





**2019 CRB CONFERENCE
EVERY DAY COUNTS...
IN THE LIFE OF A CHILD IN FOSTER CARE**

**Workshop:
HOW TO GET YOUR KIDS BACK:
ASSESSING PARENTAL PROGRESS**

*Presented by Jyl Hobbs
District 12 DHS MAPS worker*

*Facilitated by John Nichols and Maiya Hall-Olsen, JD
CRB Field Managers*

*Kent Bailey
Board Member, Baker County
CRB Advisory Committee*

NEW FAMILY REPORT

Family Report

Case number: _____

Parent(s) or guardian(s)

Parent or guardian 1 Deceased


Name: Mr. Smith	DOB: _____	Age: _____	Language: _____
Location: _____		Attorney: _____	
Paternity status: Choose one			

Parent or guardian 2 Deceased

Name: Ms. Smith	DOB: _____	Age: _____	Language: _____
Location: _____		Attorney: _____	
Paternity status: Choose one			

Child(ren)

Name of child 1: Abbey	DOB: _____	Age: _____	
Parent(s) or guardian(s): _____			
Court number: _____	Date of jurisdiction: _____	Date of last removal: _____	
Basis for jurisdiction: _____			
Primary plan: Choose one			
Concurrent plan: Choose one		Placement type: Choose one	
Date of current placement: _____		Attorney: _____	
Court appointed special advocates (CASA): _____			
Court appointed educational surrogate: _____			
Placements, visits and face-to-face contacts			
Number of face-to-face contacts with CW (cumulative): _____			
Face-to-face contacts for the last six months (dates and locations):			
Date: _____	Location: Choose one		
Number of out-of-home placements: _____			
Dates and placement settings:			
Date: _____	Location: Choose one		
How does the placement meet the child's needs? _____			
Number of visits with parent: Choose one		: Number of visits	
Number of visits with siblings: _____		: Number of visits	
Number of visits with other: <i>Enter name of other person here</i>		: Number of visits	
Notes about visits/parenting time: _____			



NEW FAMILY REPORT

[Reset form](#) | [Print](#)

Education

Current grade level: Choose one

Health

Name of medical doctor:	Date of last appointment:
Name of dentist:	Date of last appointment:
Name of eye doctor:	Date of last appointment:
Name of mental health provider:	Date of last appointment:

Psychotropic medications: Choose one
 Immunizations up to date: Choose one
 Update on child's health:

Extra curricular, cultural and social activities

Describe how DHS makes sure the child takes part in age or developmentally suitable activities. Also tell how the care provider supports and encourages these activities.

Independent living transition planning

Youth is 14 years or older

Parent or guardian 1: Mr. Smith

What does this parent want the team to know about their family and their family's culture?

Number of face-to-face contacts with case worker: _____

Additional information on parenting time:

Describe the agency's efforts to engage the parent in the case plan:

Conditions for return — What is needed to get the child(ren) home safely?

Progress toward conditions for return:

Strengths — Enhanced Protective Capacity

Challenges — Diminished Protective Capacity

Expected outcomes — What needs to happen to close the case?


Progress made toward expected outcomes:

Connections with community and natural supports:

Services

Support

Housing assistance:



NEW FAMILY REPORT

[Reset form](#) | [Print](#)

Parent or guardian 2: Ms. Smith

What does this parent want the team to know about their family and their family's culture?

Number of face-to-face contacts with case worker: _____

Additional information on parenting time:

Describe the agency's efforts to engage the parent in the case plan:

Conditions for return — What is needed to get the child(ren) home safely?

Progress toward conditions for return:

Strengths — Enhanced Protective Capacity

Challenges — Diminished Protective Capacity

Expected outcomes — What needs to happen to close the case?

Progress made toward expected outcomes:

Connections with community and natural supports:


Services

Support

Housing assistance:

Signatures

Parent or guardian printed name	Signature	Date
Child printed name	Signature (if appropriate)	Date
Caseworker printed name	Signature	Date
Caseworker supervisor printed name	Signature	Date



CHILD WELFARE CASE PLAN

CHILD WELFARE CASE PLAN

CASE NAME: ██████████	CASE PLAN DATE: 12/27/2018
-----------------------	----------------------------

PARENT/GUARDIAN(S)

Name:	██████████
Address:	██████████
City, State, Zip:	██████████
Relationship:	Self

Child's Name:	DOB:	Age:	Gender:
██████████	██████████	14	Male
Primary Language: English	Court Number: ██████████		
ICWA Status: Not Eligible	Name of Tribe:		


Active Safety Threats: One or both parents' or caregivers' behavior is violent and/or they are acting (behaving) dangerously.

