Arkansas Department of Human Services
Division of Children and Family Services
626 Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Telephone (501) 682-8008 TDD {501) 682-1442 FAX {501) 682-6988

December 11, 2001

Sharon Priest
Secretary of State
State Capitol Room 026
Little Rock, AR 72201-1094

Re: Statement of Purpose

Dear Ms, Priest:

Enclosed is the Division of Children and Family Services rule concerning the DCFS Family Services Forms Manual. The Family Services Forms Manual has been revised to reflect all updated Table of Contents. The Table of Contents has been revised to include all forms and publications promulgated to date. Obsolete forms and publications have been deleted from the Table of Contents.

In addition, this rule includes forms developed in response to the implementation of CHRIS (Child Reporting Information System). The forms represent either templates or reports. The Family Service Worker is able to directly key information into the templates. Reports are generated from data previously entered into the CHRIS system. The use of the forms will enhance the Division's ability to provide services to children and families.

A hard copy of the rule and all electronic version is included. Please note that the only forms included with the electronic file are those templates that are contained in Microsoft Word. The other forms are reports generated by CHRIS and are not available as a file copy.

If you have any questions or comments, please contact Vivian Jackson, Field Services Representative, Division of Children and Family Services. P. O. Box 1437 (S570), Little Rock, AR 72203-1437, phone 682-1577.

Sincerely,

Vivian Jackson

FAMILY SERVICES FORMS MANUAL

TABLE OF CONTENTS

Each form can be accessed based on the letter in parentheses following the form number. "R" means that the form is a report generated by CHRIS; "T" means that the form is a template contained in Microsoft WORD (A hard copy of the template is also contained in the Forms Manual); and "G" means that the form can be accessed via DHS GOLD. An asterisk besides the form number indicates that the form can be ordered from the Supply Catalog. No letter following the form number means that the form is a hard copy located in the Forms Manual to be copied as needed.

Legend: R= Report T= Template G= DHS Gold * = Supply Catalog

FORM NUMBER	TITLE		DATE
CFS-326 **(T)**	OUTCOME OF COMPLAINT INVESTIGATION		09 2000
CFS-327A*	PHYSICAL DOCUMENTATION-BODY DIAGRAM		06 92
CFS-329	CHILD DEATH NOTIFICATION		03 2000
CFS-331 **(T)**	CHANGE IN PLACEMENT REVIEW		07 93
CFS-332 **(T)**	INCOME ASSISTANCE REQUEST LOG		06 93
CFS-334 **(T)**	FOSTER CARE AUTHORIZATION FOR BILLING		07 96
CFS-336 **(T)**	EXPIRATION OF PROTECTIVE CUSTODY/PARENTAL NOTIFICATION		05 97
CFS-341	DCFS POLICY EMPLOYER CERTIFICATION		05 98
CFS-342(A) **(T)**	FOSTER CARE CRIMINAL RECORD CHECK		09 2000
CFS-342(B) **(T)**	STATE ADOPTIONS CRIMINAL RECORD CHECK		09 2000
CFS-343 **(T)**	NOTIFICATION OF COURT APPEARANCE		05 99
CFS-344 **(T)**	REQUEST FOR EMPLOYEE/APPLICANT CM CENTRAL REG. CHECK		12 99
CFS-345 **(T)**	IFS REFERRAL FORM		09 99
CFS-347 **(T)**	IFS FAMILY COUNSELOR'S TIME RECORD	REV	12 97
CFS-350*	FAMILY ASSESSMENT CHECKLIST (CI)		03 89
CFS-351* **(T)**	INITIAL DENTAL EXAMINATION		08 93
CFS-352 **(T)**	MEDICAL, DENTAL, VISION, HEARING AND PSYCHOLOGICAL EPISODIC FORM	REV.	05 94
CFS-353* **(T)**	REQUESTED MEDICAL RECORDS LOG		04 93
CFS-354*	CHECKLIST FOR HEALTH NEEDS ASSESSMENT	REV.	05 94
CFS-360 **(G)**	(REQUEST FOR CONFERENCE/TRAINING)		07 95
CFS-362*	MEDI-ALERT TO FOSTER CARE PROVIDER	REV.	08 93
CFS-364*	FAMILY MENTAL HEALTH HISTORY		08 93
CFS-365*	RECEIPT FOR MEDICAL PASSPORT		08 90
CFS-366*	HEALTH SCREENING	REV.	05 94
CFS-368 **(T)**	CHILD'S HEALTH SERVICES PLAN	REV.	05 94
CFS-370 **(T)**	INDEPENDENT YOUTH'S RESIDENCE CHECKLIST		09 89
CFS-371 **(T)**	CONTINUING DEVELOPMENTAL HISTORY SUMMARY		08 93

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FORM NUMBER	TITLE		DATE
CFS-372 **(T)**	RESULTS OF DEVELOPMENTAL EVALUATIONS	REV.	05 94
CFS-373	MEDICAL PASSPORT SUMMARY		05 94
CFS-376	AUTHORIZATION FOR BILLING AND TRUST FUND ACCOUNT ACTION		10 2001
CFS-377	REPORT OF ACCOUNT BALANCES FOR DHS PLACEMENTS		10 2001
CFS-378	CHILD SUPPORT REFERRAL		10 2001
CFS-379	CLOSE OUT/OVERPAYMENT NOTIFICATION MEMORANDUM		10 2001
CFS-380	TRUST ACCOUNT INVOICE		10 2001
CFS-381	EMPLOYEE TRAINING RECORD		10 93
CFS-386*	SERVICES FACE SHEET		10 83
CFS-393 **(T)**	ATTORNEY REPORT		02 96
CFS-397 **(T)**	EDUCATIONAL ASSESSMENT		05 94
CFS-398	REQUEST/RELEASE OF INFORMATION		07 87
CFS-400/1	ADOPTION APPLICATION	REV.	07 87
CFS-400/2	APPLICANT'S FINANCIAL STATEMENT	REV.	06 87
CFS-401	ADOPTION FACT SHEET	REV.	06 87
CFS-404	GENERAL MEDICAL FORM-ADOPTIONS	REV.	06 87
CFS-405	FAMILY ASSESSMENT INFORMATION		01 81
CFS-406	HOME STUDY REQUEST/PRELIMINARY INFORMATION FORM FOR ADOPTIVE APPLICANTS OF FOREIGN BORN CHILDREN		08 90
CFS-407	STATEMENT OF FINANCIAL RESPONSIBILITY FOR FOREIGN BORN CHILDREN		08 90
CFS-409	ADOPTION QUESTIONNAIRE	REV.	05 89
CFS-410/1,2, 3,4	WAIVER AND CONSENT TO THE APPOINTMENT OF A GUARDIAN	REV.	05 87
CFS-412	CHILD'S INFORMATION SHEET	REV.	07 78
CFS-413	INITIAL CONTACT ADOPTION	REV.	10 87
CFS-414	CHANGE OF STATUS		01 85
CFS-415	ADOPTION APPLICATION DATA	REV.	05 89
CFS-417	MONTHLY GUARDIANSHIP REPORT		12 87

