OF VISITS:

Are there any identified concerns that may warrant termination of an access visit?

YES: _____ NO: _____

Provide Details/Explanation (where applicable):

List the circumstances that may warrant an Immediate Review and potential Modification of the Access Plan:

ACCESS PLAN REVIEWS

DATES	LIST ANY MODIFICATIONS

Access Plan

Adapted from Accessing Visiting for Children in Care. An Opportunity for Engagement and Collaboration, (2005). Darlene Neimi, OACAS Collaboration Project.

☐ Preliminary Access Plan

OR ☐ Review of Access Plan

CFIS # _____

Date: _____

Parent(s): _____

Child's Name: _____ D.O.B. _____

Child's Name: _____ D.O.B. _____

Child's Name: _____ D.O.B. _____

Child's Name: _____ D.O.B. _____

Date of Admission: _____ Legal Status: _____

Court Involvement? YES: _____ (describe: _____) NO: _____

Child Protection Worker: _____

Foster Home: _____

Primary Risk/Protection Concerns: _____

Supervising Access Worker: _____

The primary purpose of access visits is to mitigate attachment-related issues for children while they are separated from their parents.

1. OBJECTIVES TO BE ACHIEVED THROUGH ACCESS VISITS:

Check Applicable Area(s):

- Preliminary Summary and Evaluation: _____

- Guidance and Education Plan: _____
- Therapeutic Contact: _____
- Supervised/Monitored Visit: _____

Follow Up Summary and Evaluation? YES: _____ NO: _____

2. DETAILS OF ACCESS PLAN:

Court Ordered? YES: _____ NO: _____

I. Frequency/Duration:

Details:

Arrangements for Telephone Contact:

Arrangements for Special Occasions:

II. Location:

Agency:

Family Home:

Other:

III. Transportation Arrangements:

For Children (provide details):

For Parent(s) (provide details):

IV. Schedule:

To be Developed by: _____

To be Reviewed with Children by: _____

To be Reviewed with Parents by: _____

To be Reviewed with Foster Caregivers by: _____

V. Extended Family Members/Siblings/Pets:

Are there plans to include significant others in access visits? YES: ____ NO: ____

Provide Details/Explanation:

VI. Overnight Access Visits:

Are there current plans for overnight visits? YES: _____ NO: _____

Provide Details/Explanation:

VII. Structure: *Describe significant components to be included in access plan ie. mealtimes, social activities, naptimes, playgroups etc.*

- a. _____

- b. _____

- c. _____

- d. _____

- e. _____

VIII. Therapeutic Contact *(where applicable):*

Reasons:

Supervising Access Worker (*should be known to child*):

Preparation with Child (*provide details*):

Preparation with Parent(s) (*provide details*):

IX. Supervised/Monitored Access Visit (*where applicable*):

a. Level Required: Fully Supervised: _____ OR Monitored: _____

Describe:

b. Check one or more of the following:

Safety Issues: _____

Explain:

Assess Ongoing Progress of Parents: _____

Explain:

Transition Period: _____

Explain:

3. SPECIAL CONDITIONS:

Describe any special conditions required of parents for visits *ie. sobriety, confirmation of attendance, provision of food, diapers etc., non-violent behaviour, age-appropriate discussions, clean home etc.*

- a. _____

- b. _____

- c. _____

- d. _____

4. TERMINATION/MODIFICATION OF ACCESS VISIT:

Are there any identified concerns that may warrant termination of an access visit?

YES: _____ NO: _____

Provide Details/Explanation (*where applicable*):

List the Criteria that may warrant an Immediate Review and potential Modification of the overall Access Plan:

5. PARENTAL INVOLVEMENT: *How often meetings with parents will occur:*

Identified Child Protection Worker(s): _____

6. ROLE OF FOSTER CAREGIVERS:

Describe how foster caregivers may be involved in access planning:

Identify how often meetings/discussions will occur with foster caregivers:

Identified Child Protection Worker(s): _____

7. CHILDREN'S INVOLVEMENT:

Identify (where applicable) how often meetings with children will occur

Identified Child Protection Worker(s): _____

8. DOCUMENTATION OF ACCESS VISITS:

Supervising Access Worker(s) Identified:

Observation Case notes to be submitted to: _____

CASE TRANSFER SUMMARY

Name: _____ Date of Birth: _____
(day/month/year)

File Number: _____ Legal Status: _____

Completed by: _____ Date: _____
(Child Protection Worker/Social Worker) (day/month/year)

Period Covered: _____ To: _____

1. Goals Achieved:

2. Goals Not Achieved:

3. Current Situation: *Factual summary of what has changed for the child and/or family, i.e. work, school, friends, housing, appointments, adjustment to placement, counselling, treatment, recreational and social interests, family relationships, emotional and social development.*

4. Reassessment: *Your thoughts on what is happening in the family, progress in the child and/or family, areas that have improved significantly or require improvement, emerging issues, long term goals.*

5. Reason for Transfer:

6. When was the Child/Family Informed of the Transfer:

CASE PLAN:

DEFINITION OF NEEDS:

- 1.
- 2.
- 3.

FAMILY STRENGTHS:

- 1.
- 2.
- 3.

GOALS: *(statements describing the desired conditions or behaviours of the child and/or parents)*

- 1.
- 2.

STEPS/TASKS/ SERVICES TO BE PROVIDED: *(specific, measurable, and realistic)*

- 1.

Who is responsible?

Date of achievement?

- 2.

Who is responsible?

Date of achievement?

DISCUSSED WITH PARENT(S) AND/OR GUADIAN(S) ON _____ (date)

DISCUSSED WITH CHILD, 12 YEARS OF AGE AND OLDER ON _____
(date)

DISCUSSED WITH FOSTER PARENT ON _____ (date)

Worker:

Date:

Supervisor:

Date:

DATE CLOSED:

NOTE: Everything in italics is to be used as a guide, and is not part of the Case Transfer Summary



Child and Family Services Minimum Contacts Schedule

EXAMPLE OF CONTACT SCHEDULE FOR VOLUNTARY SERVICES AGREEMENT (0-18) – *Child/Youth out of the Home*

Person	Frequency and Type of Contact	Month 1: January 2019	Month 2: February 2019	Month 3: March 2019	Month 4: April 2019	Month 5: May 2019	Month 6: June 2019	Month 7: July 2019	Month 8: August 2019	Month 9: September 2019	Month 10: October 2019	Month 11: November 2019	Month 12: December 2019
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF PLACEMENT Face-to-Face Contact	Face-to-Face – January 10, 2019											
	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face Contact	Telephone – January 27, 2019	Face-to-Face – February 23, 2019		Telephone – April 23, 2019	Telephone – May 19, 2019		Face-to-Face – July 15, 2019	Face-to-Face – August 20, 2019		Face-to-Face – October 17, 2019	Telephone – November 19, 2019	
	AT LEAST EVERY 90 DAYS Private Face-to-face contact			Private Face-to-Face – March 20, 2019			Private Face-to-Face – June 18, 2019			Private Face-to-Face – September 23, 2019			Private Face-to-Face – December 19, 2019
Parent(s)/ Guardian(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact	Face-to-Face – January 27, 2019	Telephone - February 20, 2019		Face-to-Face - April 17, 2019	Face-to-Face – May 18, 2019		Telephone – July 15, 2019	Telephone - August 20, 2019		Telephone - October 17, 2019	Face-to-Face - November 22, 2019	
	AT LEAST EVERY 90 DAYS Private Face-to-face contact			Private Face-to-Face – March 20, 2019			Private Face-to-Face – June 18, 2019			Private Face-to-Face - September 23, 2019			Private Face-to-Face – December 19, 2019
Foster Caregiver(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to-Face OR Email Contact	Face-to-Face - January 23, 2019	Face-to-Face - February 23, 2019		Telephone - April 23, 2019	Face-to-Face - May 26, 2019		Face-to-Face - July 15, 2019	Telephone - August 21, 2019		Face-to-Face - October 17, 2019	Telephone - November 19, 2019	
	AT LEAST EVERY 90 DAYS Private Face-to-face Contact			Private Face-to-Face - March 18, 2019			Private Face-to-Face - June 22, 2019			Private Face-to-Face - September 20, 2019			Private Face-to-Face - December 23, 2019