Ongoing Safety Plan: Plan to manage safety threats:
 ██████████ will reside in a certified non-relative foster home. The foster parent will provide supervision and monitoring while the child is in care. The foster parent will ensure that ██████████ attends all medical, dental, vision and mental health appointments. The foster parent will contact DHS immediately with any safety concerns related to the child. The foster parent has the ability to provide a safe home for the child and are able to meet the needs of the child.

The caseworker, ██████████, will have announced/unannounced visits with the child on a monthly basis and every 60 days in the foster home. These visits will ensure that the child's basic needs and safety needs are being met in the placement.

The SSA, ██████████, will provide safety and supervision during DHS supervised visits between ██████████ and his mother, ██████████. DHS provides these visits for the family at the Hermiston DHS office. These visits occur each week.

██████████: An Out of Home Safety Plan is required to ensure the safety of ██████████. Although, ██████████ has a home and shows a willingness at times to cooperate with an In Home Safety Plan. The home environment is not calm enough to allow for safety service providers and activities to occur due to ██████████ unmitigated mental health issues. In addition, ██████████ has not been able to identify any appropriate Safety Service Providers to implement the plan. ██████████ is not engaged with DHS, the case or offered services that will help her attain skills for necessary behavior to achieve



CHILD WELFARE CASE PLAN

of Human Services

an in-home safety plan.

██████████ father, ██████████, is deceased.

Conditions for Return: ██████████

██████████ will have home-like setting in which to put an in-home plan in place. This means that there is a place for ██████████ to sleep and store his belongings. There is a place for basic food preparation and cleanliness. (Home-like Setting)

Specific triggers for violence in the home are understood and recognized by the parent. There is enough DHS approved in home safety service providers to sufficiently monitor and manage behavior to control impulsivity and prevent aggressiveness. (Calm Home)

The child will be able to talk freely and express what is happening around him without fear of the parent. In Home safety service providers can be a sufficient social connection for ██████████ to monitor his feelings and emotional reactions. (Calm Home)

██████████ will be willing to allow DHS and safety service providers access to ██████████ and her home at any time at a level that allows ██████████ to remain safe in the home. ██████████ is actively engaged in services that allow her to safely parent and control any mental health issues or behavior. (Willingness)


Safety service providers will be able to intervene on ██████████ behalf if the situation warrants it without ██████████ becoming aggressive with them. There will be sufficient DHS approved safety service providers to manage ██████████ safety, 24/7 if necessary. (Sufficient Safety Service Providers)

Departmental Efforts to Prevent Removal or to Return Child(ren) Home:


Visitation
Transportation
Phone and minute cards for communication
Gas vouchers
Mental health service referral
Psychological evaluation with
Parent and child interaction
Case planning
WRAP services
963 contract Mental Health Services - flexible mental health services that could be in the home

Reasons Services Could Not be Provided to Prevent Removal of the Child from the Home:
 The agency tried to put a safety plan in place during a prior assessment. ██████████ was abused again and a new assessment was opened. During this assessment, safety service providers were not able to be identified to support he family and the mother's behavior was unpredictable and out of control.

Immediate Family Functioning:
 This case is not an ICWA or refugee status case.



CRB
CHILDREN'S REVIEW BOARD
PROTECTIVE DEPARTMENT



DHS
Oregon Department
of Human Services

Action Agreement

Case Name: [REDACTED]

Worker: [REDACTED]

Branch: Hermiston

Case Number: [REDACTED]

Date: 01/09/2019

Parent/Child(ren) Information

Parent Information:

[REDACTED]

Parent Information:

[REDACTED]

Child:

[REDACTED]

This Action Agreement documents the current child safety threats, the changes needed in parental protective capacity, and the specific actions to be taken over the next 90 days to increase the parents or legal guardians' ability to provide for the safety of their child(ren). This Action Agreement supplements and supports the Case Plan.

Identified Safety Threats to Child(ren):

One or both parents' or caregivers' behavior is violent and/or they are acting (behaving) dangerously.

Which of the above Safety Threat(s) is/are being addressed by this Action Agreement:

One or both parents' or caregivers' behavior is violent and/or they are acting (behaving) dangerously.

