

**CHILDREN AND FAMILY SERVICES
CHILD'S NEEDS AND SERVICES PLAN FOR AGES BIRTH TO 19**

CNSP must be updated at least once every 6 months and with each placement change

[Email to HSA-Placement-Request@ventura.org](mailto:HSA-Placement-Request@ventura.org)

CHILD'S NEEDS AND SERVICE PLAN (CNSP)		
<input type="checkbox"/> Initial CNSP	<input type="checkbox"/> Modification	<input type="checkbox"/> 6-Month Update
<input type="checkbox"/> Initial placement	<input type="checkbox"/> Planned placement change	<input type="checkbox"/> Placement disruption
Anticipated date: _____		Date child must move: _____
Family Team Meeting (<i>Date, time, location</i>):		
Reason for placement change:		

CHILD INFORMATION	
Name:	Primary language:
Age:	Religious preference:
Date of Birth:	Medi-Cal #
Sex:	County that issued Medi-Cal #:
City of origin:	Indian Child Welfare Act apply?

IS THE ABOVE LISTED CHILD A PARENT?: <input type="checkbox"/> No (skip to next section) <input type="checkbox"/> Yes	
Child placed with dependent parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's name:
If no, child's placement:	Age:
Is the child a Court dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	DOB:
Separate CNSP completed for child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional information:	

SIBLINGS/HALF SIBLINGS (please list all minor and adult siblings)				
Name	Age/DOB	Court dependent?	If a minor, who do they reside with?	City of residence
is this child part of a sibling group to be placed together? <input type="checkbox"/> Yes, # of siblings____ <input type="checkbox"/> No				
If no, provide reason:				

PLACEMENT

Placement Type: _____

Date of placement: _____

 A Medi-Cal card is needed. This is a county foster home eligible for a SCI Rate (specialized care increment)?

If yes, please indicate which rate.

 Moderate Severe Intensive Enriched Tri-Counties dual agency rate Relative(s) are being assessed for potential placement. A Family Finding referral was completed.

Comments:

PLACEMENT HISTORY This is the child's first placement Child had previous placements # ____

Types of prior placements:

REASON FOR DETENTION General Neglect Severe Neglect Sexual Abuse Physical Abuse Other

What were the caregivers past actions or inactions that impacted the child?

*(Harm statement)***COURT**

Permanency goal:

Next court hearing date and time: _____

Type of hearing: _____

Child's attorney:

 Pending assignment. To be assigned at the Detention Hearing Child's attorney assigned: _____ Caregiver has been provided a copy of the Court order authorizing routine medical or dental care for the minor; and permitting the child to travel throughout the United States, provided there is prior permission from HSA. Caregiver has not received a Court order yet. The social worker will provide caregiver a copy of the most recent Court order when the Juvenile Court provides that order to the social worker.

VISITATION			
	Mother	Father	Other/Relationship
Name			
Telephone number			
Type of visit? Monitored/supervised by whom			
Frequency, duration, location			
Visitation with siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No.....Reason:			
Sibling visitation plan:			
Other important connections to the child that should be maintained? <i>(name, relationship, telephone #)</i>			
What is the caregiver's availability to transport child to visits? _____ <input type="checkbox"/> Transportation to visits to be provided by caregiver <input type="checkbox"/> Caregiver unable to transport to visits. Reason:			
What is the caregiver's phone number to be provided to the child's parents/family? _____ <i>(Welfare and Institution Code 308 requires that a caregiver identify a working number that can be provided to the child's birth family to make contact with the child. It is important to support the bonds between children and families.)</i>			
Any additional considerations surrounding visits or telephone contacts? <i>(including any safety considerations)</i>			

ALL ABOUT THE CHILD	
Hobbies, extracurricular activities	Considerations for supporting cultural and ethnic identity. <i>(Including LGBTQ considerations)</i>
Food likes/dislikes, sleep routines:	What helps soothe the child when upset?

Formal supports in place (<i>provider name and telephone #</i>) <input type="checkbox"/> CASA _____ <input type="checkbox"/> Speech therapy _____ <input type="checkbox"/> Independent Living Services _____ <input type="checkbox"/> Therapist _____ <input type="checkbox"/> Occupational therapy _____ <input type="checkbox"/> Therapeutic Behavioral Services (TBS) _____ <input type="checkbox"/> Physical therapy _____ <input type="checkbox"/> Probation _____ <input type="checkbox"/> Therapeutic Visitation Center _____ <input type="checkbox"/> Relational Assessment Program (RAP) _____ <input type="checkbox"/> Tri-Counties _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	
Foster Health Link discussed? <input type="checkbox"/> Yes http://fostervckids.org/fhl/ Life book provided and discussed <input type="checkbox"/> Yes <input type="checkbox"/> No Plan for recording and sharing milestones and updates with parents: _____	

NEWBORN INFORMATION (<i>If applicable</i>)	
Formula type: <input type="checkbox"/> Milk-based <input type="checkbox"/> Soy-based Breast fed: <input type="checkbox"/> Yes <input type="checkbox"/> No Formula brand: _____ Born drug exposed <input type="checkbox"/> Yes <input type="checkbox"/> No Drugs exposed to: _____	Birth hospital _____ Feeding problems <input type="checkbox"/> Yes <input type="checkbox"/> No Withdrawal symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____

MENTAL HEALTH SERVICES
Therapist/Psychiatrist name and contact information:
Date and time of next appointment _____
Current medication(s): Prescription needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Court authorization for psychotropic medication in place (JV220)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needed
Any confirmed diagnosis within the last year (date & provider):

