

*Tool 7*

JV#, Child first and last name

**Choose an agency**

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

**Protective Capacities Progress Assessment (PCPA)**

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| [ ]   | In-Home Case Plan |
| [ ]   | *Absent effective preventative services, out of home care is the planned arrangement for the child.* |
| [ ]  | Out-of-Home Case Plan |
| *If sufficient progress is not made, the case plan is used to help achieve a permanent plan other than return home.* |
| **DEMOGRAPHIC INFORMATION** |
| **FRAME#** | Enter FRAME # | **CPS Assessment #** | Enter Assessment # |
| **Case Manager** | First and last name | **Supervisor**  | First and last name |
| **Case Name** | Enter case name | **FRAME Program Type** | [ ]   | In-Home |
|  |  |  | [ ]   | Foster Care |
| **Legal Status** | [ ]   | Parent/Caregiver Custody | **Current Safety Plan Type** | [ ]   | In-Home |
|  | [ ]   | Agency Custody |  | [ ]   | Foster Care |
| **Date of Warm Handoff 2** | Select date |
| **Date of Most Recent Child & Family Team Meeting** | Select date |
| **Date of Next Child & Family Team Meeting** | Select date |
| **CHILDREN** |
| **Child’s Name** | First, Middle, Last | Age | **years old** | **DOB** |  MM/DD/YY |
| **Biological Mother** | First, Middle, (Maiden), Last | **Biological Father** | First, Middle, Last |
| **Aliases**  | **Aliases**  |
| [ ]  N/A*No known aliases for this person.* | [ ]  N/A*No known aliases for this person.* |
| List all known aliases for biological mother | List all known aliases for biological father |
| **Does the child have Native American heritage?**  |
|[ ]  Yes | Enter Tribe | [ ]  | No | [ ]  | Unknown |
| **Date Enrollment Inquiry Sent** | Select date | **Date Enrollment Application Sent** | Select date |
|  | [ ]  | N/A *This child is not ICWA eligible.* |  | [ ]  | N/A *This child is not ICWA eligible.* |
| **Enrollment Number** | Enter number | [ ]  N/A *This child is not ICWA eligible.* |
| **Child’s race** *Check all that apply.* | [ ]   | White | [ ]   | American Indian/Alaskan Native |
|  |[ ]  Black |[ ]  Asian/Pacific Islander |
| **Is the child Hispanic?** |[ ]  Yes |[ ]  No |[ ]  Unable to Determine |
| **Is the child in a Nexus-PATH placement?** |[ ]  Yes |[ ]  No |
| **If yes, what level of care?** | [ ]   | Treatment Foster Care (TFC) | [ ]   | Regular Foster Care (RFC) |[ ]  N/A |
| **Nexus-PATH Case Manager** | First and last name | Contact information |

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

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| **SECTION I*****Assessing Parent/Caregiver Progress*** |
| [ ]   | N/A *This case is post-TPR or 18+* |
| **PARENT/CAREGIVER**  | First and last name |
| **Case Plan Goal** |
| Enter the parent’s/caregiver’s goal. |
| **Status of Goal** | [ ]  | Goal remains the same |
| [ ]  | Goal has been revised |
| [ ]  | Goal has been achieved and no new goal identified |
| **Measurement Criteria** | [ ]  | No progress | [ ]  | Progress | [ ]  | Goal achieved |
| Describe progress made (or lack of progress made) since last assessment including rationale for goal revision. |

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

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| **SECTION IV*****Assessing Safety Management*** |
| [ ]  | N/A *This case is post-TPR or 18+* |
| **DANGER THRESHOLD CRITERIA** |
| [ ]   | Observable |  |
| [ ]   | Vulnerable Child |  |
| [ ]   | Out of Control |  |
| [ ]   | Imminent |  |
| [ ]   | Severity |  |
| **Is there Impending Danger?** | [ ]  | Yes |
| [ ]  | No |

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| **Status of Impending Danger** |
| Document information regarding the status of Impending Danger. |
| [ ]   | **N/A** *No Impending Danger was identified during the PCFA process.* |

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| **SECTION V*****Safety Determination Analysis*** |
| [ ]   | N/A *This case is post-TPR or 18+* |
| **Home** |
| 1. Does/do the child(ren)’s primary parent(s)/caregiver(s) have a suitable place to reside where an in-home safety plan can be considered?
 | [ ]   | Yes |
|  | [ ]   | No |
| 1. Given the current location of the family, can this safety plan be carried out?
 | [ ]   | Yes |
|  | [ ]   | No |
| **Calm and Consistent Enough** |
| 1. Is the home environment calm and consistent enough to allow safety services in accordance with the safety plan, and for people participating in the safety plan to be in the home safely without disruption (e.g., reasonable schedules, routine, structure, general predictability of family functioning)?
 | [ ]   | Yes |
|  | [ ]   | No |
| **Willing and Able** |
| 1. Is/are the primary parent(s)/caregiver(s) cooperative with child welfare services and willing to participate in the development of an in-home safety plan?
 | [ ]   | Yes |
|  | [ ]   | No |
| 1. Is/are the primary parent(s)/caregiver(s) willing to allow safety services and actions to be provided in accordance with the safety plan?
 | [ ]  | Yes |
|  | [ ]   | No |
| 1. Do/does the primary parent(s)/caregiver(s) have the ability to participate in an in-home safety plan and do what they must do as identified in an in-home safety plan?
 | [ ]  | Yes |
|  | [ ]  | No |
| **Sufficient Resources** |
| 1. Are there sufficient resources within the family or community to perform the safety services necessary to manage the identified impending danger threats?
 | [ ]   | Yes |
|  | [ ]   | No |
| **JUSTIFY YES AND NO RESPONSES** |
| Provide justification for “Yes” and “No” responses above. |
| **SAFETY PLAN TYPE** |
|[ ]  An out-of-home safety plan is indicated. |
|[ ]  An out-of-home safety plan has been in place, but the use of an in-home safety plan is indicated.  |
|[ ]  In-home safety plan remains sufficient. |
|[ ]  In-home safety plan has been revised, as needed. |
|[ ]  No safety plan is needed; child is safe. |

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| **SECTION VI*****Permanency Plan and Process*** |
| [ ]   | N/A *An in-home safety plan is in place.* |
| **Permanency Goal(s)** | [ ]   | Reunification |
|  |[ ]  Guardianship |
|  |[ ]  Placement With Relative |
|  |[ ]  Adoption |
|  |[ ]  Another Planned Permanent Living Arrangement (APPLA) |
| **When reunification is an established permanency goal:** |
| Describe the reunification plan. |
| Summarize the quality of family contact with the child(ren) |
| [ ]   | N/A*No family contact because* | Describe reason(s) for no family contact |
| **When the established permanency goal(s) does/do not include reunification:**  |
| Describe the permanency plan for all identified permanency goals identified for the child(ren). |
| [ ]  | N/A*Reunification is the only permanency goal.* |
| **When adoption is an established permanency goal:** |
| **Date adoption added**  |  Select date  |
|  |[ ]  N/A  *Adoption is not an established permanency goal.* |
| **Child(ren) with adoption permanency goal** | First and last name of each child |
| **Date AASK Referral Sent** | Select date |
| **AASK Adoption Specialist** | First and last name | Contact information |

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| **SECTION VII*****Case Closure*** |
| [ ]   | N/A *Case remains open.* |
| [ ]   | The child is safe and has resided in the family home for Enter number months. |
| [ ]  | Case is being closed. |
| Summarize the status of the case at closure. |

**PCPA Signature Page**

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

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

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

**Supervisor’s Approval**

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