Child and Family Services Minimum Contacts Schedule

VOLUNTARY SERVICES AGREEMENT (0-18) – *Child/Youth out of the Home*

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF PLACEMENT Face-to-Face contact												
	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face Contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Parent(s)/ Guardian(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Foster Caregiver(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face OR Email contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

SUPPORT SERVICES AGREEMENT (16-18) – Youth out of the Home

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF PLACEMENT Face-to-Face contact												
	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face Contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Foster Caregiver(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face OR Email contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

EXTENDED SUPPORT SERVICES AGREEMENT (19-22) – *Young Adult in or out of the Home*

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

PLAN OF CARE AGREEMENT OR SUPERVISION ORDER (0-15) – *Child/Youth in the Home*

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Child/Youth and Parent(s)/Guardian(s)	AT LEAST EVERY 60 DAYS Private Face-to-Face contact												
Parent(s)/Guardian(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

PLAN OF CARE AGREEMENT (0-15) – *Child/Youth out of the Home*

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF PLACEMENT Face-to-Face contact												
	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Child/Youth and Parent(s)/Guardian(s)	AT LEAST EVERY 60 DAYS Private Face-to-Face contact												
Parent(s)/Guardian(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Foster Caregiver(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face OR Email contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

TEMPORARY CUSTODY (0-18) – INCLUDES EXTENSIONS AND YOUTH PROTECTION ORDERS - *Child/Youth out of the Home*

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF PLACEMENT Face-to-Face contact												
	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Child/Youth and Parent(s)/Guardian(s)	AT LEAST EVERY 60 DAYS Private Face-to-Face contact												
Parent(s)/Guardian(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Foster Caregiver(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face OR Email contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

PERMANENT CUSTODY (0-18) –INCLUDES EXTENSIONS AND YOUTH PROTECTION ORDERS - *Child/Youth out of the Home*

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF PLACEMENT Face-to-Face contact												
	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Child/Youth and Foster Caregiver(s)	AT LEAST EVERY 60 DAYS Private Face-to-Face contact												
Foster Caregiver(s)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face OR Email contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

IN TERRITORY SPECIALIZED SERVICE AND GROUP HOME RESOURCE (0-18)

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF PLACEMENT Face-to-Face contact												
	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Parent(s)/Guardian(s) (Not Applicable to Permanent Custody Children/Youth)	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Specialized Service/Group Home	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Email contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												



Child and Family Services Minimum Contacts Schedule

OUT OF TERRITORY SPECIALIZED SERVICE (0-18)

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	ADMISSION In person												
	DISCHARGE In person												
	AT LEAST EVERY 30 DAYS Telephone OR Electronic Communication contact												
	ONCE A YEAR Private visit												
Parent(s)/Guardian(s) <i>(Not Applicable to Permanent Custody Children/Youth and Extended Support Services Agreements)</i>	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Courtesy Supervision Worker	AT LEAST EVERY 30 DAYS Telephone OR Electronic Communication contact												
Specialized Service	AT LEAST EVERY 30 DAYS Telephone OR Electronic Communication contact												



Child and Family Services Minimum Contacts Schedule

CHILD/YOUTH PLACED IN A FOSTER PLACEMENT OUTSIDE OF THE TERRITORY (0-18)

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	AT LEAST EVERY 30 DAYS Telephone OR Electronic Communication contact												
	ONCE A YEAR Private visit												
Parent(s)/Guardian(s) <i>(Not Applicable to Permanent Custody Children/Youth)</i>	AT LEAST EVERY 30 DAYS Telephone, Electronic Communication OR Face-to Face contact												
	AT LEAST EVERY 90 DAYS Private Face-to-face contact												
Courtesy Supervision Worker	AT LEAST EVERY 30 DAYS Telephone OR Electronic Communication contact												
Foster Caregiver(s)	AT LEAST EVERY 30 DAYS Telephone OR Electronic Communication contact												



Child and Family Services Minimum Contacts Schedule

TRANSFERRING A FILE – When a file is transferred to a new Child Protection Worker

CLIENT NAME(S): _____ MATRIX #: _____ DATE: _____

Person	Frequency and Type of Contact	Month 1:	Month 2:	Month 3:	Month 4:	Month 5:	Month 6:	Month 7:	Month 8:	Month 9:	Month 10:	Month 11:	Month 12:
Child/Youth	WITHIN THE FIRST 7 CALENDAR DAYS OF THE FILE BEING ASSIGNED Telephone, Electronic Communication OR Face-to-Face contact												
Parent(s)/Guardians	WITHIN THE FIRST 7 CALENDAR DAYS OF THE FILE BEING ASSIGNED Telephone, Electronic Communication OR Face-to-Face contact												
Foster Caregiver(s)	WITHIN THE FIRST 7 CALENDAR DAYS OF THE FILE BEING ASSIGNED Telephone, Electronic Communication OR Face-to-Face contact												

LEGEND:

Types of Contact:

- In Person (INP)
- Telephone (T)
- Face-to Face (F-T-F)
- Private Face-to-Face (P-F-T-F)
- Email (E)

This form may be used to record all contacts, but it is not mandatory.

Child's Medical Examination

Date: _____

Name			Date of Birth (day/month/year)		
Address: Street: _____ Apartment Number: _____ City: _____ Territory/Province: _____ Postal Code: _____ Phone Number () - _____					
Health History					
NO	YES	SPECIAL SENSE DISEASE (Hearing Loss Vertigo Visual Defects, etc.)	NO	YES	SKELETAL DISEASE
		CARDIO VASCULAR DISEASE (Angina, Infraction Heart Failure Arrhythmia Stroke, etc.)			GASTRO-INTESTINE DISEASE
		RESPIRATORY DISEASE (Asthma, Chronic Bronchitis, Emphysema, etc.)			METABOLIC DISEASE (Diabetes, Thyroid Disease, etc.)
		NEUROLOGIC DISEASE (Epilepsy, Parkinson Disease, Multiple Sclerosis, etc.)			PSYCHIATRIC ILLNESS
		MEDICATION BEING TAKEN (If Yes, specify details below)			ADDICTIONS (Alcohol, Sedatives, Tranquillisers, Narcotics, etc.)
		OTHER DISEASES (If yes, specify details below)			
Details (explain "yes" answers fully)					
NWT Childhood Immunization Schedule Check and Provide Dates of When Immunized					
<input type="checkbox"/> 1 Month Hepatitis B <input type="checkbox"/> 4 Months Pentacle <input type="checkbox"/> 12 Months MMR <input type="checkbox"/> 18 Months Pentacle <input type="checkbox"/> MMR <input type="checkbox"/> 14 Years Mantoux			Birth BCG (if from community or at risk of TB) Hepatitis B <input type="checkbox"/> 2 Months Pentacle (DPTP-HIB) <input type="checkbox"/> 6 Months Hepatitis B <input type="checkbox"/> Pentacle <input type="checkbox"/> 4-5 Years Uadracel (DPTP) <input type="checkbox"/> 9-10 Years Hepatitis B Serious if not previously given		

Physical Examination											
HEIGHT	WEIGHT	BLOOD PRESSURE	SYSTOLIC	DIAGNOSTIC	LABORATORY TESTS	URINE					
						NORMAL	ABNORMAL (SPECIFY)				
Other Tests (Specify tests and findings)											
Vision (w/o glasses)		Right	Left	W/ Glasses	Right	Left	Peripheral	Right	Left	Colour Vision	Right Left
NO	YES				NO	YES					
		Eye Disease					Gastro-intestinal disease				
		Ear Disease					Neurologic Disease				
		Respiratory Disease					Skeletal Disease				
		Cardiovascular Disease					Psychiatric Disease				
		Medication Prescribed Specify:					Impetigo, Scabies, Lice, or other Skin Infection				
		Allergies					Communicable Diseases				
Medical Practitioner Notes											
<p>General Physical Condition:</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p> <p>Recommendations:</p>											
<p>MEDICAL PRACTITIONER'S SIGNATURE: _____</p> <p>ADDRESS:</p>											

Consent to Services for a Child

I/We, _____, of _____, NT, am/are
Parent(s) and/or Guardian(s) *City/Town/Hamlet*
parent(s) of _____, born on _____,
Child's Name *Day/Month/Year*
Health Care # _____.