TRAUMA AND PRESENTING BEHAVIOR		
Traumas the child has experienced (<i>separate from the reason for detention</i>)	Presenting behavior	Effective strategies to help the child cope (if known):
<input type="checkbox"/> Bullying <input type="checkbox"/> Commercially sexually exploited child	<input type="checkbox"/> Eating issues <input type="checkbox"/> Fire-setting <input type="checkbox"/> Physical harm	

<input type="checkbox"/> Deceased parent or other important person in their life <input type="checkbox"/> Medical trauma <input type="checkbox"/> Multiple placement changes <input type="checkbox"/> Reentry into foster care <input type="checkbox"/> 7-day notice <input type="checkbox"/> Separated siblings <input type="checkbox"/> Victim of sexual abuse <input type="checkbox"/> Victim of domestic violence <input type="checkbox"/> Other(s): _____	<input type="checkbox"/> Runs away <input type="checkbox"/> Self harm <input type="checkbox"/> Sexually related issues <input type="checkbox"/> Sleeping challenges <input type="checkbox"/> Substance use <input type="checkbox"/> Toileting issues <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	
<p>Narrative required for any presenting behavior(s) listed above:</p>		

EDUCATION		
Who is the educational rights holder?		
Child's school of origin: Child's grade level: Child to remain in their school of origin? <input type="checkbox"/> Yes <input type="checkbox"/> No. If not, why? _____ New school to attend: _____ Caregiver to provide transportation to school of origin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Travel reimbursement to be submitted for maintaining child in school of origin		
Additional school considerations		
<input type="checkbox"/> Honors/GATE <input type="checkbox"/> Perfect attendance <input type="checkbox"/> School clubs/activities <input type="checkbox"/> Sports	<input type="checkbox"/> Credit deficient <input type="checkbox"/> Expulsions <input type="checkbox"/> IEP-current <input type="checkbox"/> IEP-previously in place	<input type="checkbox"/> School counseling <input type="checkbox"/> Suspensions <input type="checkbox"/> Tutoring <input type="checkbox"/> Truancy
Comments:		
MEDICAL AND DENTAL		
Primary physician (<i>Name, contact information, date of last exam</i>)		
Dentist (<i>Name, contact, and date of last exam</i>)		

<input type="checkbox"/> Future scheduled appointments:
<input type="checkbox"/> Current medications: <input type="checkbox"/> Pharmacy: <input type="checkbox"/> Prescriptions needed: <input type="checkbox"/> Vaccines current
Medical conditions: <input type="checkbox"/> Allergies <input type="checkbox"/> California Children's Services (CCS) <input type="checkbox"/> Exposure to infections/contagious disease(s) within the last year <input type="checkbox"/> Lice <input type="checkbox"/> Public health nurse assigned <input type="checkbox"/> Recent hospitalizations <input type="checkbox"/> Special diet <input type="checkbox"/> Universal Precautions <input type="checkbox"/> Other: Additional Information:
Individual Health Care Plan (IHCP) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Needed Next steps:

I, the caregiver, have reviewed, understood, and agreed to support the child's plan.

Caregiver name and phone number: _____

CWSW Name: _____ **Phone:** _____ **E-Mail:** _____

CWSW supervisor's name, phone, email: _____

X _____

CWSW signature/Date

X _____

Caregiver signature/Date

X _____

Youth signature/Date

Caregiver Acknowledgements (Social worker to review, caregiver to initial)

1. _____ I have received and understand:
 - The Placement Agreement form (California Department of Social Services Manual of Policy and Procedures section 31-075).
 - **County of Ventura Children & Family Services 24 hour hotline phone number: (805) 654-3200** (CDSS MPP sec. 31-405).
 - Notice to Foster Caregiver Regarding CHDP Medical and Dental Examination Requirements (form 56-12-80). I understand that the initial examinations must be completed within 30 days of the child's placement in my home unless completed previously (CDSS MPP sec 31-075 & 31-405).
 - I have received a copy of the child's Life Book and discussed plans for recording and updating milestones with the birth parents (CDSS MPP sec 31-405).
 - I have received and will complete the child's Client/Resident Personal Property and Valuables list (LIC 621) at time of placement and when child changes placement, returns home, or emancipates.
 - I have received and acknowledge the Ventura County QPI Partnership Agreement.

2. _____ I have been informed of:
 - Any dangerous propensities and/or behavioral problems of the child per the foster/shelter/relative/group home care placement agreement (CDSS MPP sec. 31-075, 31-310 & 31-405).
 - The child's health history as known and any suspected medical problems. I understand the social worker is to provide the child's immunization records or make arrangements for provision of the immunization records (CDSS MPP sec31-405).
 - Child's family history that is relevant to providing care to the child. (CDSS MPP sec 31-405). Type and number of the child's previous placements and the reason for change in placement (CDSS MPP sec 31-405). The child's grade, educational status and current school, as age appropriate (CDSS MPP sec 31-405).
 - I have been informed of the expectation to provide travel arrangements for the child to their school of origin and may receive reimbursement for providing such transportation if eligible.

3. _____ I acknowledge that
 - Any facts regarding the child's known or suspected dangerous behavior(s) are confidential and that unauthorized disclosure could result in a \$1,000 fine (CDSS MPP sec 31-310 and 31-405).
 - The child will remain in their school of origin. I understand that the child will not change schools without prior consent from the social worker.
 - Youth 16 years and older will receive transitional independent living services as described in a Transitional Independent Living Plan (TILP) developed between the youth and the social worker. My input and assistance may be needed to help develop the plan.
 - It is the expectation that I assist with transporting the child to visits with family members, including siblings in other placements.
 - I will participate in Family Team Meetings (FTM) regarding the child. Childcare may be requested by caregivers for children in their home to support their participation in FTM's. The child has confidentiality rights that include having their private or personal information maintained in confidence (CDSS section 11-08, WIC 827)