FORM NUMBER	TITLE		DATE
CFS-418	NOTICE OF CUSTODY WITH POWER TO CONSENT TO ADOPTION PROCEDURE		07 84
CFS-419	AUTHORIZATION-RELEASE FROM LIABILITY		04 79
CFS-420	PRE-GUARDIANSHIP PLACEMENT AGREEMENT	REV.	01 85
CFS-421/1 **(T)**	HOME STUDY/SUPERVISION CLIENT QUESTIONNAIRE		09 88
CFS-421/2 **(T)**	REASONABLE FEE INCOME STATEMENT	REV.	04 92
CFS-421/3 **(T)**	REFERENCE LETTER FOR HOME STUDY		09 88
CFS-421/4 **(T)**	HOME STUDY ATTACHMENT/ADOPTION		09 88
CFS-421/5 **(T)**	HOME STUDY ATTACHMENT/CUSTODY		09 88
CFS-421/6 **(T)**	HOME STUDY ATTACHMENT/PLACEMENT		09 88
CFS-421/7 **(T)**	HOME STUDY ATTACHMENT/YOUTH SERVICES CENTER		09 88
CFS-422 **(T)**	HOME STUDY/SUPERVISION FEE BILLING STATEMENT	REV.	08 98
CFS-424	BILLING	REV.	06 82
CFS-425 **(T)**	APPLICATION FOR ADOPTION SUBSIDY	REV.	02 88
CFS-426 **(T)**	STATEMENT OF INCOME AND RESOURCES FOR ADOPTION SUBSIDY	REV.	06 84
CFS-427 **(T)**	DETERMINATION OF ELIGIBILITY FOR ADOPTION SUBSIDY	REV.	06 84
CFS-428/1 **(T)**	ADOPTION ASSISTANCE - STATE FUNDED SUBSIDY		09 2000
CFS-428/2 **(T)**	ADOPTION ASSISTANCE - FEDERAL IV-E ASSISTANCE		09 2000
CFS-428/3 **(T)**	ADOPTION ASSISTANCE - NON-RECURRING EXPENSE PAYMENT		09 2000
CFS-429	SPECIAL ADOPTION SUBSIDY REEVALUATION	REV.	06 84
CFS-434	AFFIDAVIT/REGISTRATION FORM (MCVAR)		06 88
CFS-435	ADOPTION CASE PLAN		03 87
CFS-436	INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE/NOTICE OF TRANSFER		01 87
CFS-437	INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE/NOTICE OF ACTION		01 87
CFS-438	MEDICAID COVERAGE OF TITLE IV-E CHILDREN/NOTICE OF TRANSFER		01 87

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FORM NUMBER	TITLE		DATE
CFS-439	MEDICAID COVERAGE OF TITLE IV-E CHILDREN/NOTICE OF ACTION		01 87
CFS-440	ICU LETTER		06 88
CFS-441	HOME EVALUATION		11 76
CFS-442	REQUEST FOR OUT-OF-STATE HOME EVALUATION		05 99
CFS-443	REQUEST FOR TRAVEL PERMIT AND SUPERVISION		11 76
CFS-444	AFFIDAVIT OF VERIFICATION		11 76
CFS-448	REQUEST/TRANSMITTAL OF INFORMATION		07 86
CFS-449 **(T)**	REFERENCE LETTER		09 2000
CFS-450	FAMILY FOSTER HOME STUDY/APPLICATION		01 96
CFS-450* ATT.	ATTACHMENT-FAMILY FOSTER HOME STUDY/APPLICATION		05 87
CFS-451*	FAMILY FOSTER PARENT REEVALUATION		05 87
CFS-454	AGREEMENT FOR RESIDENTIAL SERVICES	REV.	10 87
CFS-455*	REQUEST/CONSENT FOR HEALTH DEPARTMENT SERVICE	REV.	02 89
CFS-456 **(T)**	BIOLOGICAL FAMILY BACKGROUND INFORMATION	REV.	05 99
CFS-457	HOSPITAL DATA	REV.	08 82
CFS-460	PLAN FOR FOSTER CHILD ATTAINING MAJORITY		08 84
CFS-462	INITIAL FAMILY FOSTER HOME AGREEMENT	REV.	05 94
CFS-462A	FAMILY FOSTER HOME AGREEMENT ADDENDUM		07 90
CFS-463	KNOWLEDGE OF PRE-SERVICE TRAINING MATERIAL	REV.	05 87
CFS-464	FAMILY FOSTER PARENT EVALUATION		03 80
CFS-466	VOLUNTARY TEMPORARY FC AGREEMENT		09 79
CFS-472	INFORMATION CHECKLIST FOR JUVENILE COURT		07 85
CFS-473	REQUEST LEGAL EXPENSES FC		03 83
CFS-474	PURCHASE APPROVAL FOR FOSTER CHILD	REV.	08 94
CFS-475*	CHECKLIST FOR COMPLIANCE	REV.	04 94
CFS-476	GRADUATION CERTIFICATE	REV.	02 93

CFS-478	PHYSICIAN'S REPORT	06 80

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FORM NUMBER	TITLE		DATE
CFS-479	FAMILY FOSTER HOME REEVALUATION NOTICE		07 81
CFS-480	ALTERNATE COMPLIANCE-WATER		04 87
CFS-481	FAMILY FOSTER HOME APPROVAL CERTIFICATE	REV.	02 93
CFS-485*	FAMILY FOSTER HOME FACE SHEET		04 85
CFS-487	APPLICATION FOR TITLE IV-E PAYMENTS/MEDICAID		01 93
CFS-489 **(T)**	REQUEST FOR CONSIDERATION TO ADOPT		09 88
CFS-491	CONSENT FOR USE OF FUNDS AND RESOURCES		08 90
CFS-493*	TITLE IV-E/MEDICAID RE-DETERMINATION		01 93
CFS-495 **(T)**	NOTIFICATION OF CHANGE	REV.	08 93
CFS-496	ASSESSMENT FOR INCOME ASSISTANCE		06 93
CFS-531	NOTICE TO APPLICANTS FOR CHILD CARE SERVICES		09 93
CFS-537	REQUEST FOR DAY CARE (PROTECTIVE/FOSTER CARE)		03 94
CFS-579 **(T)**	AGREEMENT FOR PROVIDER SERVICES		02 89
CFS-590* **(T)**	INVITATION TO FAMILY-CENTERED MEETING		08 94
CFS-592	FINANCIAL/MEDICAL PLAN ICPC		10 2001
CFS-4330	CHILD WELFARE STUDENT STIPEND AGREEMENT		10 2001
CFS-4331	EDUCATIONAL LEAVE CONTRACT FULL TIME/PART TIME MSW STUDENT		10 2001
CFS-4332	CHID WELFARE STUDENT STIPEND APPLICATION		10 2001
CFS-6001 **(R)**	REFERRAL INFORMATION REPORT		12 2001
CFS-6002 **(R)**	CLIENT INFORMATION		12 2001
CFS-6003 **(R/T)**	REPORT TO PROSECUTING ATTORNEY		12 2001
CFS-6004 (**T**)	ELIGIBILITY DETERMINATION		12 2001
CFS-6005 **(R)**	CLIENT SERVICES		12 2001
CFS-6006 **(R)**	TREATMENT CONTACTS/VISITS		12 2001
CFS-6007 **(R)**	PLACEMENT PLAN - PLACEMENT PROVIDER INFORMATION		12 2001

CFS-6008	**(R)**	PLACEMENT PLAN	12 2001

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FORM NUMBER		TITLE	DATE
CFS-6009	**(R)**	FAMILY STRENGTHS AND NEEDS ASSESSMENT	12 2001
CFS-6010	**(R/T)**	CASE PLAN REV.	12 2001
CFS-6011	**(R/T)**	COURT REPORT	12 2001
CFS-6012	**(R)**	CLIENT MEDICAL AND PSYCHOLOGICAL INFORMATION	12 2001
CFS-6013	**(R/T)**	APPLICATION FOR EMERGENCY SERVICES	12 2001
CFS-6014	**(R/T)**	DIFFICULTY OF CARE PAYMENT REQUEST AND NOTIFICATION	12 2001
CFS-6015	**(R/T)**	ADOPTION STAFFING NOTES	12 2001
CFS-6016	**(R)**	AFFIDAVIT OF INFORMATION DISCLOSURE FOR ADOPTION	12 2001
CFS-6017	**(R/T)**	ADOPTION SUBSIDY APPLICATION	12 2001
CFS-6018	**(R)**	CHILD PLACEMENT HISTORY	12 2001
CFS-6019	**(R)**	PLACEMENT REQUEST FORM	12 2001
CFS-6020	**(R/T)**	PLACEMENT WORKSHEET (template titled “Plcmtwk”)	12 2001
CFS-6021	**(R)**	TREATMENT/COURT INFORMATION	12 2001
CFS-6022	**(R)**	CASE SUMMARY	12 2001
CFS-6023	**(R)**	CLIENTS TO BE REGISTERED/CHANGED/CLOSED	12 2001
CFS-6024	**(R/T)**	PERMANENCY PLANNING COURT REPORT	05 99
CFS-6025	**(R)**	HEALTH AND SAFETY CHECKLIST	07 99
CFS-6026	**(R)**	RISK ASSESSMENT	07 99
CFS-6027	**(R)**	SAFETY RESPONSE	07 99
CFS-6040	**(R)**	WAITING LIST OF STAFF PERSONS REQUESTING TRAINING	12 2001
CFS-6050	**(R)**	TICKLER LIST	12 2001
CFS-6051	**(R)**	WORKLOAD LIST	12 2001
CFS-6052	**(R)**	REFERRAL ACCEPTANCE SNAPSHOT	12 2001
CFS-6053	**(R)**	INVESTIGATION CLOSE SNAPSHOT	12 2001