I/We hereby authorize the Child Protection Worker or _____,
to **consent to:** *Name of Other Person*

- ☐ **Any form of medical treatment, immunization, surgical operation, dental treatment, anaesthetics or any other form of health care** which a physician, surgeon, dentist or other qualified health professional considers necessary or advisable for the above named child.
- ☐ **Any diagnostic techniques** required including X-ray.
- ☐ Any **school or daycare related activities** including field trips and extracurricular activities
- ☐ Any **recreational activities** that the above named child would like to pursue.
- ☐ Any **therapeutic interventions** or evaluations deemed necessary by a physician or the Child Protection Worker.

I/We understand that the Child Protection Worker will make every reasonable effort to advise me/us of treatment and diagnostic techniques provided to my/our child. Unless otherwise noted, I/we have not placed any limitations on the authority to give consent to the treatment, services and activities outlined above.

Exceptions to the Above Consent:

I specifically **DO NOT AUTHORIZE** the following types of treatment, procedures, services or activities and wish to be contacted personally for my consent

This Consent is in effect from _____ to _____

Dated this ____ day of _____, 20____

Signature of Parent

Signature of Witness

Signature of Parent

Signature of Witness



Section 9 - Case Management

Form 6.16.2

Follow Up Report

Regional Health and Social Services Authority:	
Client Name:	
Status:	
Ethnic Identity:	
Indigenous Organization Membership, if applicable:	
Matrix Number:	
Date of Birth (Month/Day/Year):	
Date of Serious Occurrence:	
Date of Initial Serious Occurrence Report:	
Date of Follow Up:	
Child Protection Worker/Designate Name:	
Supervisor Name:	
FACTUAL DESCRIPTION:	
Update on information given in the Serious Occurrence Report:	
Outcome of the Regional Health and Social Services review of the incident, if applicable:	
Outcome of any RCMP investigation(s) including whether charges under the <i>Criminal Code of Canada</i> have been laid or are anticipated, if applicable:	
Results of any medical examinations as to the cause of the Serious Occurrence, medical follow-up, and/or treatment required:	



Section 9 - Case Management

Form 6.16.2

Further actions indicated or planned by the Regional Health and Social Services: Plan to follow up with those impacted by the Serious Occurrence, plan to address the child, youth, young adult or parent/caregiver(s)' needs as they relate to the Serious Occurrence including change of placement, treatment interventions, safety planning, foster care resource needs, etc.

In the case of death, whether the Coroner will be involved:

Signatures:

(Child Protection Worker Signature)

(day/month/year)

(Supervisor/Manager Signature)

(day/month/year)

For NTHSSA Use Only:

Received by NTHSSA Deputy Director of Practice (initials):

Date

For Departmental Use Only:

Received by Director or Child and Family Services or Designate (initials):

Date

Director of Child and Family Services or Designate Notified within the timelines: ☐ Yes ☐ No

Date Entered into Serious Occurrence Database: _____

Further Action:

☐ Director's File Review ☐ Director's Case Review ☐ Nothing Required: ☐ Other: _____

Guidance and Education Plan During Access Visits

Adapted from *Accessing Visiting for Children in Care. An Opportunity for Engagement and Collaboration*, (2005). Darlene Neimi, OACAS Collaboration Project.

Goals:

- To help improve parent-child relationships and parenting skills while the child or youth remain in care as well as providing the parent(s) and/or guardian(s) with the opportunity to practice these new skills/behaviours in environment that is non-threatening.
- When specific parenting behaviours are problematic as per the preliminary **Summary and Evaluation Plan**, the Worker must further assess parenting skills through a **Guidance and Education Plan**.
- When it would be in the child or youth's best interests to support their parent(s) and/or guardian(s) efforts to make access visits enjoyable, even when there are plans for the child or youth to be placed in the permanent care of the Director.

In some cases, the parent(s) and/or guardian(s) might not know how to interact with their child or youth in a positive way, so it may be necessary for the Worker to “teach” them how to play with and enjoy their children during their access visits. Furthermore, in order to give reunification a chance, it's important for the Worker to provide the parent(s) and/or guardian(s) with effective intervention strategies to nurture the parent-child relationship.

When a **Guidance and Education Plan** is necessary, it is essential that the Plan be developed in consultation with the parent(s) and/or guardian(s), child over 12 years of age, and the case manager. During this process, it is important to keep in mind that the plan must be realistic to the parent(s) and/or guardian(s) needs. The Plan should not require “perfection” from the parent(s) and/or guardian(s), rather than focus on “good enough” caregiving behaviour. The types of behavioural techniques that might be included in a Plan are modeling, and teaching and reinforcing of positive caregiving behaviour.

The **Guidance and Education Plan** should be written for the parent(s) and guardian(s) with small, measurable goals that are manageable for the family. The goals should be reviewed weekly or monthly depending on the family's situation at which time comments regarding their progress and compliance should be discussed and documented on the Plan. This will also be very useful in terms of court.

Overall, the **Guidance and Education Plan** will help the Worker define what specific parenting behaviours are problematic as well as help determine whether reunification is possible.

CFIS # _____

GUIDANCE AND EDUCATION PLAN DURING ACCESS VISITS

To enhance the overall quality of access visits and promote the development of greater parenting skills.
(Attach to Current Access Plan)

Family Name: _____

Completed By: _____ Date: _____

Period to be Covered: _____

Date Plan Reviewed With Parent(s) and/or Guardian(s): _____

Start Date: _____

Will Access Visits be videotaped as part of the Plan?

YES: _____ (signed consent form required)

NO: _____

PARENTING STRENGTHS

Based on observations, the following areas have been identified as parenting strengths and will continue to be reinforced during access visits:

- 1.
- 2.
- 3.
- 4.
- 5.

CURRENT ACCESS GOALS

AREAS OF FOCUS:

- ☐ Parent Attendance
- ☐ Parent-Child Reunions
- ☐ Social Activities
- ☐ Parenting Skills

- ☐ Parent-Child Interaction
- ☐ Parent-Child Relationship
- ☐ Parent-Child Separations

1.) Access Goal: _____

Importance for Child(ren):

Parenting Tasks:

2.) Access Goal: _____

Importance for Child(ren):

Parenting Tasks:

3.) Access Goal: _____

Importance for Child(ren):

Parenting Tasks:

4.) Access Goal: _____

Importance for Child(ren):

Parenting Tasks:

5.) Access Goal: _____

Importance for Child(ren):

Parenting Tasks:

FUTURE ACCESS GOALS

List any future goals that may be integrated upon subsequent reviews or modification of this plan:

1.

2.

3.

4.

5.

DATE REVIEWED: _____

PROGRESS

DATE REVIEWED: _____

PROGRESS:

Date of Next Review of Guidance and Education Plan: _____

Signatures:

Parent and/or Guardian: _____ Date: _____

Parent and/or Guardian: _____ Date: _____

Child Protection Worker: _____ Date: _____

Supervisor: _____ Date: _____

Interprovincial Placement Agreement (IPPA Form)

The Interprovincial Placement Agreement (IPPA):

- is negotiated prior to a child/youth moving to another jurisdiction: with a foster family; to a family member or other approved care provider; to a temporary treatment or residential facility where there is supervision and monitoring role for the receiving jurisdiction; to an out of care placement; or, a supervision and monitoring role is required with a young person who was a former ward and has entered into an agreement for post care or extended services.
- must be completed after the review and consideration of each jurisdiction's obligations as outlined in the *Provincial/Territorial Protocol on Children and Family Moving Between Provinces and Territories (the Protocol)*; and
- must be reviewed every 12 months or earlier at the request of either jurisdiction.

Part A - Instructions

Completion of this form involves the following steps:

1. Prior to placement the originating child welfare organization initiates contact with the appropriate receiving child welfare organization. The Interprovincial Coordinator in your jurisdiction may assist with identifying the appropriate contact.
2. The case worker/designate in the originating jurisdiction arranges a planning conference with the case worker/designate in the receiving jurisdiction to review and coordinate services and negotiate the IPPA pursuant to the Protocol.
3. Once plans are finalized between the originating and receiving case workers/designates, the originating case worker/designate completes the IPPA and sends two signed copies to the receiving case worker/designate.
4. The case worker/designate in the receiving jurisdiction has both copies of the form signed, returning one copy to the case worker/designate in the originating jurisdiction.
5. The case worker/designate in each jurisdiction sends copies of this form and related documentation to its Interprovincial Coordinator(s) and others as may be required.
6. The IPPA will be reviewed annually or earlier if circumstances change.