Expected Outcomes:

Activity or Service: Counseling and Therapeutic Services
Activity or Service: Individual and Family Therapy (Lifeways)

Participant: [REDACTED] / Lifeways


Responsibilities:

Individual Therapy: [REDACTED] will make regular appointments with her therapist to facilitate family therapy sessions. [REDACTED] will be able to talk about her current circumstances, discuss goals, achievements and needs with a service provider who can help her attain the goal of reunification with her child. She will recognize when she needs the assistance of her therapist and be able to reach out for help when needed.


Family Therapy: [REDACTED] and her son will be able to talk and relate in their appropriate roles of mother and son. Boundaries and rules will be established. [REDACTED] will be open to discussing his

CF 1147 (03/07)
Page 1 of 4

ACTION AGREEMENT



CRB
CHILDREN'S REVIEW BOARD
PROTECTIVE DEPARTMENT



DHS
Oregon Department
of Human Services

Action Agreement

Case Name: [REDACTED]

Worker: [REDACTED]

Branch: Hermiston

Case Number: [REDACTED]

Date: 01/09/2019

feelings and wants with his parent. [REDACTED] will have an accurate perception of Jesse and be able to engage him in an appropriate way. They will both be able to process their traumas and history in a safe way.

Start/End Dates: Ongoing

Court Order: Yes

Activity or Service: Visitation

Participant: [REDACTED]

Responsibilities: [REDACTED] will maintain regular contact and a bond with her child through frequent and appropriate visitation. [REDACTED] will attend supervised visits with her child at the DHS office. Her behavior will be appropriate and she will maintain communication with SSA's regarding check in times and availability.

Start/End Dates: Ongoing

Court Order: Yes

[REDACTED] will be able to talk about her current circumstances, discuss goals, achievements and needs with a service provider who can help her attain the goal of reunification with her child.

Activity or Service: Case Planning

Participant: [REDACTED] / [REDACTED]

Responsibilities: DHS will meet with [REDACTED] on a monthly basis to discuss progress in services and goals. [REDACTED] will communicate regularly and productively with DHS caseworker [REDACTED]

Start/End Dates: Ongoing

Court Order: Yes


Activity or Service: Psychiatric Evaluation/ Medication Management

Participant: [REDACTED] / Lifeways

Responsibilities: [REDACTED] will make an appointment for a follow up to her psychiatric assessment where she accurately describes her situation and mental health symptoms. The [REDACTED] assessment was not helpful as [REDACTED] was evasive about her mental health symptoms and circumstances of her life. [REDACTED] will provide the psychiatrist with a copy of her psychological to aid in treatment. [REDACTED] will participate in evaluation to determine if she would benefit from medication

CF 1147 (03/07)
Page 2 of 4

ACTION AGREEMENT



ACTION AGREEMENT

Case Name: _____ Case Number: _____
 Worker: _____ Date: 01/09/2019
 Branch: Hermiston

to regulate mental health issues and be open to their recommendations. She will follow the recommendations of a Lifeways psychiatrist for medication management if it is prescribed. _____ will take any prescribed medications on a regular basis and participate in their management with Lifeways.

Start/End Dates: Ongoing
Court Order: Yes

Activity or Service: Housing Services/ Budgeting Services
Participant: _____ / CAPECO

Responsibilities: When _____ is ready to engage in this service, she will reach out to DHS for a referral. _____ will have long term, stable housing and be able to keep a budget. She will be able to meet her son's basic needs on a regular and ongoing basis. She will be willing to utilize services available to her in order to provide this stability when necessary.

CAPECO will help _____ plan and budget her funding to maintain long term housing.

Start/End Dates: Referral available upon request
Court Order: Yes

_____ will receive an alcohol and drug evaluation with UA's. Goal: _____ will be free of illegal substances which could effect her parenting.

Activity or Service: Drug and Alcohol Assessment / Urinalysis
Participant: _____ / DHS Addiction Recovery Team


Responsibilities: _____ will be free of illegal substances which could effect her parenting. _____ will submit regular urinalysis when called. She will maintain a current phone number with DHS. If she needs help with a phone, she will contact her caseworker, _____ for assistance. She will make UA's a priority and respond promptly to communication about them. She will attend a drug and alcohol assessment with _____ _____ will honestly answer all questions in the assessment and follow any recommendations for ongoing treatment.