CFS-6054 **(R)**	CLIENT MERGE SNAPSHOT		12 2001
CFS-6056 **(R)**	STAFF LIST		12 2001

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FORM NUMBER	TITLE		DATE
CFS-6057 **(R)**	ON-CALL STAFF LIST		12 2001
CFS-6058 **(R)**	INDIVIDUAL TRAINING RECORD		12 2001
CFS-6059 **(R)**	INITIAL REFERRAL SNAPSHOT		12 2001
CFS-6060 **(R)**	CASE CONNECTION SNAPSHOT		12 2001
CFS-6061 **(R)**	INVESTIGATION EXTENSION REPORT		12 2001
CFS-6063 **(R)**	COUNTY RESOURCES INFORMATION REPORT		12 2001
CFS-6064 **(R)**	COUNTY VACANCIES INFORMATION REPORT		12 2001
CFS-6065 **(R)**	CHILD WELFARE WORKSHOP ROSTER		12 2001
CFS-6086 **(R)**	AFCARS DATA ELEMENT LIST		12 2001
CFS-6087 **(R)**	CLAIM ADJUSTMENTS BY RESOURCE		12 2001
CFS-6088 **(R)**	ESTIMATED CLAIMS BY RESOURCE		12 2001
CFS-6089 **(R)**	MALTREATMENT SUMMARY REPORT		12 2001
CFS-6090 **(R)**	NEW FOSTER PARENTS ENTERED BY RESOURCE DURING		12 2001
CFS-7000 **(R)**	CASE STAFFINGS LOG		12 2001
ICPC-100A **(T)**	INTERSTATE COMPACT PLACEMENT REQUEST	REV.	06 86
ICPC-100B **(T)**	INTERSTATE COMPACT REPORT ON CHILD'S PLACEMENT STATUS	REV.	06 86
ICPC-101 **(T)**	ASSOCIATION OF ADMINISTRATORS OF THE ICPC/SENDING STATE PRIORITY HOME STUDY REQUEST		08 96

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FORM NUMBER	TITLE		DATE
JC A	PETITION FOR REQUISITION TO RETURN A RUNAWAY JUVENILE		06 66
JC B	ORDER OF DETENTION		06 66
JC I	REQUISITION FOR RUNAWAY JUVENILE		06 66
JC IA	APPLICATION FOR COMPACT SERVICES		06 66
JC II	REQUISITION FOR ESCAPEE OR ABSCONDER		06 66
JC III	CONSENT FOR VOLUNTARY RETURN BY RUNAWAY, ESCAPEE OR ABSCONDER		06 66
JC IV	PLACEMENT INVESTIGATION AND SUPERVISION REQUEST		06 66
JC V	REPORT OF SENDING STATE UPON PAROLEE OR PROBATIONER BEING SENT TO ANOTHER JURISDICTION		06 66
JC VI	MEMORANDUM OF UNDERSTANDING AND WAIVER-PAROLEE OR PROBATIONER	REV.	11 72
SS-5 **(T)**	APPLICATION FOR A SOCIAL SECURITY NUMBER CARD		05 88
DCO-22*	REQUEST FOR UNIQUE PSEUDO SSN	REV.	07 01
DCO-75 **(G)**	CASE REEVALUATION NOTICE	REV.	03 93
DCO-104 **(G)**	LETTER TO THE ABSENT PARENT	REV.	07 97
DCO-2609	PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM		07 96
DCO-2611	LETTER RE: PHYSICIAN CHOICE		08 96
DCO-2613	NOTICE TO MEDICAID APPLICANTS/RECIPIENTS		09 96
EMS-57*	ACES SINGLE MEMBER DATA SHEET		07 93
EMS-92	IV-E TRANSFER OF RESIDENCE AND ASSIGNMENT		08 87
DHS-47	REQUEST FOR ADMINISTRATIVE COPY OF CERTIFICATE OF BIRTH	REV.	03 93
DHS-81 **(G/T)**	CONSENT FOR RELEASE OF INFORMATION		05 94
DHS-82	CONSENT FOR MEDICAL TREATMENT	REV.	09 79
DHS-91*	DEMS/DCFS REFERRAL/INFORMATION TRANSMITTAL	REV.	03 92
DHS-160* **(G)**	NOTICE TO ACTION TO APPLICANTS FOR, AND RECIPIENTS OF, TITLE SSBG SERVICES	REV.	02 01

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FORM NUMBER		TITLE		DATE
DHS-355		AUTHORIZATION AND BILLING	REV.	04 87
DHS-375		VOLUNTEER TRAVEL LETTER	REV.	09 93
DHS-484		AUTHORIZATION FOR TRANSPORTATION	REV.	09 86
DHS-1200*	**(G)**	APPEAL FOR HEARING		11 99
DHS-1558		PROBATE COURT SUMMONS	REV.	04 82
DHS-1910*	**(G)**	INCIDENT REPORT	REV.	05 01
DHS-3100		MEMO, SUPPORT PAYMENT FOR FOSTER CHILD/CHILDREN		05 88
DHS-3101		MEMO, SUPPORT PAYMENTS FOR FOSTER CHILDREN		05 88
DHS-3102		MEMO, TERMINATION OF SUPPORT PAYMENTS FOR FOSTER CHILD/CHILDREN		05 88
DHS-3300*		INFORMATION/REFERRAL INFORMATION/REFERRAL CODING GUIDE		11 86 01 89
AOV-7000		VOLUNTEER RESOURCES INFORMATION		08 86
AOV-7001		REQUEST FOR INFORMATION		07 88
AOV-7002		VOLUNTEER APPLICATION		08 88
AOV-7003		VOLUNTEER INTERVIEW		08 88
AOV-7004		VOLUNTEER AGREEMENT		08 88
AOV-7005		AGENCY EVALUATION REPORT		08 88
AOV-7006		VOLUNTEER MONTHLY HOUR LOG		08 88
AOV-7007		VOLUNTEER SIGN-IN SHEET		08 88
AOV-7008		VOLUNTEER SERVICES ACTIVITY SIGN-IN SHEET		08 88
AOV-7009		GROUP VOLUNTEER REPORT		08 88
AOV-7010		EXIT INTERVIEW		08 88
AOV-7011		VOLUNTEER ATTENDANCE RECORD		08 88

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PUBLICATIONS

PUB NUMBER	TITLE	DATE
PUB-001*	Day Care Family Homes Min Lic Requirements	10 91
PUB-002*	Minimum Lic Requirement Day Care Centers	07 95
PUB-004	Min Lic Standards for Child Welfare Agencies	04 99
PUB-005*	Day Care Family Home Voluntary Registry	11 92
PUB-006	Adopting a Foreign Child	08 90
PUB-011*	Your Child and Foster Care	06 90
PUB-013*	Aid To Families With Dependent Children	10 90
PUB-016*	Parent Guide to Registered Family Day Care	10 91
PUB-022*	Standards for Approval of Family Foster Homes	01 96
PUB-028*	Early Periodic Screen Diag Treat Prog	03 89
PUB-030*	Family Foster Parent Handbook	06 98
PUB-035*	Child Maltreatment: The Ark Law & Child Protective Services	09 95
PUB-038	Medical Passport	08 90
PUB-040*	Your Guide To Medicaid Services in Arkansas	06 92
PUB-043	Choices - Adoption Is An Option	04 94
PUB-051*	Pre-Service Foster Parenting Training	03 88
PUB-052*	Child Protective Services - A Caretaker's Guide	02 2001
PUB-053	Directory of Residential Therapeutic Child Care Providers	10 2001
PUB-057	After Hours Directory	09 92
PUB-059*	Out-of-Home Protective Services	11 91