Part B – An Agreement Between:

Originating Jurisdiction (province/territory)

Originating Child Welfare Organization		Contact Person (who can be contacted about this Agreement)	
Address			
Telephone	Fax	Email	
Alternate Contact (name)		Alternate Contact (phone number and email address)	

Receiving Jurisdiction (province/territory)

Receiving Child Welfare Organization		Contact Person	
Address			
Telephone	Fax	Email	
Alternate Contact (name)		Alternate Contact (phone number and email address)	

Part C – Information on Child or Youth (you must complete a separate agreement for each child/youth)

Full Legal Name of Child/Youth		Alternate Name of Child/Alias
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Aboriginal Status <input type="checkbox"/> Not Applicable <input type="checkbox"/> Status Indian <input type="checkbox"/> Non-Status Indian <input type="checkbox"/> Inuit <input type="checkbox"/> Métis
Aboriginal Community/Band (include applicable contact information and their level of involvement with the child/youth)		
Legal Status (indicate and attach a copy of order or Agreement)	Expiration Date of Legal Status	
The receiving jurisdiction agrees to support/enforce/defend the status of the child while monitoring and supervising the child/youth's care in the receiving jurisdiction. Any attempt to change this status will be redirected to the originating jurisdiction.		
The originating jurisdiction agrees to not allow the order/agreement to lapse or terminate without notifying the receiving jurisdiction and the jurisdictions will review/ revise this Agreement in the event there is a significant change in circumstances or placement disruption.		

Current Placement

Name(s)	Type of Resource (e.g. family, foster family, residential, out of care placement, etc.)
Address	
Telephone	Email

Receiving Placement

Name(s)	Type of Resource (e.g. family, foster family, residential, out of care placement, etc.)
Address	
Telephone	Email

Part D – Summary of Responsibilities

Notification & Negotiation <input type="checkbox"/> Child/Youth Moving with Foster Family <input type="checkbox"/> Child/Youth Moving to Family or Other Approved Provider <input type="checkbox"/> Child/Youth Moving to Residential Facility <input type="checkbox"/> Child/Youth Moving to Temporary Treatment Facility <input type="checkbox"/> Youth Formerly in Care
Case Planning & Management (detail expectations of case workers or any service providers involved and identify schedule/timeframes) In collaboration, the case plan will be developed according to the legislation and policy standards of the originating jurisdiction (e.g. case conferencing, contact standards, progress reports, case plan reviews, visitation, decisions and consents that may be authorized by the receiving jurisdiction etc.) The receiving jurisdiction agrees to immediately or as reasonably possible notify the originating jurisdiction of any serious occurrences/incidents as per the Protocol. Both jurisdictions will maintain a file record on the child/youth and will have a case worker assigned to the child/youth. Jurisdictions must notify the other of any change in the assignment of case workers.
Documentation- 8.4 of the Protocol Outlines information on the child to be shared. (list attachments) <input type="checkbox"/> Certified copy of birth registration <input type="checkbox"/> Legal Order/Agreement <input type="checkbox"/> Copy of Life Book <input type="checkbox"/> Social History <input type="checkbox"/> Medical Assessments <input type="checkbox"/> Psychological Assessments <input type="checkbox"/> Educational Assessments <input type="checkbox"/> Current Case Plan <input type="checkbox"/> Other i. The originating jurisdiction agrees to provide the required documentation to the receiving jurisdiction pursuant to the Protocol. ii. The receiving jurisdiction agrees to forward to the originating jurisdiction all reports on the progress of a child/youth completed according to the standards in the originating jurisdiction or as otherwise negotiated.

Placement Disruption-8.5 of the Protocol outlines placement disruptions and placement decisions in the event of a disruption.

The receiving jurisdiction agrees to make all emergency and non-emergency placement changes wherever possible in consultation with the originating jurisdiction; following placement disruptions the jurisdictions agree to renegotiate a case plan that is in the best interests of the child.

Financial Arrangements- Placement and Service Expenditures

As per the Protocol, the originating jurisdiction agrees to:

- i. make maintenance and service payments to the service provider; and
- ii. provide any costs not covered by the receiving jurisdiction's medical plan.

Any expenditure must be pre-approved by the originating jurisdiction.

☐ Other (indicate as negotiated):

Receiving Child/Youth Maintenance Amount	Other	Approved Exceptional Funding

Current Source of Funding

☐ Province/Territory ☐ Federal Government (Canada) ☐ Other (indicate):

Part E – Signatures

Local Child Welfare Organization in Originating Province

Name of Signing Authority (Print)	Signature	Date

Central Authority in Originating Province (complete only if required)

Name of Signing Authority (Print)	Signature	Date

Local Child Welfare Organization in Receiving Province

Name of Signing Authority (Print)	Signature	Date

Central Authority in Receiving Province (complete only if required)

Name of Signing Authority (Print)	Signature	Date

Distribute as follows:

- ☐ Copies of IPPA Agreement on files in both originating and receiving jurisdiction
- ☐ Copy Originating Jurisdiction Interprovincial Coordinator
- ☐ Copy Receiving Jurisdiction Interprovincial Coordinator

Life Book

Adapted from *the Yukon CFSA Policy Manual (2012)*.

Photo of Child:



Full legal name of child: _____

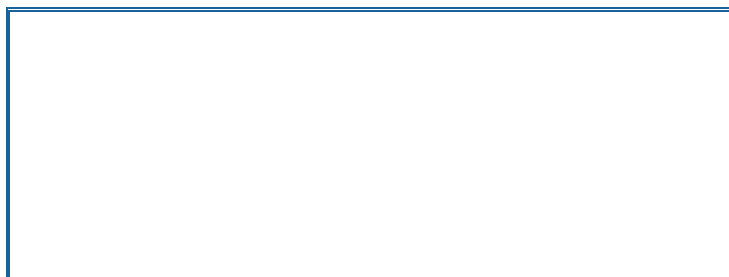
Date and place of birth: _____

Legal status and date obtained: _____

My Journey.....

Information about my Birth

Photographs of me as a baby



Information about my developmental milestones when I was an infant and/or toddler

My Health Information

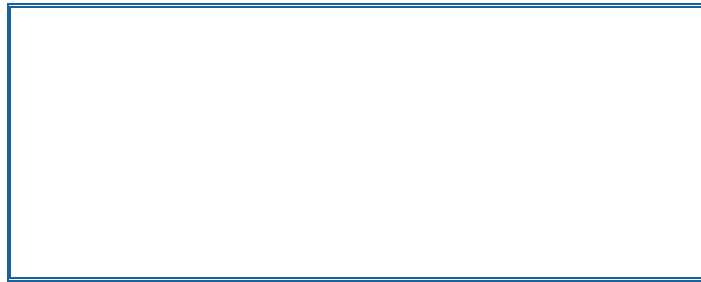
- List of appointments
- Growth and weight charts
- Diagnosed illnesses
- Medications and treatments

Information about my Parent(s) and/or Guardian(s)

Mother information:

- Mother's name
- Mother's hair colour
- Mother's eye colour
- Date of Birth
- Grew up in
- Grandparent(s) names
- Sibling(s) and extended family

Photographs of mother, grandparent(s), sibling(s) and/or extended family



Father information:

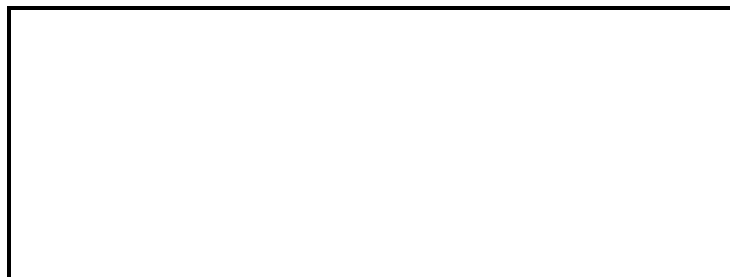
- Father's name
- Father's hair colour
- Father's eye colour
- Date of Birth
- Grew up in
- Grandparent(s) names
- Sibling(s) and extended family

Photographs of father, grandparent(s), sibling(s) and/or extended family



Information about my sibling(s), pet(s) and other people significant in my life

Photographs of my sibling(s), pet(s) and other significant people



**What My Parent(s) were doing When I Was Born?
Visits with my Parent(s) and/or Guardian(s), Sibling(s), Extended
Family or Significant People**

Family Background

- Genogram
- Family Tree

Culture I Belong To

- Traditional/Ceremonial Objects
- Traditional Ceremonies/Foods/Artwork

Religious, Spiritual and Cultural Activities

Reasons for not living with my Birth Family

- An honest, yet sensitive description about why the child or youth is not living with their parent(s) and/or guardian(s).