Start/End Dates: Ongoing
Court Order: Yes

Progress will be measured by:

_____ will attend to her mental health needs without need for intervention from an outside agency. She will recognize the indicators of mental health crisis and

CF 1147 (03/07)
Page 3 of 4



ACTION AGREEMENT

Case Name: _____ Case Number: _____
 Worker: _____ Date: 01/09/2019
 Branch: Hermiston

When she needs routine appointments. She will seek these services regularly and remain engaged long term. _____ will talk openly to mental health services providers about her life. She will not edit her responses, blame others, or avoid talking about the circumstances of her life. She will be able to accurately describe the circumstances of her life. _____ will be willing to work with the service provider to follow the recommendations and accept help.

_____ behavior will be stable and predictable. Her son will be able to engage her without fear for his safety. _____ will be able to express his feelings with his mother and supports who can help him stay safe in his mother's care. The family will not isolate themselves. There will be enough support relationships that could intervene for the child or support the family when needed.


_____ will be engaged in recommended drug treatment and actively participate in her recovery. This includes participating in UA's. _____ will have control over her impulses to use alcohol and illegal drugs. She will recognize her triggers and be able to manage them. _____ will be able to recognize the need and ask for help with regard to her addiction. _____ will build healthy relationships with individuals who are clean and safe for support.

DHS, community partners and safety service providers will report that _____ communicates openly and regularly with them. She will make herself available and be able to track appointments. _____ will be able to articulate responsibility and a plan for keeping her son safe.


- I will actively participate in services and activities that will help me to make and demonstrate needed changes.
- I understand that changes I make must be noticed over time by significant others, including my child(ren), my caseworker and other professionals.
- I will stay in contact with my caseworker and will notify my caseworker within 24 hours if my address or phone number changes.
- I understand that this agreement may be followed by additional agreements as I work toward regaining sole responsibility for assuring the safety of my child.

Parent: *Parent did not sign, but took a copy* Date: 1.11.2019
 Caseworker: _____ Date: 1/9/2019

Date to Review/Update the action Agreement: _____




LETTER OF EXPECTATION



Oregon

Kate Brown, Governor

Department of Human Services
Children, Adults & Families - Morrow County
 103 SW Kinkade Road / PO Box 498
 Boardman, OR 97818
 Phone (541) 481-9482
 Fax (541) 481-2960
 Toll Free (800)547-3897



November 7, 2018

██████████
 ██████████
 ██████████

RE: Letter of Expectation

Dear ██████████,

The purpose of this letter is to clearly state the Department of Human Services Child Welfare Program's expectation of you concerning the return home of your son, ██████████. At this time DHS is reminding you of the expectations that you will need to complete in order to move towards the reunification, safety and well-being of the child.


██████████ will demonstrate impulse control. She will not act on her urges or desires to use substances. ██████████ will develop an understanding of how her drug usage effected the safety and well-being of her son, ██████████. ██████████ will have gained an understanding of her triggers. She will have maintained her sobriety. ██████████ will understand how her actions have not been safe for her son, ██████████. She will demonstrate she is motivated to develop the knowledge and skills necessary to keep her child safe and healthy.

THE FOLLOWING ARE EXPECTATIONS FOR ██████████:

- ██████████ will complete a drug and alcohol assessment and follow all recommendations.
- ██████████ will engage in visitation to better understand ██████████'s needs, abilities and development.
- ██████████ will make herself available for monthly face to face contact with her DHS case worker.
- ██████████ will keep her residence and personal contact information available and current with DHS Child Welfare.

The Department of Human Services Child Welfare Program will provide the following:

- DHS will make referral to and stay in contact with service providers to monitor progress and treatment recommendations.



DHS will be available to meet with ██████████ and/or her service providers to discuss evaluations, assessments and progress and will provide appropriate referrals as needed.

DHS will facilitate visitation between ██████████ and ██████████. DHS will arrange gas vouchers when needed.

DHS will be available for face to face contacts with ██████████ at least every thirty days.

DHS will provide other referrals as needed for case plan success.

Should you have questions regarding this Letter of Expectation, please contact me at: ██████████

Sincerely,

██████████

██████████, Social Service Specialist
 ██████████, Social Service Supervisor
 ██████████, Program Manager



2019 CRB CONFERENCE
EVERY DAY COUNTS...
IN THE LIFE OF A CHILD IN FOSTER CARE

Workshop:
HOW TO GET YOUR KIDS BACK:
ASSESSING PARENTAL PROGRESS

*Presented by Jyl Hobbs
District 12 DHS MAPS worker*

*Facilitated by John Nichols and Maiya Hall-Olsen, JD
CRB Field Managers*

*Kent Bailey
Board Member, Baker County
CRB Advisory Committee*