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PUB NUMBER	TITLE		DATE
PUB-069	Summary Licensing Req Day Care Centers		06 90
PUB-070	Summary Licensing Req Day Care Family Homes		06 90
PUB-080	Intensive Family Services Guidelines		07 90
PUB-102	Parenting in Arkansas		09 90
PUB-112*	Adoption Services in Arkansas		06 88
PUB-113	Mutual Consent Voluntary Adoption Registry		06 88
PUB-116	Sometime Friends Need Help		12 90
PUB-131*	FC Compliance Requirements/A Desk Guide		10 90
PUB-132*	Children with Special Needs and Subsidy		02 90
PUB-141*	If You Need Us		04 95
PUB-151*	Planning a Quality Program For Children		1986
PUB-152*	If you really care... Foster Care!		1987
PUB-169*	Food Stamps		11 92
PUB-178	The Homemaker and Your Family		12 88
PUB-252	"What Do You Think?" - Adoption Choices	REV	10 2001
PUB-261	Relative/In-Home Day Care Registration		11 92
PUB-262	Child Care Assistance for Teen Parents and Low Income		11 92
PUB-267*	Division of Children and Family Services		11 90
PUB-273*	Department of Human Services		07 93
PUB-275	Freedom of Information Act		09 90
PUB-295	Family Day Care Voluntary Registration		07 91

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PUB NUMBER	TITLE	DATE
PUB-321	DCFS Eligibility Specialist Handbook	10 92
PUB-333	Health Check-ups for Children in Foster Care- A Pamphlet for Family Foster Parents	09 93
PUB-334	Health Check-ups for Children in Foster Care- A Pamphlet for Medical Providers	09 93
PUB-343	Family Assessment Manual	08 94
PUB-357*	Child Maltreatment Assessment Protocol	07 2000
PUB-384	Local Cash Accounts Guidelines	07 98

Legend: *=Supply Catalog

Arkansas Department of Human Services

Report to Prosecuting Attorney

12/18/2001

A. REFERRAL INFORMATION

Family Name	Case Number	Referral Number	Referral Date

Referral Synopsis

Case Clients

Referral Clients

B. CHILDREN

No Children

Name	Date of Birth	Gender	Alleged Victim	Tribe	In Household

C. PARENT / PERSON RESPONSIBLE FOR CHILD (PRFC)

No Parents/PRFC

Name	Date of Birth	Gender	Alleged Perpetrator	Tribe	In Household	Relationship to Child

D. ADDITIONAL INFORMATION

Indian Heritage Addressed?

Child is a Ward of Another Court?

Other Custody Proceedings Pending?

Emergency Existed?

Preventive Services Were Offered?

Children in protective custody? ☐Yes ☐No

Child Name	Date Removed	Date Returned	Referral

E. CENTRAL CHILD ABUSE REGISTRY / OTHER RECORDS

Prior Referrals

No Prior Referrals

Referral Number	Date	Overall Finding

List Other Documents/Records Attached

F. SUMMARY / RECOMMENDATION

Summary/Recommendation

G. INVESTIGATIVE FINDING

Overall Finding

H. INVESTIGATION CLOSURE

Approved By:
Approve Date:

Family Service Worker **Date**

Supervisor **Date**

County

I. ADDRESSES/LOCATIONS

No Children

Children

Child Name
Date of Birth
SSN
Race
School

Child Name
Date of Birth
SSN
Race
School

No Parent/PRFC

Parent/PRFC

Adult Name
Date of Birth
SSN
Race
Home Address
Home Phone
Employer
Start Date
End Date
Work Address
Work Phone

Adult Name
Date of Birth
SSN
Race
Home Address
Home Phone
Employer
Start Date
End Date
Work Address
Work Phone

No Collaterals/Witnesses

Collaterals/Witnesses

Name
Relation to Family
Date of Birth
SSN
Race
Address
Home Phone
Work Phone

Name
Relation to Family
Date of Birth
SSN
Race
Address
Home Phone
Work Phone

J. VICTIM INTERVIEW

No Victim Interviews

Victim Name			**Date of Birth**
Date Interviewed/Contacted	**Time Interviewed**	**Type of Contact**	
Interview Location			
Others Present During Interview			
Interview Summary			
Current Physical Condition/Functioning?			
Worker's Observations			
Additional Information			
Interviewer Name			**Interviewer County**
Explanation of Reasonable Diligence:			

K. SIBLING INTERVIEW

No Sibling Interviews

Sibling Name			**Date of Birth**
Date Interviewed/Contacted	**Time Interviewed**	**Type of Contact**	
Interview Location			
Others Present During Interview			
Interview Summary			
Current Physical Condition / Functioning?			
Worker's Observations			
Additional Information			
Interviewer Name			**Interviewer County**

L. PRFC / ALLEGED PERPETRATOR INTERVIEW

No PRFC/Alleged Perpetrator Interviews

PRFC/Alleged Perpetrator		**Name**	**Date of Birth**
Date Interviewed/Contacted	**Time Interviewed**	**Type of Contact**	
Interview Location			
Others Present During Interview			
Interview Summary			
Functioning Level / Capacity to Protect Child			
Worker's Observations			
Additional Information			
Interviewer Name			**Interviewer County**
Explanation of Reasonable Diligence			

M. COLLATERAL INTERVIEW

No Collateral Interviews

Collateral Name		Relationship to Family	Type of Collateral
Date Interviewed/Contacted	Time Interviewed	Type of Contact	
Interview Location			
Interview Summary			
Additional Information			
Interviewer Name			Interviewer County

For Severe Maltreatment (Priority I Reports) Immediate Notification Must Be Made to Law Enforcement/Prosecuting Attorney, followed by CFS-310:

_____ _____ _____ _____

Signature of Person Calling Law Enforcement **Date of Call** **Time of Call**

CFS-310 mailed to Law Enforcement _____

Date

Person Contacted: _____

_____ _____ _____ _____

Signature of Person Calling Prosecuting Attorney **Date of Call** **Time of Call**

CFS-310 mailed to Prosecuting Attorney _____

Date

Person Contacted: _____

Arkansas Department of Human Services

Eligibility Determination

To: _____ **From:** County - ☐ New Application

Re: _____ **Date:** 12/18/2001 ☐ Change of Application

_____

A. DEMOGRAPHIC INFORMATION -

First Name Middle Name Last Name				**Gender**	**Race**
DOB	**SSN**	**Citizenship/Alien Status**		**Current School**	**Current Grade**
Date of Removal Order	**Removal Date**	**Placement Date**	**County of Placement**	**Current Placement**	
Type of Custody		**Court Number (JFJ#)**	**Court of Jurisdiction**	**Is the Child in Tribal Custody?**	
Has the Court Order checked for accuracy? **Is this a DHS Voluntary Foster Care placement?** **Is this person a child of a custody child?**					

B. PARENTAL/CARETAKER INFORMATION -

First Name Middle Name Last Name			**Relationship to Child**	**Race**
DOB	**SSN**	**Marital Status**	**Employer**	
Address				
Still Retain Parental Rights?			**Paying Child Support? If So, Monthly Amounts**	
Role In Ths Case: Absent Parent? Payee?				

C. INCOME, RESOURCE, AND INSURANCE INFORMATION -

Income:

Income Type	Monthly Amount	Start Date	End Date

Benefits:

Program/Funding Source	Adoption Subsidy	Payments	Case Number

Assets:

Asset Type	Actual Value	Cash Value	Face Value	Location

Insurance:

Insurance Type	Company	Policy Number	Policyholder Last Name	Holder SSN	Coverage Start Date	Coverage End Date

D. OTHER INFORMATION -

☐ ***DO NOT PURSUE CHILD SUPPORT***

☐ Good Cause ☐ Best Interest of Child Exemption

☐ ***PURSUE CHILD SUPPORT***

By Signing this application, the client assures that they have read and understand their rights and entitlements as stated in the following documents:

☐ Chapter 25, Appendix G - Statement of Understanding, Cooperation and Assignment - AFDC

☐ Chapter 25, Appendix H - Statement of Understanding, for Securing Medical Support Only - Medicaid

☐ Chapter 25, Appendix F - Statement of Understanding, for Full Child Support Services - Medicaid

_____ _____

Custodian Signature **Date**

☐ ***ADDITIONAL FORMS***

☐ Birth Certificate

☐ Application for SSN

☐ VS151

IV-E Eligibility

☐ Certified ☐ Denied Effective Date _____

_____

Reason:

Title XIX Eligibility

☐ Certified ☐ Denied Effective Date

Reason:

Signature: _____

Signature: _____

CLIENT'S RIGHTS AND RESPONSIBILITIES

A. Arkansas Law (36.O.S. § 3624.2) provides direct payment to the Department of Human Services from insurers for some medical expense reimbursements. Any person who files a claim with an insurance company must tell the insurance company if he/she has applied for or received medical assistance form the Department of Human Services. Failure to do this is considered a misdemeanor. I understand that insurance payments must be paid to the medical facility or doctor first, and that I may be responsible for the balance if the insurer's payment is more than the amount paid by this Department.