Moves I Have Made

- An honest, yet sensitive description about why the child or youth may have experienced a change in placement.
- Names of foster parent(s) and other family members.

Photographs of my foster family



Significant Family Events, Traditions or Special Visits

Schools I Attended

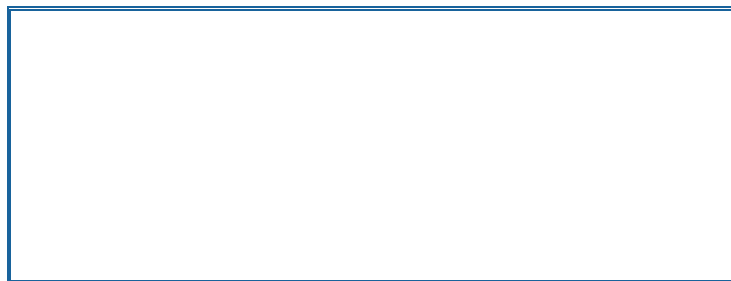
Friends

Letters and Awards

- Records and mementos of special achievements, e.g., report cards, art work, awards, outings and certificates.

My Birthdays and other Celebrations

Photographs of the events



Holidays/Vacations

Important Names and Addresses

Things I Want to Do in the Future

Other items or observations I would like to include

Completed by:
CPW and/or Foster Parent: _____ Date: _____

NOTE

The Life Book is the property of the child or youth. A copy must be placed in the child or youth's file.

SUPERVISION FORM: Case Management *Use one form per family/client

Date: _____

Name of Supervisee: _____ Name of Supervisor: _____

Family/Child Name and Matrix File Number: _____

Case Updates/ Issues/ Improvements Since Last Supervision:	New Areas to Discuss/Questions Worker Has:	Decisions Made, and Who Will Do What and When:	Action Completed?

Supervisee Signature _____

Supervisor Signature: _____

☐ **Form has been uploaded onto Matrix**

☐ **Form has been placed on the client's physical file**

Parents' Consent to Travel**Travel Authorization
Within/Outside Canada**☐ Within Canada☐ Outside Canada**Send to DHSS for GNWT Letterhead**DATE: _____
(day/month/year)Re: _____
(Name of Child/Youth)DATE OF BIRTH: _____
(day/month/year)

STATUS: _____ HEALTH CARE NUMBER: _____

To Whom It May Concern:

My/Our child _____ is receiving services/in the care of the
Director of Child and Family Services under a _____ and is
(Agreement/Status type)
placed in the foster home of _____ of _____, NT.
(name of foster parents) (community)

I/We, _____, of _____
(full name of parent(s)) (Address)hereby consent to my/our child travelling with _____
(Full name of caregiver/chaperone)to _____ on _____ returning on _____.
(destination) (day/month/year) (day/month/year)While travelling, the caregiver(s)/chaperone can be reached at _____.
(phone)

I/We, give the caregiver(s)/chaperone the authority to consent to non-life threatening
medical treatment required by my/our child provided they notify me/us at _____
(phone)
and the Director of Child and Family Services of the Northwest Territories or his/her
designate, _____ as soon as possible at
(Child Protection Worker)

(office & on-call numbers)

In a case where surgical treatment, the use of anaesthetics or any life-threatening procedures is required, permission must be obtained from me/us AND notify the Director of Child and Family Services or the Deputy Director of Child and Family Services.

During business hours the Director of Child and Family Services can be reached at

_____ and the Deputy Director at _____ and via fax
(phone) (phone)

_____. After-hours the Director or Deputy Director can be reached at

(phone)

Sincerely,

(Parent)

Signature

(Parent)

Signature

cc: Director of Child and Family Services, Fax No.: _____

Original to caregivers/chaperone, copy to parent, child's file and the Director of Child and Family Services

Release 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)

regarding _____ born: _____
(name of person) (day/month/year)

to the _____, the _____
(name of person/agency) (name of community)

(Signature)

(Witness)
(Relationship to the client, e.g.
self/parent/guardian)

Dated this _____ day of _____, 20_____.

Request for Patient Medical Information

I, _____, Child Protection Worker with the
_____, am requesting patient information
Health and Social Services Authority

with regards to, _____, born on _____,
Child's Name Day/Month/Year

Health Care # _____.
HCP#

This child is:

- ☐ Under **Apprehension Status** (copy attached)
- ☐ Under a **Temporary Custody Order** (copy attached)
- ☐ Under a **Permanent Custody Order** (copy attached)
- ☐ Part of an investigation into allegations of child abuse or neglect (copy of parent(s)' consent attached)

I understand that the information provided is confidential.

Dated this _____ day of _____, 20_____

Signature of Child Protection Worker

Signature of Supervisor

Date



Section 9 - Case Management

Form 6.16.1

Serious Occurrence Report

Regional Health and Social Services Authority:				
Client Name:				
Status:				
Ethnic Identity:				
Indigenous Organization Membership, if applicable:				
Matrix Number:				
Date of Birth (Month/Day/Year):				
Current Placement (if applicable):				
Date and Time of Serious Occurrence:				
Location of Serious Occurrence:				
Date and Time Child Protection Worker received notification of Serious Occurrence:				
Date and Time of notification to Supervisor/Manager:				
Date and Time of Notification to Parent and/or Caregiver(s):				
Child Protection Worker/Designate Name:				
Supervisor Name:				
Category of Serious Occurrence:	<input type="checkbox"/> Severity Level 1	<input type="checkbox"/> Severity Level 2	<input type="checkbox"/> Severity Level 3	<input type="checkbox"/> Severity Level 4
Type of Serious Occurrence:				
FACTUAL DESCRIPTION:				
Circumstances Leading Up to/Surrounding the Serious Occurrence (If the Specialized Service completed a Serious Occurrence Report with this information, there is no need to complete this section. Please attach the Specialized Services's Report): How did it happen? Why did it happen?				
Details of Serious Occurrence (If the Specialized Service completed a Serious Occurrence Report with this information, there is no need to complete this section. Please attach the Specialized Service's Report): What happened? When and where did it happen? Who was involved? Location of the child, youth, young adult and/or parent/caregiver(s)				



Section 9 - Case Management

Form 6.16.1

Current Situation:

Specific Staff Response and Actions: What actions were taken to respond to the incident?

Assessment of Child, Youth, Young Adult or Parent/Caregiver(s)' Needs: Information should be gathered from the child, youth, young adult, parent/caregiver(s) and/or other professionals regarding the medical, emotional, physical and cognitive needs of those involved in the Serious Occurrence. Develop Safety Plan, and case conference if appropriate.

Assessment Foster Care Resource Needs: Information should be gathered from the foster care resource regarding their financial, emotional and physical needs as it relates to the Serious Occurrence. Determine the need for an investigation, Quality of Care Review, suspension, closure or formal review, if applicable.

Is Follow Up Required: Serious Occurrence is unresolved and requires further follow up. See Follow Up Report to document efforts.

Signatures:

(Child Protection Worker Signature)

(day/month/year)

(Supervisor/Manager Signature)

(day/month/year)

For NTHSSA Use Only:

Received by NTHSSA Deputy Director of Practice (initials):

Date



Section 9 - Case Management

Form 6.16.1

For Departmental Use Only:

Received by Director of Child and Family Services or Designate (initials):

Date

Director of Child and Family Services or Designate Notified within the timelines: ☐ Yes ☐ No

Date Entered into Serious Occurrence Database: _____

Further Action:

☐ Director's File Review ☐ Director's Case Review ☐ Nothing Required: ☐ Other: _____

Supervised Visit Observation

Adapted from *Accessing Visiting for Children in Care. An Opportunity for Engagement and Collaboration*, (2005). Darlene Neimi, OACAS Collaboration Project.

Goals:

- If there are serious safety concerns, the Worker must provide a safe environment for the parent-child interactions.
- To monitor the parent(s) and/or guardian(s) progress in addressing the child protection concerns, while developing recommendations regarding parenting abilities.
- When a child or youth is going to be reunified with his or her parent(s) and/or guardian(s), it is essential that the Worker assists with the transition, gradually allowing the parent(s) and/or guardian(s) to assume greater responsibility. The child or youth should not be returned to the parent(s) and/or guardian(s) care until there has been a sufficient period of successful unsupervised Visits.

Some parent(s) and/or guardian(s) present serious risks to their child's well-being; therefore it is vital that all access be supervised in order to protect the child from further harm. The level of supervision must be based on the parent(s) and/or guardian(s) ability to manage interactions with their child and are not emotionally, verbally, physically or sexually abusive and neglectful as well as stressful for their child. For situations involving infants, toddlers and pre-school children, it may be necessary to supervise these visits if there are any questions about the parent(s) and/or guardian(s) ability to ensure their child's safety.

When deciding whether the level of supervision is to be decreased or terminated, it is important for the Worker to assess the child or youth's ability to recognize and manage potentially dangerous situations. The Worker will assess the child's age, vulnerability, capacity for self-care and ability to protect him or herself.

In general, it is recommended that when a child or youth are placed in care, all visits should be supervised for several days or weeks to further assess the protection concerns and gather information about the family's access needs. Once reunification has been determined and there are no further concerns, the level of supervision should be gradually withdrawn, while the parent(s) and/or guardian(s) gradually assume maximum parenting responsibility.

CFIS # _____

SUPERVISED VISIT OBSERVATION

To be completed by the Worker supervising the Visit and maintained within the child or youth's file

Family Name: _____ Date: _____

Start Time: _____ End Time: _____

Location: _____

Supervising Access Worker: _____

Type of Visit:

Fully Supervised: _____ OR Monitored: _____ (describe): _____

Case Note to be submitted to (copied if necessary): check where applicable

Child Protection Worker: _____ Name: _____

Supervisor: _____ Name: _____

Children in Attendance: _____

Transported By: _____

Parent(s) and/or Guardian(s) in Attendance: _____

Other Adults in Attendance: _____

COMPLETE THE FOLLOWING AREAS

TRANSPORTATION OF CHILDREN TO VISIT

Information Update by Foster Parent(s)/ other caregivers to be Shared with Parent(s) and/or Guardian(s) (i.e. feeding, sleeping, medical, school etc.) :

Behaviour/Discussion of Children En Route to Visit: _____

OBSERVATIONS OF PARENT-CHILD REUNION

Time and/or Attendance Concerns of Parent(s) and/or Guardian(s): _____

Location: _____

Verbal Greeting: _____

Physical Contact: _____

Emotional/Behavioural Presentation of Parent(s) and/or Guardian(s): _____

Emotional/Behavioural Response of Children: _____

Parent and/or Guardian's Response to Information Update: _____

OBSERVATIONS DURING VISIT

(Provide general description and/or sequence of events. This area may also be used to comment on the **Guidance and Education Plan** to describe parenting progress, concerns, attitude/cooperation with intervention.)

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

SOCIAL ACTIVITIES

RANGE OF ACTIVITIES:

(Check where applicable)

COMMENTS/EXAMPLES:

(Provide where applicable)

- ☐ **pretend play**
- ☐ **exploration**
- ☐ **creative play**
- ☐ **physical play**
- ☐ **construction play**
- ☐ **teaching/learning**
- ☐ **passive activities**
- ☐ **activities that promote relationship building**

ADDITIONAL COMMENTS:

PARENTING SKILLS

RANGE OF ACTIVITIES:

(Check one in each area)

COMMENTS/EXAMPLES:

(Provide where applicable)

Feeding/Mealtime

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

Hygiene/Physical Care

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

Supervision/Safety

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

Response to Emotional Needs

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

Child Discipline

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

Role/Boundaries

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

GENERAL OBSERVATIONS OF PARENTING SKILLS:

PARENT-CHILD INTERACTION

AREAS OF FOCUS:

(Check one in each area)

COMMENTS/EXAMPLES:

(Provide where applicable)

Parent's Ability to Engage Child

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

Parent's Ability to Sustain Activities

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

Parent's Level of Involvement

- ☐ concerns observed
- ☐ strengths observed
- ☐ not applicable

PARENT-CHILD RELATIONSHIP

DEVELOPMENTAL STAGES:

(Check applicable area)

- ☐ Infants (0 – 18 months)

- ☐ Toddlers (18 months – 3 ½ years)

- ☐ Pre-Schoolers/Early School Age Children (3 ½ - 6 years)

- ☐ Latency Age Children (6 – 12 years)

- ☐ **Adolescents (12 – 18 years)**

OVERALL QUALITY OF PARENTING BEHAVIOUR

OBSERVATIONS OF KEY PARENTING BEHAVIOURS:

(Check applicable areas and provide comments/examples regarding particular strengths or concerns)

- ☐ **SENSITIVITY**

- ☐ **ACCEPTANCE**

- ☐ **COOPERATION**

- ☐ **ACCESSIBILITY**

OBSERVATIONS OF PARENT- CHILD SEPARATION

Preparation: _____

Location: _____

Verbal /Physical Contact: _____

Emotional/Behavioural Presentation of Parent(s): _____

Emotional/Behavioural Response of Child(ren): _____

Information to be shared with Foster Parent(s): _____

FEEDBACK TO PARENT(S) AND/OR GUARDIAN(S) (where this has been determined to be appropriate)

OVERALL PRESENTATION OF PARENTS AND/OR GUARDIANS (describe any concerns regarding influence of substances, emotional/physical/mental health concerns etc.)

TRANSPORTATION OF CHILDREN FROM VISIT

Behaviour/Discussion of Children En Route to Foster Home: _____

Children's Reaction Upon Arrival to Foster Home: _____

Child Protection Worker: _____ Date: _____

Supervisor: _____ Date: _____

Supervision Record

DATE:

TIME:

CONSULTATION WITH:

CONSULT NOTES:

DIRECTION/RECOMMENDATION:

CHILD PROTECTION WORKER'S SIGNATURE: _____

SUPERVISOR'S SIGNATURE: _____

Travel Authorization
(Outside Canada)**Send to DHSS for GNWT Letterhead**DATE: _____
(day/month/year)Re: _____
(Name of Child/Youth)DATE OF BIRTH: _____
(day/month/year)

STATUS: _____ HEALTH CARE NUMBER: _____

To Whom It May Concern:

_____ is in the care of the Director of Child and Family Services
(full name of child)under a _____ and is placed in the foster home of:
(Agreement/Status type)_____ of _____, NT.
(full name of foster parents) (community)This child will be travelling with _____ to _____
(full name of caregiver/chaperone) (destination)on _____ returning on _____.
(day/month/year) (day/month/year)

While travelling, the caregiver(s)/chaperone have the authority to consent to non-life threatening medical treatment required by the child provided they notify the Director of Child and Family Services of the Northwest Territories or his/her designate,

_____ (CPW) as soon as possible at _____.
(office & on-call numbers)

In a case where surgical treatment, the use of anaesthetics or any life-threatening procedures is required, permission must be obtained from the Director of Child and Family Services or the Deputy Director of Child and Family Services.

The Director of Child and Family Services can be reached at _____.

The Deputy Director at _____ and via fax _____.
After-hours the Director of Child and Family Services and/or Deputy Director can be

reached at _____.