B. I transfer, assign, and authorize payment to the Department all claims I have or may have against Health Insurance or Liability Insurance Companies, or other third parties. This covers all payments for medical services made by the Department for me or my dependents.

C. I have read this application, or the application has been read to me, and I fully understand it. I further understand that if I give a false statement(s) for the purpose of obtaining medical services and/or money payments, I may be prosecuted for perjury. If I am found guilty, I may be imprisoned for not more than five years in a state penal institution. If my false statement(s) result in my receiving medical services and/or money payments, I may also be prosecuted for fraud. If I am found guilty of fraudulently receiving $500 or less, I may be fined up to $500 or be imprisoned for not more than three months, or both fined and imprisoned. If I am found guilty of fraudulently receiving more than $500, I may be fined up to $5,000 or imprisoned for up to two (2) years, or both fined and imprisoned.

D. I understand that by completing this application I have applied for Medical Assistance, and I certify that the information I have given is correct and complete to the best of my knowledge. I agree to tell the County Human Services Office if I have a change in living arrangement, address, income, bank accounts, automobile, other resources of any kind, health insurance or expenses. I agree to report changes within 10 days of when I know of the change.

I also understand that, if I am eligible for Medical Assistance, payment(s) may be made only for those services and to those providers that are approved under the Arkansas Medicaid plan.

E. I understand that the information I have given will be carefully studied and that I might be asked to provide proof of my answers. I authorize the Department of Human Services to make any necessary investigation to prove the information I have given. I authorize the release of any necessary information from individuals, business, public or private organizations to determine my eligibility for assistance. I understand that if I am eligible payment may be made for medical services received on or after the 1st day of the 3rd month prior to this application.

F. For the purpose of determining whether any payment will be made in behalf of the patient for any medical services, hereafter reported, I authorize the Department, or representative authorized for the purpose of determining compensability of claims in the patient's behalf, to inspect all hospital and medical records pertaining to any hospitalization or medical services. I further authorize the hospital, physician or other medical provider to release and furnish to the Department and its representatives any information shown in such records. If the patient is a minor, the statement regarding the patient's resources applies also to the resources of the patient's parents.

G. I understand that I have the right to appeal any action of the Department of Human Services which I consider improper. I can also appeal any delay in decision. I understand if I appeal, a fair hearing may be held. (Requests for a fair hearing may be made at the County Human Services Office.)

H. I understand that the Social Security numbers of persons included in this application, or whose income or resources are used in determining my eligibility, are required and will be used to match with income information from other government agencies, i.e., Social Security Administration, Internal Revenue Service and Arkansas Employment Security Commission. They may also be used for verification of medical eligibility. The information will be used to help determine my eligibility assistance.

I. I agree to cooperate with the Department in identifying, locating and securing medical support from the absent parent(s) and, if applicable, establishing paternity. I also agree to cooperate with the Department in obtaining any other payments due me or the children for whom I am applying or who may later be found eligible. I agree to provide any information known be me in order to comply with the above agreement. I understand if I fail to cooperate without good cause, my needs will not be included in the Medical Assistance benefits.

J. I declare under penalty or perjury that the foregoing information is true and correct. (28 U.S.C. 1746).

_____ *(Signature)*

Social Worker
County
Div/Unit
Phone #

2	2	4	6	5	4	10

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILDREN AND FAMILY SERVICES

CASE PLAN

Case ID:

Date of Last Court Hearing:

Date of Next Court Hearing:

I. GENERAL INFORMATION

Date Initial Plan:	Revision Dates:

Target Date of Current Plan:	

Case Plan Addresses Child's Health and Safety Needs: [ ] yes [ ] no
Docket Number:

Goal (What is the goal of the case?)	

Concurrent Plan (If applicable)	

II. CASE PLAN PARTICIPANTS - ALL FAMILY MEMBERS & RELATIONSHIPS

Associated Client	Relationship	Client

CASE PLAN PARTICIPANTS - OTHER THAN FAMILY MEMBERS

Participant Name(Other than Family Members)

III. CASE PLAN

Problems Being Addressed	

FAMILY PRESERVATION SERVICES NOT APPROPRIATE ***YES/NO:***	***COMMENTS:***

ACTIONS TAKEN TO ELIMINATE OR CORRECT THE IDENTIFIED PROBLEMS

Permanency Goal

	Services/Activities to be Provided Addressing Identified Problems	Parent/Child Name	Time Frames to Provide These Services	Status

	Needs Statement	Performance Criteria	Status Comments	Service Details

Concurrent Plan

	Services/Activities to be Provided Addressing Identified Problems	Parent/Child Name	Time Frames to Provide These Services	Status

	Needs Statement	Performance Criteria	Status Comments	Service Details

*Actions That Must be Taken by Guardian or Foster Parent to Eliminate or Correct Identified Problems	*Client Name	*Time Frames for Actions to be Taken	*Status

IV. *No Preventive Services are Provided for the Following Reason(s):

V. *Are any ADA (Americans with Disability Act) accommodations needed? If so, what and how will the accommodations be provided?

VI. *Who is the father of the client? What is his status as to the client?

Child Name	*Father Name	*Status

VII. SERVICES PROVIDED TO THE FAMILY MEMBERS INCLUDING THE CHILD'S CURRENT HEALTH AND SAFETY NEEDS (Services to Meet Needs of Child/Client while in Out-of-Home Placement/Adoptive Placement)

Client	Service

SERVICES PROVIDED TO THE FAMILY MEMBERS INCLUDING PREVENTIVE SERVICES/PRE-ADOPTIVE SERVICES (Services Provided in Last 6 Months)

Agency Name	Client Name	Service	Begin Date	End Date	Review Date	Service Frequency	Service Status

VIII. *Is the client in an out-of-home placement? ☐ **Yes** ☐ **No**
If so, answer the following:

Reason for Removal. (Problems or conditions that required placement of the client outside the home)	
Client	**Conditions**

***How will these problems or conditions be remedied?**
***When do you anticipate the client returning home?**

PLACEMENT QUALIFICATIONS/EFFORTS
(Why Out-Of-Home Placement Was Selected)

Client	**Unique Qualifications of Current Placement That Meet Child's Special Needs Including the Child's Current Health and Safety Needs**	**Efforts to Place Child with Relative**

APPROPRIATENESS OF OUT-OF-HOME PLACEMENT
(Why this Particular Placement was Selected)

Client	**Placement Proximity**	**How Current Placement is Least Restrictive**

SOCIAL AND FAMILY SERVICES THAT MUST BE PROVIDED BY DHS WHILE CHILD IS IN AN OUT-OF-HOME PLACEMENT

PARENT

*Services / * Reason for Services:
*Do you anticipate that these services will promote the availability of the juvenile to a continuous and stable living environment, promote family autonomy, strengthen family life and promote reunification? ☐ Yes ☐ No

GUARDIAN

*Services / *Reason for Services:
*Do you anticipate that these services will promote the availability of the juvenile to a continuous and stable living environment, promote family autonomy, strengthen family life and promote reunification? ☐ Yes ☐ No

CUSTODIAN

*Services / *Reason for Services:
*Do you anticipate that these services will promote the availability of the juvenile to a continuous and stable living environment, promote family autonomy, strengthen family life and promote reunification? ☐ Yes ☐ No

FOSTER PARENT

Client	Services to Foster Parent

*Do you anticipate that these services will promote the availability of the juvenile to a continuous and stable living environment, promote family autonomy, strengthen family life and promote reunification? ☐ Yes ☐ No

FINANCIAL/EDUCATIONAL/HEALTH/EMPLOYMENT INFORMATION

*Is a copy of the child's health and education records attached? (CFS-6007, pertinent educational records, such as Report Cards, recognition certificates, expulsions, etc.) ☐ Yes ☐ No	
*Does Parent or Guardian have health insurance? ☐ Yes ☐ No	
*Mother's Place of Employment	*Weekly Salary
*Father's Place of Employment	*Weekly Salary
*Guardian's Place of Employment	*Weekly Salary

SIBLING INFORMATION

*Are there any siblings? ☐ Yes ☐ No
*Location of Siblings
*Reason For Separation Of Siblings
*Is sibling visitation appropriate? ☐ Yes ☐ No
*If so, what efforts will be made to enable the siblings to maintain regular contact?
*Is reunification of siblings a possibility? ☐ Yes ☐ No

INDEPENDENT LIVING SERVICE

*Is the client appropriate for Independent Living Services? ☐ Yes ☐ No	
List programs and services that are available to help the child transition from Foster Care to Independent Living.	
Client	Services

*FAMILY VISITATION PLAN

Child(ren):

Date Developed: **Dates Revised:** ; ;

Supervision Required by DCFS? ☐ **Yes** ☐ **No** **Explain:**

RESPONSIBILITIES/RIGHTS:

DIVISION:

FAMILY:

CUSTODIAN(S):

CAREGIVER(S):

Date	TIME	PLACE	FAMILY MEMBERS VISITING
1)			
COMMENT:			
2)			
COMMENT:			
3)			
COMMENT:			
4)			
COMMENT:			
5)			
COMMENT:			
6)			
COMMENT:			
7)			
COMMENT:			
8)			
COMMENT:			
9)			
COMMENT:			
10)			
COMMENT:			

FAMILY VISITATION PLAN

Date	TIME	PLACE	FAMILY MEMBERS VISITING
11)			
COMMENT:			
12)			
COMMENT:			
13)			
COMMENT:			
14)			
COMMENT:			
15)			
COMMENT:			
16)			
COMMENT:			
17)			
COMMENT:			
18)			
COMMENT:			
19)			
COMMENT:			
20)			
COMMENT:			

*STATEMENT OF UNDERSTANDING/DISTRIBUTION

I understand:

- ☐ The Case Plan. I have read it or had it read to me.
- ☐ I do not read (understand) English. This plan was read (interpreted) to me.
- ☐ I am to be given a copy of any change in the Case Plan.
- ☐ I may ask for a review of the Case Plan, if I disagree with it.

If this Case Plan resulted from court-ordered services, I understand I may ask the court:

- ☐ To settle any disagreement I have with the Case plan.
- ☐ For a hearing on any change to the Case plan I disagree with.

If this Case Plan resulted from a court-ordered placement, I understand:

- ☐ My rights and duties and the rights and duties of the Department of Human Services while my child is in Foster Care.
- ☐ I may lose my rights as a parent if I don't meet the conditions in this Case Plan including material failure to comply substantially (only after notice and a court hearing). A.C.A. §9-27-338 requires that a Permanency Planning Hearing be held no later than twelve (12) months after the date the child enters an out-of-home placement in order to enter a new disposition in a case. Families must comply with the tasks identified in the case plan. If a family has not shown that they have worked to improve their ability to safely care for their child, DCFS will recommend to the court, at the Permanency Planning Hearing, that their parental rights be terminated unless a compelling reason exists.

I affirm that:

- ☐ I agree with the Case Plan.
- ☐ I disagree with part(s) of the Case Plan: (specify): _____
- ☐ I disagree with all of the Case Plan.; or
- ☐ I make no comment.

NOTICE TO PARENTS:

- ☐ I understand that my participation in the development or the acceptance of a Case Plan shall not constitute an admission of dependency-neglect.
- ☐ I understand that this Case Plan is subject to court approval upon review by the court.

SIGNATURES

Mother	Date	Father	Date
Child	Date	Child	Date
Child	Date	Child	Date
Custodian	Date	Caregiver	Date
Family Service Worker/Child	Date	Family Service Worker/Parents	Date
Supervisor	Date	Supervisor	Date
Family Support Specialist	Date	CASA	Date
Foster Parent	Date	Other	Date

***CHECK ONE:**

☐ The parent(s)/custodian signed the Case Plan after it was developed and discussed with them.
☐ The parent(s)/custodian refused to sign the Case Plan after it was discussed with them.
☐ The parent was unwilling to participate.

Reason:

***DISTRIBUTION:**
Persons receiving the Case Plan:

☐ Mother	Date:
☐ Father	Date:
☐ Custodian	Date:
☐ Children	Date:
☐ Caregiver	Date:
☐ Guardian ad litem	Date:
☐ OCC	Date:
☐ Court	Date:
☐ Foster Parent	Date:
☐ CASA	Date:
☐ Other(specify):	Date:

Family Service Worker making distribution:

Signature: _____ Date: _____

Family Name:

CHRIS Case Number:

Arkansas Department of Human Services

COURT REPORT

I. COURT INFORMATION

Hearing Type: **Hearing Date:**

Docket #:

County of Jurisdiction: **Judge's Name:**

II. CHILD(REN)

Name	Date of Birth	Location	Placement Type

III. PARENT(S)/LEGAL CUSTODIAN(S)

Name	Address

IV. FINANCIAL INFORMATION

Mother's Place of Employment:
Weekly Salary:
Father's Place of Employment:
Weekly Salary:

V. DHS RECOMMENDATIONS

[☐] Return Home
[☐] Continued Foster Care and Work With Family
[☐] Placement With Relatives
[☐] Proceed Toward Custody With Parental Rights Terminated

VI. DHS INFORMATION

Family Service Workers Involved:

Worker Name	County

VII. FAMILY PROGRESS

A. Child Welfare Background and Reasons for Intervention:

B. Child(ren)'s Situation (physical, emotional, educational, psycho-social) Including Current Health and Safety Needs and Current Placement (Independent Living, if appropriate):

C. Children's Adjustment in Placement and Progress in School:

D. Parent's Current Living Situation (Financial, Physical, Mental, and Emotional):

E. Parent's Progress on Disposition Order/Court Order/Treatment Plan/Efforts to Correct Conditions(s):

F. Visitation (Between Child(ren) and Parents, Relatives, Siblings, etc., and Results):

G. Permanency Plan:(Include Independent Living Information, if Appropriate):

H. Additional Information (location of siblings, services offered, etc.):

VIII. SIGNATURES

Family Service Worker	Date
Supervisor	Date

Application for Family Preservation

I. Case Name _____ **Case No:** _____ **County:** _____

II. Family Members

No Family Member

(First Name, MI, Last Name)	Date of Birth	Relation	Sex	Race	Social Security #

I Certify that to the best of my knowledge that the above information is true, correct and complete.

Signature (Applicant or Worker on behalf of child) Date

III. Eligibility Citeria - (Check all that apply)

A. ☐ An emergency exists involving a child who is listed above because of abuse, neglect, or abandonment, the need to remove a child from the child's home of imminent threat of these, or lack of a proper caretaker.

B. ☐ The emergency did not arise because the child or a specified relative refused to accept employment or training without good cause.

C. ☐ There are insufficient resources immediately available to alleviate the emergency.

D. ☐ The child has lived with a specified relative during a period of time within the last six months.

E. ☐ Title IV-A EA/AFDC or Family Preservation Services have not been authorized under this program within the last 12 months.

IV. Eligibility Decision

YES _____ **NO** _____

Service Authorization Start Date	Employee Signature	Date

Arkansas Department of Human Services

12/18/2001 10:53 AM

Difficulty of Care Payment Request and Notification

Social Worker		
Child's Name		
Case Number	**County**	**Date of Birth**

MEDICAL NEEDS/HISTORY

Medical Conditions:

Drug/Alcohol Problems:

Special Conditions:

Allergies: (Food, Medications, or Environmental):

Special Diets:

Medical History:

PSYCHOLOGICAL NEEDS/HISTORY

Psychological History:

Diagnosis:

Recommendation:

CHARACTERISTICS

Physical/Medical:

Behavioral/Psychological:

Other:

Please identify the care and supervision needs of the child based on the difficulty of care rate description:

Rate I:	Rate III:
☐ (a) Requires on-going scheduled medical or psychological appointments that routinely occur more than twice weekly. ☐ (b) Displays emotional difficulties that result in destruction of property or special equipment. ☐ (c) Requires noncompensable medical and/or educational supplies on a routine basis. ☐ (d) Requires regular physical therapy performed by the foster parents .	☐ (a) Requires noncompensable medical supplies, special equipment and/or educational supplies on a routine basis. ☐ (b) Requires specialized substitute care.
Rate II:	Rate IV:
☐ (a) Requires 24 hour intensive supervision due to severe medical or emotional needs. ☐ (b) Requires special food preparation and feeding due to a condition that restricts normal eating ☐ (c) Requires special equipment for transportation that results in restricted mobility for child and foster parents. ☐ (d) Displays incontinence of the bladder and bowel that is not age appropriate. ☐ (e) Displays multiple handicaps, birth defects or brain damage that prevents normal functioning intellectually and/or physically. ☐ (f) Requires strict monitoring of medication. ☐ (g) Requires assistance in movement which is very difficult due to child's size. ☐ (h) Requires post-hospitalization care such as frequent changing of bandages, tubes and special hygiene techniques. ☐ (i) Displays emotional disturbances, developmental delay or mental retardation that results in behavior such as constant difficulties in school, aggressive and delinquent activities, destructiveness, resistance to authority and/or sexual disturbances.	☐ (a) Requires special equipment such as apnea monitor, suction machine, gastrostomy tube, oxygen tracheotomy tube, shunt, etc. ☐ (b) Requires feeding, medication or nursing care around the clock. ☐ (c) Requires frequent nighttime supervision and care. ☐ (d) Displays such frequent seizures or other abnormal physical reactions that 24 hour monitoring is required. ☐ (e) Displays bizarre, socially unacceptable behavior, violent tendencies, potentially harmful behavior to himself or others, and/or sexually predatory to others and/or animals. ☐ (f) Previous inpatient mental health treatment and recent discharge from an inpatient facility. ☐ (g) Requires such intensive care that foster parents are severely restricted in normal daily activities and are frequently homebound.

Maximum Monthly Rate (by age)

RATE	Ages 0 - 5	Ages 6 - 12	Ages 13 - 18+
Rate I ($50/Month, $1.67/day)	$350	$410	$470
Rate II ($100/Month, $3.33/day)	$400	$460	$520
Rate III ($150/Month, $5.00/day)	$450	$510	$570
Rate IV ($225/Month, $7.50/day)	$525	$585	$645

Difficulty of Care Notification of Approval or Cancellation

Please list any additional information on the child's special needs which will help to determine the Difficulty of Care Payment Rate:

Case Number	**Child's Name**	
Submitted by		
County	**Date** 12/18/2001	**Phone**

_____ _____

CW Social Worker Supervisor

State Office Approval

Difficulty of Care Level (please check one) ☐ I ☐ II ☐ III ☐ IV

Amount Approved: _____

Dates Effective From: To:

State Office Representative's Signature _____

Notice of Cancellation

☐ Cancellation of Payments

Reason:

_____ _____

Signature Date

Arkansas Department Of Human Services
Adoption Staffing Notes

CLIENT INFORMATION CHILD

Child's Name			**Staffing Date**		
Race			**Ethnicity**		
Primary Tribe		**Secondary Tribe**		**Tribe Verified Date**	
How Indian Tribe Verified Text					
SSN	**Birth Date**	**Gender**	**County of Placement**	**County Of Adjudication**	
Birthplace City Name			**Birthplace (State)**		

CLIENT INFORMATION CHILD

AKA Name	**AKA Type**

WORKER INFORMATION

Worker's Name	**Worker's County**	**Worker's Telephone**

Xerox a Good Picture of Child (ren)
and Place it Here

CHILD CHARACTERISTICS

Sensitive Information on Paper

Distinguishing Characteristics
Other Specified Characteristics
Physical/Medical
Behavioral / Psychological

CHILD STRENGTHS

Strengths

CHILD'S EDUCATION

School Name	**School Address**	**School Phone**
Date Last Attended	**Date Last Updated**	**Date IEP/IHP**
Current Grade Level	**Grade Last Completed**	**Functional Grade Level**
School Performance	**Educational Status**	**Educational Placement**
Educational Strength		
Educational Needs		

1. CUSTODY AND LEGAL STATUS : Referral Information - Why we received custody of child, date parental rights were terminated or are set to be terminated _____.

Client Name

Terminated Parent Name					
Relationship	**Effective Date**	**Notice Type**	**Notice Date**	**Legal Code**	
Termination Appealed	**Appeal Date**	**Court Check**	**Court Check Date**	**Petition Date**	**Hearing Date**
Hearing Outcome					
Continuance Requested					
Continuance Reason					
Referred to Adoption Planning					

PLACEMENTS: Chronological list of all placements, dates and reasons for the moves.

Entry Date	**Exit Date**	**Exit Reason**	**Exit Comments**
Placement Resource	**Resource type**	**Agency name**	

SIBLINGS: List all of this child's siblings, their dates of birth, race if different from this child, if they are or are not currently placed with this child and why. List the permanent placement goal for each sibling.

Sibling's Name	**Birth Date**	**Ethnicity**
Permanent Placement Goal		

PARENTS: List each parent separately, include physical description, health problems, educational attainment, work history, and if there is any retardation, mental illness, substance use or abuse or family hereditary issues, please explain.

Parent Name	**Physical Description**

Health Problems	
Educational Attainment	
Work History	
Any Mental Problems	
Family or Hereditary Issues	

ICWA: Does it apply? Is there a court determination? Tribe?

PREPARATION FOR ADOPTION: Has child completed "What Do You Think" workbook? (Bring the workbook and leave with staffing coordinator). Briefly describe the child's understanding of and acceptance of adoptive placement and what work you have done in this area with the child.

DESCRIPTION OF CHILD: Describe the child physically, behaviorally, emotionally, medically, educationally (include grade and level of placement), personality, strengths, weaknesses, interests and activities. List the nature and extent of the abuse/neglect the child suffered, who the perpetrator was and how the child is dealing with the CA/N. Is the child in counseling/therapy? What will the child need regarding this in her/his adoptive placement? **If placement separate from sibling(s) is approved, will visitation be an issue?**

VISITATION: If the child is currently visiting parents, relatives or others, explain that as an issue in placement. When did the child last visit parents, siblings or significant others?

CHILD'S HEALTH: When did the child last have health, dental, vision screening ? Will there be any special health care issues in placement? If so, explain. Any use of alcohol, drugs, tobacco? Is child taking ongoing medications? Specify. Are immunizations current?

Medical History
Medical Conditions
Special Conditions
Allergies
Special Diets
Drug/Alcohol Problems

IMMUNIZATIONS

Type	Immunization Date	Due Date	Doctor/Clinic Name

PSYCHOLOGICAL FUNCTIONING

Psychological History
Diagnosis
Recommendation

PSYCHOLOGICAL EVALUATIONS

Full Scale IQ	Verbal	Performance	Functioning Level	Evaluation Date	Agency Name
Other Tests					
Reasons for Evaluation					

Outcome
Evaluation Diagnosis

PSYCHOLOGICAL TESTS

RELIGION: Has child been baptized into a specific religious group? Is religion an issue for this child in placement? Any preferences?

EXTENDED FAMILY: Have all extended family been explored? Are there any issues related to family?

TYPE OF FAMILY RECOMMENDED: Be realistic but include if rural or urban, presence or absence of other children, working or non-working mother, if available, any prohibitions, i.e., smoking, pets, etc.

ATTACHMENTS: Please attach or proof of request.

1. **Birth certificate (Original).**
2. **Immunization record.**
3. **Psychological (if any), IEP'S (if any) other assessments.**
4. **Current Adoption Summary.**

Arkansas Department of Human Services

Adoption Subsidy Application

Adoptive Family's Last Name

Section I

CHILD'S INFORMATION

Child's Name			
Child's Birth Name			
Date of Birth	SSN	Child's Original Case #	ICWA? Yes☐ No☐
Tribal Affiliation		Ethnicity/Race	

ELIGIBILITY INFORMATION

Case No.	PC	Benefit Type	Benefit Status	Reason	Effective Date	Payment
If Title IV-E, name of Payee:						

If SSI, attach award letter

ADOPTIVE FAMILY INFORMATION

Address			
Phone #		Phone Extension #	
Prefix	Adoptive Father's Name		Suffix
Date of Birth	SSN	Work Telephone	
Prefix	Adoptive Mother's Name		Suffix
Date of Birth	SSN	Work Telephone	

ADOPTIVE FAMILY'S MEDICAL INSURANCE

Insurance Type	Agency	Policy Number	Policy Holder Name

Section II

General, Special Services and Non-Recurring Adoption Subsidy Assistance

Date of Adoptive Placement	**Foster Parent Adoption** Yes ☐ No ☐	**Relative Adoption** Yes ☐ No ☐

Category of Eligibility of Child(ren)

☐ Physical Disability ☐ Age ☐ Mental Disability ☐ Sibling Relationship

☐ Emotional Disturbance ☐ Racial or Ethnic Factor ☐ High Risk of Physical or Mental Disease

Efforts to Place Child without Subsidy:

Comments:

Section III

Post-Legal Adoption Subsidy Assistance

Date of Adoptive Placement:	**Date of Subsidy Requested**

1. Causitive, pre-existing condition which was not identified or known prior to legal adoption:

Treatment for severe medical or psychiatric condition:

Section IV

Benefits Requested

☐ Agreement Only - No Benefits now but in the future if needed.

What future needs may your child have?

	Amount of Subsidy	Per Month	Non-Recurring	Special Services
1.	☐ Medicaid	☐	☐	☐
2.	☐ Medicaid	☐	☐	☐
3.	☐ Medicaid	☐	☐	☐

Submitted by: _____ **County** _____ **Date** _____

Adoption Specialist

Phone Number _____

_____ _____ _____ _____

Signature of Adoptive Father **Date** **Signature of Adoptive Mother** **Date**

_____ _____

Social Security Number **Social Security Number**

Section V

Committee Recommendation: **See Adoption Subsidy Committee member's recommendations and signatures in Section Below**

_____ Approved

_____ Disapproved

Section VI

_____ Department Representative
Child Welfare Services

_____ Disapproved

_____ Approved

Section VII

Recommendation Reasons and Comments	Eligibility and Legal Policy Citation	Committee Member Signature and Date

Arkansas Department of Human Services
Placement Worksheet

Worker's Name	Worker's Telephone	Supervisor's Name	Supervisor's Telephone

CLIENT INFORMATION - CHILD

Child's Name		Current Status of Child
CHRIS Case Number	CHRIS Client ID	Medical Related DHS Case Number

GENERAL INFORMATION

SSN		Birth Date	Gender	County of Service	US Citizen
Eye Color	Hair Color	Weight	Height	Religion	
Race			Ethnicity		
Primary Tribe	Secondary Tribe		Tribe Verified Date		
How Indian Tribe Verified Text					
Birthplace City Name			Birthplace State		
Need Interpreter ?					

AKA Name	AKA Type

Languages Known

CHARACTERISTICS

Sensitive Information on Paper:
Distinguishing Characteristics:
Other Specified Characteritics:

Physical / Medical

Behavioral / Psychological

Strengths

Current Reason for placement above foster family care:

CHILD ADDRESS/TELEPHONE/LIVING ARRANGEMENT

Child Name
Address Type
Address
Address Comments

Foreign Address
Foreign Country

Phone Number Type
Phone Number

Current Living Arrangement
Caretaker Name
Caretaker Relationship to Child

SIBLING INFORMATION

Sibling Name
Birthdate
Current Living Arrangement
Custody Status

PARENT/PRFC ADDRESS/PHONE

Parent/PRFC Name
Address Type
Address
Address Comments

Foreign Address
Foreign Country

Phone Number Type
Phone Number

CHILD'S EDUCATION

School Name	School Address	School Phone
Date Last Attended	Date Last Updated	Date IEP/IHP
Current Grade Level	Grade Last Completed	Functional Grade Level
School Performance	Educational Status	Educational Placement

Educational Strength		
Educational Needs		

COURT NUMBERS

Court Number	Jurisdiction County	Jurisdiction State	Court Type

INDIVIDUAL HEARING

Legal Status	Legal Date	Custody Status	Custody Date	Dispositional Status	Dispositional Date
Custodian Name					
Court Appointed Special Advocate Name					
Guardian Ad Litem					

Court Number	Adjudicated	Adjudication Date	Next Hearing Type	Next Hearing Date

EMERGENCY FAMILY

Is the child an SSI recipient?
Date of SSI Application
Is the child eligible for DDSD?
An application for DDSD Certification has been made
Date of DDSD Certificate Application

ADOPTION INFORMATION

Child Referred for Adoption Planning?

CLIENT MEDICAL AND PSYCHOLOGICAL INFORMATION

MEDICAL COVERAGE INFORMATION

Coverage/HMO Name	Coverage/HMO Phone #	Coverage Type	Policy ID

P.O. Box #	Rural Route	Rural Route #

Street #	Pre Direction	Street Name	Street Suffix	Post Direction	Unit Type	Unit #

City	State	Zip	County	Additional Address Head

Additional Comments

Policy Holder Name

Public Review Date	Spend Down Involved	Other Medical Coverage

MEDICAL INFORMATION

Medical History
Medical Conditions
Special Conditions
Allergies
Special Diets
Drug/Alcohol Problems

MEDICATIONS

Prescription Start Date	:
Medication Name	:
Dosage	:
Reason for prescription	:
Prescribing Physician Name	:
Prescribing Physician Number	:
Pharmacy Name	:
Pharmacy Phone Number	:

IMMUNIZATIONS

Type	Immunization Date	Due Date	Doctor/Clinic Name

PSYCHOLOGICAL FUNCTIONING

Psychological History
Diagnosis
Recommendation

PSYCHOLOGICAL EVALUATIONS

Full Scale IQ	Verbal	Performance	Functioning Level	Evaluation Date	Agency Name
Other Tests					
Reasons for Evaluation					
Outcome					
Recommendation					

PSYCHOLOGICAL TESTS

CIVIL COMMITMENT HEARING INFORMATION

Hearing Date	Review Date	Commitment End Date
Hearing Description	Hearing Findings	

TREATMENT/COURT INFORMATION

ASSESSMENT(S)
FAMILY

Plan Creation Date
Client Perception
Worker Perception
Social History
Participants Present/Location
Comments

Strengths

Underlying Causes	Details

ASSESSMENT(S)
CHILD

Plan Creation Date
Child Name

Strengths

Needs	Risk Exists	Need Details

Comments

INDEPENDENT LIVING INFORMATION

Client Name	:
Checklist Date	:
Client not Capable of Receiving IL Services	:
IL section in case record	:
CCC Referral	:
CCC Seminar Attendance	:
Completed Treatment Plan Addressing IL Services Received by Youth	:
Life Skills Assessment Completed	:
Life Skills Date	:
Plan Signed by Caregiver	:
Plan Signed by Worker	:
Plan Signed by Youth	:
Assessment Copy to Social Worker	:
Assessment Copy to Youth	:
IL is Stated Goal on Court Report	:
List of IL Services Provided that assist transition from Foster Care to IL	:
Judicial Finding of IL Services	:
Authorized Supervised Practiced Living	:
Youth Possesses Copy of Birth Certificate	:
Received Social Security Card	:
Youth Possesses Drivers License	:
Statewide Teen Conference	:

TERMINATION OF PARENTAL RIGHTS

Client Name			**Terminated Parental Name**		
Relationship	**Effective Date**	**Notice Type**	**Notice Date**	**Legal Code**	
Termination Appealed	**Appeal Date**	**Court Check**	**Check Date**	**Petition Date**	**Hearing Date**
Hearing Outcome					
Continuance Requested					
Continuance Reason					
Referred to Adoption Planning					

CHILD PLACEMENT HISTORY

PLACEMENT INFORMATION

Entry Date	Exit Date	Exit Reason

Placement Resource	Resource Name	Agency Name

Entry Date	Exit Date	Exit Reason	
Placement Resource		Resource Type	Agency name
Reasons for Recommendation			
Worker's Comments			
Anticipated Length of Placement			
Post Placement Planning			

ADMINISTRATIVE PLACEMENT OFFICER'S COMMENT

Title	Name	Recommendation