Sincerely,

Director of Child and Family Services

cc: Director of Child and Family Services, Fax No.: _____

Original to caregivers/chaperone, copy to parent, child's file and the Director of Child and Family Services

Travel Authorization
Within Canada/Outside Canada (Select one)

Use HSSA Letterhead

DATE: _____
(day/month/year)

Re: _____
(Name of Child/Youth)

DATE OF BIRTH: _____
(day/month/year)

STATUS: _____ HEALTH CARE NUMBER: _____

To Whom It May Concern:

_____ is in the care of the Director of Child and Family Services
(full name of child)

under a _____ and is placed in the foster home of:
(Agreement/Status type)

_____ of _____, NT.
(full name of foster parents) (community)

This child will be travelling with _____ to _____
(full name of caregiver/chaperone) (destination)
on _____ returning on _____.
(day/month/year) (day/month/year)

While travelling, the caregiver(s)/chaperone has the authority to consent to non-life threatening medical treatment required by the child provided they notify the Director of Child and Family Services of the Northwest Territories or his/her designate, _____ (CPW) as soon as possible at _____.
(office & on-call numbers)

Where surgical treatment, anaesthetics or any life-threatening procedure is required, permission must be obtained from the Assistant Director of Child and Family Services, or in absence, the Director/Deputy Director of Child and Family Services or designate, as per the following contact information:

	Assistant Director of Child and Family Services	Director/Deputy Director of Child and Family Services
Office/Cell		867-445-6253
After-Hours		867-445-6253
Fax:		867-873-7706

Sincerely,

Child Protection Worker (Within Canada) Date
Or Assistant Director of Child and Family Services (Outside Canada)

Original to caregivers/chaperone, copy to parent, where applicable, and CFS file

Visit Summary and Evaluation

Adapted from Accessing Visiting for Children in Care. An Opportunity for Engagement and Collaboration, (2005). Darlene Neimi, OACAS Collaboration Project.

GOALS:

As soon as a child or youth enter care, it's important to evaluate and gather the necessary information about the parents and/or guardians' potential for change. This process is completed by documenting the observations and assessments of parenting capacity such as parental reliability, parenting skills, parent-child behaviour, parent-child interactions, children's responses, and children's behaviour, etc.

In order to assess the future risk of harm to the child or youth, the Worker must evaluate the child or youth's attachment relationship to his or her parent(s) and/or guardian(s). To determine whether the Guidance and Education Plan, for e.g., parent training is appropriate.

The focus of the preliminary Summary and Evaluation is to gather information through observation of the visits, not to provide clinical intervention through guidance and/or education. Depending on the case, the Worker may need to focus on parenting behaviour such as parental reliability, parenting skills, parent-child behaviour, parent-child interactions, children's responses, and children behaviour, etc. when developing the access plans. During this process, it is recommended that visits be supervised and carefully controlled in terms of location, length and participants.

This provides generalizations and themes observed in visits (summary) over a period of time in order to evaluate how access should proceed (whether it should be decreased/increased, reduced in the level of supervision, change in location etc.). This Plan should be completed within **two (2) weeks** of a child or youth's admission to foster care and then **every two (2) to four (4) months or as necessary**. During this time, it is essential for the Worker to determine how further visits should proceed and to consider the themes and patterns observed and whether further observations are required. Furthermore, these could be attached to Affidavits as exhibits which is very helpful and saves time for the Child Protection Worker who must report to the Court on visits and the parents' progress.

CFIS # _____

SUMMARY AND EVALUATION OF VISITS

To be completed after initial period of visits and subsequently as deemed necessary.

Preliminary Summary: (To be completed at the initial meeting upon children's admission to foster care.)

OR

Follow Up Summary: (To be completed at a case review meeting or earlier as necessary.)

Family Name: _____

Parent(s) and/or Guardian(s): _____

Child's Name: _____ D.O.B. _____

Child's Name: _____ D.O.B. _____

Child's Name: _____ D.O.B. _____

Child's Name: _____ D.O.B. _____

Date of Placement: _____ Legal Status: _____

Child Protection Worker: _____ Completion Date: _____

DETAILS OF ACCESS PLAN:

Start Date: _____ Period Covered: _____

Fully Supervised: _____ OR Partially Supervised/Monitored :(describe): _____

Number of Visits Scheduled: _____ Number of Visits Attended: _____

Frequency of Visits: _____ Duration of Visits: _____

Location: _____

Supervising Workers Involved: _____

Primary Risk/Protection Concerns: _____

**THE FOLLOWING IS A SUMMARY OF OBSERVATIONS BASED ON THEMES AND
RECURRING PATTERNS NOTED IN VISITS**

1. OBSERVATIONS OF CHILDREN

GENERAL PRESENTATION OF CHILD(REN):

(Describe level of development, adjustment to foster care, personality features, likes/dislikes etc.)

2. OBSERVATIONS OF PARENTS AND/OR GUARDIANS

a. GENERAL PRESENTATION OF PARENTS AND/OR GUARDIANS:

(Describe mood, motivation, energy level, ability to focus, substance use, hygiene, emotional well-being, mental health, physical health, parental relationship etc.)

b. ATTENDANCE OF PARENTS:

(Describe level of attendance/absences, promptness, any issues with access schedule/transportation etc.)

3. OBSERVATIONS OF VISITS

a. SOCIAL ACTIVITIES:

- i. Describe Range of Activities (i.e. pretend play, exploration, creative play, physical play, construction play, teaching/learning, passive activities, relationship building activities)**

- ii. Describe Quality of Activities (nurturing, mutually engaging, child-focused, of interest to child, age appropriate, based on child's lead, spontaneous involvement)**

b. PARENTING SKILLS:

- i. Feeding/Mealtime:**

- ii. Hygiene/Physical Care:**

iii. Supervision/Safety:

iv. Response to Emotional Needs:

v. Child Discipline:

vi. Roles/Boundaries:

4. PARENT-CHILD INTERACTION/RELATIONSHIP:

i. Describe Parent-Child Reunions and Separations:

ii. Describe Parent and/or Guardian's Ability to Engage Child:

iii. Describe Parent and/or Guardian's Ability to Sustain Activities:

iv. Describe Parent and/or Guardian's Level of Involvement with Child:

5. OVERALL QUALITY OF PARENTING BEHAVIOUR:

a. Describe parenting behaviour in the following areas:

i. Sensitivity

ii. Acceptance

iii. Cooperation

iv. Accessibility

6. EVALUATION OF VISITS

b. Comment on the identified strengths/concerns in the following areas:

i. Social Activities

ii. Parenting Skills

iii. Parent-Child Interaction/Relationship

iv. Quality of Parenting Behaviour

7. RECOMMENDATIONS

i. FREQUENCY OF VISITS:

- ☐ increase
 - ☐ decrease
 - ☐ maintain at current level
- Comments:

ii. DURATION OF VISITS:

- ☐ increase
 - ☐ decrease
 - ☐ maintain at current level
- Comments:

iii. LOCATION OF VISITS:

- ☐ Authority
- ☐ Family Home
- ☐ Community

Specify: _____
Comments:

iv. LEVEL OF SUPERVISION:

- ☐ Unsupervised
 - ☐ Monitored/Partially Supervised
 - ☐ Fully Supervised
- Specify: _____
Comments:

8. SPECIAL CONDITIONS: (List specific conditions that are expected by the parent and/or guardian i.e. confirm attendance, discipline, substance use, condition of home, safety measures etc.)

9. **STRUCTURE:** (List specific activities that are expected to occur during visits ie. mealtimes, naptimes, assistance with homework, medical appointments, school meetings, playgroups etc.)

10. **ACCESS MANAGEMENT PLAN:**

	Check Applicable Area(s)	Person(s) Responsible	Date(s) for Completion or Review
1. Summary and Evaluation of Visits			
2. Guidance and Education Plan			
3. Maintenance of Access Plan			

Signature: _____ DATE: _____

Supervisor: _____ DATE: _____

AVIS DE MESURE IMPORTANTE AU PARENT, AU FOURNISSEUR DE SOINS ET AU CORPS DIRIGEANT AUTOCHTONE (FORMULAIRE 10.16.1)

Vous recevez cet avis, car les Services à l'enfance et à la famille pourraient prendre une mesure importante qui affectera un enfant ou un adolescent que vous pourriez connaître.

Votre opinion est importante. Selon nous, il en va de l'intérêt fondamental de l'enfant ou de l'adolescent que vous participiez à la prise de décisions et à la planification le concernant.

Ce formulaire contient l'information dont vous aurez besoin pour le faire. Nous vous invitons à poser des questions, à faire des suggestions et à nous faire part de vos inquiétudes. Nous tiendrons compte de tout ce que vous direz avant de prendre une mesure importante.

Il arrive qu'une mesure importante proposée ou une autre doive être prise immédiatement pour la sécurité de l'enfant ou de l'adolescent. Si c'est le cas, vous en serez informé dès que possible. Nous vous expliquerons pourquoi nous ne pouvons pas attendre. Votre opinion demeure importante et nous voulons en discuter avec vous dès que possible, afin de travailler ensemble à la poursuite de la planification pour l'enfant ou l'adolescent.

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 :

Avis de mesure importante au parent, au fournisseur de soins et au corps dirigeant autochtone

Remarque : Un formulaire séparé doit être rempli pour chaque enfant ou adolescent, même si plus d'un enfant résidant dans un même foyer est sujet à une mesure importante.

Nom de l'enfant ou de l'adolescent :

Date de naissance [aaaa-mm-jj] :

Nom du ou des parent(s) :

Nom du ou des fournisseurs de soins :

Nom du corps dirigeant autochtone :

Date de l'avis de mesure importante [aaaa-mm-jj] :

Date limite pour répondre à l'avis de mesure importante [aaaa-mm-jj] :

Comme autorisé par le directeur des Services à l'enfance et à la famille, en vertu de l'alinéa 51(3)c) de la *Loi sur les services à l'enfance et à la famille*, je **prévois prendre la mesure importante décrite ci-dessous** pour l'enfant ou l'adolescent susmentionné.

Si vous souhaitez donner votre avis à propos de la mesure importante proposée, veuillez communiquer avec moi ou mon superviseur ou gestionnaire aux coordonnées ci-dessous.

Mesure(s) importante(s) prévue(s)

Plan du Comité de prise en charge et accord de placement d'un enfant ou adolescent en famille d'accueil

- ☐ Un accord de prise en charge est en cours d'élaboration (alinéas 10(1)c), 11(3)c), ou article 14)
- ☐ Un accord de prise en charge est conclu en vertu de l'article 19
- ☐ Un accord de prise en charge est examiné en vertu du paragraphe 20(1)
- ☐ Un accord de prise en charge est en cours de prorogation en vertu du paragraphe 20(2)
- ☐ L'accord de prise en charge est résilié en vertu de l'alinéa 13(2)a)

Appréhension

- ☐ Appréhension d'un enfant (art. 10)
- ☐ Appréhension d'un enfant (art. 11)
- ☐ Appréhension d'un enfant (art. 31)

Procédure judiciaire

- ☐ Une requête de confirmation d'une appréhension (par. 12.1)
- ☐ Une ordonnance de protection de l'enfant (art. 28)
 - ☐ Ordonnance de surveillance
 - ☐ Ordonnance de garde temporaire
 - ☐ Ordonnance de garde permanente
- ☐ Une requête pour une ordonnance de protection de l'enfant (par. 29.2)
 - ☐ Ordonnance de garde temporaire
 - ☐ Ordonnance de garde permanente
- ☐ Une requête pour la prorogation d'une ordonnance de garde temporaire d'enfant ou d'adolescent [par. 47(3)]
- ☐ Une requête pour la prorogation d'une ordonnance de garde permanente d'enfant ou d'adolescent [par. 48(2)]
- ☐ Annulation de la garde temporaire [alinéa 28(9)c)]
- ☐ Annulation de la garde permanente (art. 49)

Retrait d'une procédure judiciaire ou retour de l'enfant au parent

- ☐ Retrait de la requête avant la tenue de l'audience portant sur l'appréhension [par. 12.6 ou alinéa 13(2)b)]
- ☐ Retour de l'enfant au parent après l'appréhension (moins de 72 heures) (art. 12)

Placement en famille d'accueil, nouveau placement ou changement de placement

- ☐ Un enfant ou un adolescent est placé dans une famille d'accueil, commence un nouveau placement ou change de placement

Adoption

- ☐ Le directeur des adoptions place un enfant ou un adolescent chez un demandeur approuvé pour une adoption administrative (par. 18(2) de la *Loi sur l'adoption*)
- ☐ Le directeur des Services à l'enfance et à la famille consent à une adoption administrative (art. 21 de la *Loi sur l'adoption*)

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 :

Numéro de téléphone d'urgence
en dehors des heures de bureau :

Courriel ou numéro de télécopieur :

Adresse :

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 :

NOTICE OF SIGNIFICANT MEASURE TO PARENT(S), CARE PROVIDER(S) AND INDIGENOUS GOVERNING BODY (FORM 10.16.1)

You are receiving this notice because child and family services might be taking a significant measure that will affect a child or youth who you might know.

Your views matter. We believe your involvement and participation is in the best interests of the child or youth.

This form includes the information you need to participate in decisions and planning for the child or youth. We invite you to ask questions, make suggestions, and let us know about your concerns. Everything you say will be considered before a significant measure is taken.

If it is in the child or youth’s best interests to take the proposed significant measure or another significant measure immediately, we will contact you about the significant measures taken as soon as possible. We will tell you why we could not wait. Your views are still important, and we want to discuss them with you as soon as possible to work together as we continue to plan for the child or youth.

The personal information on this form has been collected under the authority of the *Child and Family Services Act* and/or *Access to Information and Protection of Privacy Act*, and is used for the purpose of administering the *Child and Family Services 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:

Notice Significant Measure to Parent(s), Care Provider(s), and Indigenous Governing Body
Note: A separate form is required for each child/youth, even if more than one child of the same household is subject to significant measure(s).
Name of child/youth:
Date of Birth (yyyy-mm-dd):
Name of Parent(s):
Name of Care Provider(s):
Name of Indigenous Governing Body:
Date of Notice of Significant Measure (yyyy-mm-dd):
Date to Respond to the Notice of Significant Measure (yyyy-mm-dd):

As authorized by the Director of Child and Family Services, under s.51(3)(c) of the NWT’s *Child and Family Services Act*, **I intend to take the significant measure as outlined below** in relation to the above listed child/youth.

If you would like to provide your views about the proposed significant measure, please contact me or my Supervisor/Manager at the contact information listed below.

Intended Significant Measure(s)

Plan of Care Committee and Agreement placing a child/youth out of the home

- ☐ A Plan of Care Committee is being established (s.10(1)(c), 11(3)(c), or 14)
- ☐ A Plan of Care Agreement is being entered into under s.19
- ☐ A Plan of Care Agreement is being reviewed under s.20(1)
- ☐ A Plan of Care Agreement is being extended under s.20(2)
- ☐ Plan of Care Agreement is being terminated under s.13(2)(a)

Apprehension

- ☐ Apprehension of a child (s.10)
- ☐ Apprehension of a child (s. 11)
- ☐ Apprehension of a child (s.31)

Court Process

- ☐ An application to confirm an apprehension (s.12.1)
- ☐ An application for a child protection order (s.28)
 - ☐ Supervision order
 - ☐ Temporary custody order
 - ☐ Permanent custody order
- ☐ An application for a youth protection order (s.29.2)
 - ☐ Temporary custody order
 - ☐ Permanent custody order
- ☐ An application for an extension of a child or youth temporary custody order (s.47(3))
- ☐ An application for an extension of a child or youth permanent custody under (s.48(2))
- ☐ Discharging temporary custody (s.28(9)(c))
- ☐ Discharging permanent custody (s.49)

Withdraw from a court proceeding or returning child to parent

- ☐ Withdrawal of application before apprehension hearing (s.12.6 or 13(2)(b))
- ☐ Return of child to parent after apprehension (less than 72 hours) (s.12)

Out-of-home living arrangement, new placement, or change in placement

- ☐ A child/youth is being placed in an out-of-home living arrangement, is starting a new placement, or is changing placement

Adoption

- ☐ The Director of Adoptions is placing a child or youth with an approved applicant for a departmental adoption (s.18(2) of the *Adoption Act*)
- ☐ The Director of Child and Family Services is consenting to a departmental adoption (s.21 of the *Adoption Act*)

Child and Family Services Contact Information

Name of Child Protection Worker or Authorized Person
(acting on behalf of the Statutory Director):

Business Phone Number:

After-Hours Emergency Phone Number:

Email / Fax Number:

Business Address:

Name of Manager / Supervisor:

Manager / Supervisor Phone Number:

Signature of Child Protection Worker or Authorized Person: