Permanency Specialty

Williams Family Case File

TN Department of Children's Services| CHPS1005| Ver. 21.7

Williams Legal Referral

LEGAL REFERRAL

`CM/CPSI: Angelo Midgett
Approval TL: _____
Approval TC: _____
Approval Legal: _____
Date & Time Consulted Legal/Legal Approved: _____
Assigned TL: _____
Assigned TC: _____
Assigned Legal: _____

Action Requested:

□ Application for Investigation **□ Petition Responding to Bench Order**
□ Petition to Control Conduct **□ Temporary Restraining Order/Injunction**
□ IPA/Safety Plan/Custody to Relative **x Removal to DCS Custody**
□ Seek a Finding of Severe Abuse **□ Restore Custody to Parent/Unrestrict**
□ Other: _____

Name of Children:

1. Ariana Williams, DOB: 3/15
2. Jewel Williams, DOB: 7/19
3. Justin Williams, DOB: 8/11
4. _____, DOB: _____

Who currently has custody of the children (i.e., from whom are we removing custody) – Include Name, Address[1], Phone Number, and relationship to children if different from Parents' information below:

Renee Williams, 243 Blythe Avenue, Gallatin TN 37066

Mother(s) – Include Name, Address[1], and Phone Number. If unable to be located, please list efforts made in your diligent search:

Renee Williams, unknown

[1] Always include a zip code with the address.

LEGAL REFERRAL

Father of Child 1. – Include Name, Address[1], and Phone Number. If unable to be located, please list efforts made in your diligent search:

□ **Married to Mother** □ **On Birth Certificate**

□ **Alleged Biological Father** □ **Legitimated through Court**

Deceased

Father of Child 2. – Include Name, Address[1], and Phone Number. If unable to be located, please list efforts made in your diligent search:

□ **Married to Mother** □ **On Birth Certificate**

□ **Alleged Biological Father** □ **Legitimated through Court**

Russ Williams, incarcerated

Father of Child 3. – Include Name, Address[1], and Phone Number. If unable to be located, please list efforts made in your diligent search:

□ **Married to Mother** □ **On Birth Certificate**

□ **Alleged Biological Father** □ **Legitimated through Court**

Russ Williams, incarcerated

Father of Child 4. – Include Name, Address[1], and Phone Number. If unable to be located, please list efforts made in your diligent search:

□ **Married to Mother** □ **On Birth Certificate**

□ **Alleged Biological Father** □ **Legitimated through Court**

Alleged Perpetrator(s) – Include Name, Address[1], and Phone Number if different from Parents' information above:

LEGAL REFERRAL

Frank Smith, 243 Blythe Avenue, Gallatin, TN 37066
Renee Williams

Proposed Custodian(s) – Include Name, Address[1], and Phone Number if different from Parents' information above, as well as Relationship to Children:

Other witnesses – Include Name, Address[1], and Phone Number:

DCS History – Please include a brief summary of previous DCS involvement; include relevant information regarding prior reasonable efforts of the Department:
There is no known previous DCS involvement.

Court History – Please include a brief summary of any previous court involvement, including any active Court Orders and in which county they exist:
There is no known previous court involvement.

Current Allegations:

- □ **Physical Abuse**
- □ **Environmental Neglect**
- □ **Medical Neglect**
- **X Lack of Supervision**
- □ **Child Sexual Abuse**
- □ **Drug-Exposed Child**
- □ **Nutritional Neglect**
- □ **Educational Neglect**
- □ **Abandonment**
- □ **Psychological Harm**

LEGAL REFERRAL

□ **Child Death**

Facts of your investigation – Include only things that you have learned through your interviews, observations, etc. Do *not* include information just because it was in the referral unless it is followed with information of how it was proven/disproven:
CPSA Midgett responded to a referral at the home of Renee Williams. Ms. Williams was unable to be located. Ariana, Justin, and Jewel were in the care of Frank Smith, Ms. Williams' boyfriend. The children reported they are scared of Frank as reportedly has a bad temper. The children are without a known guardian.

Efforts to Prevent Court Action – Indicate any and all attempts to prevent removal, highlighting current efforts at finding Relative Placements, providing services, etc.:
Russ Williams, father of the youngest two children is currently incarcerated. No other relatives were able to be located at this time.

FPP – Include if we are asking the Respondents to complete certain tasks[2]:

□ **Mental Health Assessment/Counseling for** _____
□ **Alcohol and Drug Assessment/Counseling for** _____
□ **Random Drug Screens/Pill Counts for** _____
□ **Parenting Assessment for** _____
□ **Parenting Classes for** _____
□ **Anger Management Classes/Counseling for** _____
□ **Domestic Violence Offender Classes/Counseling for** _____
□ **Domestic Violence Non-offender Classes/Counseling for** _____
□ **Maintain Contact with CM for** _____
□ **Comply with DCS and Provider In-home Services for** _____
□ **Resolve Legal Issues/Refrain from New Charges for** _____
□ **Obtain/Maintain Transportation Plan for** _____

[2] **Do not include this section if the child is removed into DCS custody.**

LEGAL REFERRAL

□ **Obtain/Maintain Legal Source of income for** _____
□ **Obtain/Maintain Safe and Stable Housing for** _____
□ **Other:** _____
□ **Other:** _____

Visitation – Indicate what contact, if any, the Parents or other Respondents should have with the children. This cannot be left blank:
Mother: □ **No contact** □ **Supervised Contact** □ **Unrestricted**
Father: □ **No contact** □ **Supervised Contact** □ **Unrestricted**
Other _____**:** □ **No contact** □ **Supervised Contact**
□ **Additional details regarding visitation:**

_____

_____

Family Case ID (if established and linked): _____

Initial Intake Packet

Tennessee Department of Children's Services

Custody Intake Packet

Complete the information below so that the information populates to all the other forms in the packet. (The information in the forms will not be visible until you print initialy or look at print preview after all subsequent changes.)

Signature Dates	1/1
Childs First Name	Ariana
Childs Middle Name	
Childs Last Name	**Jones**
Childs Social	**111-11-1111**
Childs Date of Birth	**5/15**
Childs Age	**13**
Childs Gender	F
Childs Custody Date	**1/1**
Childs Race	W
Childs Person ID	
Childs Place of Birth	Nashville, TN
Case Supervisor	
Childs Assigned FSW	Sandra Littleton
Interviewer	Angelo Midgett
Childs School	Gallatin Middle School
School City/State	Gallatin, TN
Childs Grade Level	8
Childs Mental Health Diagnosis	None
Childs Physical Health Issues	None
Childs Medications	None
Childs Allergies	None
Childs Allergic Reactions	None
Childs Disabilities	None

Childs Past Mental Health Providers	None
Childs Current Mental Health Provider	N/A
Childs Health Insurance	Unknown
Childs Language	English
Committing County	
Childs Adjudication	
DCS County Office Phone	
DCS Office Address	
DCS Office City State Zip	
DCS Region	
Mothers First Name	Renee
Mothers Middle Name	
Mothers Last Name	Williams
Mothers Street Address	243 Blythe Avenue
Mothers City	Gallatin
Mothers State	TN
Mothers Zip Code	37066
Mothers Social	111-11-1111
Mothers Employer	
Employers Street Address	
Mothers Employers City	
Mothers Employers State	
Mothers Employers Zip	
Mothers Phone	615-555-1567
Mothers DOB	3/15
Mothers Maiden Name	
Fathers First Name	Timmy
Fathers Middle Name	
Fathers Last Name	Jones
Fathers Street address	Deceased

Fathers City

Fathers State

Fathers Zip Code

Fathers Social

Fathers Phone

Fathers DOB

Fathers Employer

Fathers Employer Address

Fathers Employer City

Fathers Employer State

Fathers Employer Zip

Custodian #1s Information if not the parent or the Parent themselves (PRIMARY CUSTODIAN)

Custodians First Name

Custodians Middle Name

Custodians Last Name

Relationship to the foster child

Custodians Removal Street Address

Custodians City

Custodians State

Custodians Zip

Custodians Social

Custodians Birth Date

Custodians Birth Place

Custodians Phone

Custodian #2s information if not the parent (SECONDARY CUSTODIAN)

Custodians First Name

Custodians Middle Name

Custodians Last Name

Custodians Street Address

Custodians City

Custodians State

Custodians Zip

Custodians Social

Custodians Birth Date

Custodians Birth Place

Custodians Phone

_____

1st Sibling In The Home

Sibling 1 First Name **Justin**

Sibling 1 Middle Name

Sibling 1 Last Name **Williams**

Sibling 1 Birth Date **8/11**

Sibling 1 Birth Place **Nashville, TN**

Sibling 1 Social **111-11-1111**

_____

2nd Sibling in the Home

Sibling 2 First Name **Jewel**

Sibling 2 Middle Name

Sibling 2 Last Name **Williams**

Sibling 2 Birth Date **7/19**

Sibling 2 Birth Place **Nashville, TN**

Sibling 2 Social **111-11-1111**

_____

3rd Sibling in the Home

Sibling 3 First Name

Sibling 3 Middle Name

Sibling 3 Last Name

Sibling 3 Birth Date

Sibling 3 Birth Place

Sibling 3 Social

_____

4th Sibling in the Home

Sibling 4 First Name

Sibling 4 Middle Name

Sibling 4 Last Name

Sibling 4 Birth Date

Sibling 4 Birth Place

Sibling 4 Social

Tennessee Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name:	Ariana Jones	Child DOB:	5/15	Person ID:	

Initiated By: Angelo Midgett Title: CPS Date: 1/1

Revised By: Title: Date:

Person Providing Information to DCS: Ariana Jones Relationship to Child/Youth: Self

Current insurance coverage ☐ Yes ☐ No ☒ Unknown **If yes, provide details:** Unknown

Child/Youth Information

Name of Child/Youth:	Ariana Jones	E-mail Address:		SSN:	111-11-1111

DOB:	5/15	Sex:	F	Race:	White/Cauca	Hispanic:	☐ Yes ☒ No	U.S. Citizen:	☒ Yes ☐ No Provide Birth Certificate Verification

Is Child/Youth of Native American Descent?	☐ Yes ☒ No ☐ Unable to Determine	If "Yes" Tribal Affiliation	

Child/Youth's Marital Status *(check one)* ☒ Never Married ☐ Divorced ☐ Widowed ☐ Married ☐ Separated

Has Youth been placed in out of home care prior to this custody episode? If yes please list dates and placements: ☐ Yes ☒ No

Current Description of the Child/Youth

Physical Description Date	January 1	Primary Language Spoken	English

Height	5'4	Weight	100	Hair Color	Blonde	Eye Color	Brown

Religion:	Baptist	Identifying Marks or Tattoos:	None

Special Needs/Disabilities:	None
Special Medical Equipment:	None
Scheduled Appointments: (*date, provider, location, type of appt*)	Unknown

Allergies: ☐ Yes ☒ No

Allergic to:	Medication:		Describe reaction:	
	Food:		Describe reaction:	
	Insect Sting:		Describe reaction:	
	Other:		Describe reaction:	

Medical modified/Religious diet?	☐ Yes ☒ No	If yes, describe	

Medications: Prescribed and Over the Counter

Current medications (*name, route, frequency, dosage & days of meds left)*	None

Child Name:	Ariana Jones	Child DOB:	5/15	Person ID:	

Are meds given in school?	☐ Yes ☒ No	**Which meds?**	
Consent signed for psychotropic meds:	☐ Yes ☐ No ☒ N/A	**Next med appointment:**	
Has Foster Parent received medication:	☐ Yes ☒ No	**Explain:**	

Health History of Child Explain any items checked Now/Past in "COMMENTS" section

No	Now	Past		No	Now	Past	
☒	☐	☐	Birth defects	☒	☐	☐	Gastrointestinal problems
☒	☐	☐	Vision problems	☒	☐	☐	Kidney/urinary problems
☒	☐	☐	Hearing problems	☒	☐	☐	Hepatitis/liver problems
☒	☐	☐	Skin problems	☒	☐	☐	Cancer
☒	☐	☐	Head injuries	☒	☐	☐	Tuberculosis (TB)
☒	☐	☐	Headaches	☒	☐	☐	Autism/Asperger's (circle one)
☒	☐	☐	Sickle cell disease	☒	☐	☐	Developmental delays
☒	☐	☐	Anemia/blood disorder	☒	☐	☐	Learning disability
☒	☐	☐	Epilepsy/seizures	☒	☐	☐	Sleep problems
☒	☐	☐	Bedwetting	☒	☐	☐	Incontinence: ☐ Urine ☐ Stool
☒	☐	☐	Diabetes	☒	☐	☐	Other medical *(describe below)*
☒	☐	☐	Asthma/Respiratory Disease	☒	☐	☐	Accidents *(describe below)*
☒	☐	☐	Heart murmur	☒	☐	☐	Hospitalizations *(describe below)*
☒	☐	☐	Heart problems	☒	☐	☐	Surgeries *(describe below)*
☒	☐	☐	High blood pressure	☒	☐	☐	Problems with anesthesia
☒	☐	☐	Physical disabilities	☒	☐	☐	Other developmental disabilities

Child/Youth is currently hospitalized:	☐ Yes ☒ No	**If yes, where and why:**	

Comments/Additional health information/ongoing health related services:	None

Childhood Illnesses

No	Yes	Approx date		No	Yes	Approx date	
☒	☐		Measles	☒	☐		Chicken pox
☒	☐		German measles	☒	☐		Scarlet fever
☒	☐		Mumps	☒	☐		Rheumatic fever

Trauma Screening

Indicate *known* history of abuse/adverse experiences. Explain any yes answers in "COMMENTS" section

No	Yes		No	Yes	
☐	☒	Neglect	☐	☒	Domestic violence
☒	☐	Physical assault/abuse	☒	☐	School violence
☒	☐	Sexual assault/abuse	☒	☐	Community violence
☒	☐	Emotional abuse	☒	☐	Extreme interpersonal violence
☒	☐	Traumatic loss/separation	☒	☐	Natural disaster
☒	☐	Extended illness/medical trauma	☒	☐	Impaired caregiver (substance abuse/mental illness)
☒	☐	Serious injury	☐	☐	Other trauma, describe:

Child Name:	Ariana Jones Ariana Jones	Child DOB:	5/15	Person ID:	

Has abuse been reported? ☒ Yes ☐ No ***If no, call CPS 877-237-0026***

Comments/Additional health information:	Ms. Williams reports she was in an abusive relationship in the past. She stated she left the relationship and took Ariana to a shelter. The children were also left alone with Frank when Ms. Williams was arrested for possession of marijuana and cocaine. The children report they are afraid of him due to his drug use and temper.

Behavioral/Mental Health History

No	Now	Past	
☒	☐	☐	Intense anger, if yes, describe
☒	☐	☐	Oppositional, if yes, describe
☒	☐	☐	Negative Peer Association, if yes, describe
☒	☐	☐	Extreme Attention Seeking, if yes, describe
☒	☐	☐	Makes False Statements, if yes, describe
☐	☒	☐	School Difficulties, if yes, describe Ariana is truant from school
☒	☐	☐	Damage of Property, if yes, describe
☒	☐	☐	Habitual Lying, if yes, describe
☒	☐	☐	Stool Smearing, if yes, describe
☒	☐	☐	Stealing, if yes, describe
☒	☐	☐	Runaway, if yes, describe
☒	☐	☐	Hoarding, if yes, describe
☒	☐	☐	Problems with concentration and attention,if yes, describe
☒	☐	☐	Excessive Hyperactivity/does not respond to safety instructions, if yes, describe
☒	☐	☐	Requires Constant Supervision, if yes describe
☒	☐	☐	Anxiety, if yes, describe
☒	☐	☐	Depression, if yes, describe
☒	☐	☐	Seeing or hearing things that aren't there, if yes, describe
☒	☐	☐	Fire-setting, if yes, describe
☒	☐	☐	Animal cruelty, if yes, describe
☒	☐	☐	Animal fear, if yes, describe
☒	☐	☐	Self-injurious behavior/Other Self Harm, if yes, describe
☒	☐	☐	Aggressive, dangerous or destructive behaviors, if yes, describe
☒	☐	☐	Sexual aggression, if yes, describe
☒	☐	☐	Had homicidal thoughts, if yes, describe
☒	☐	☐	Had suicidal thoughts, if yes, describe
☒	☐	☐	Attempted suicide If yes, describe
☒	☐	☐	Had other mental health or behavioral problems, if yes, describe
☒	☐	☐	Other mental health diagnosis, if yes, describe

Has the Child/Youth received counseling or therapy?	☐ Yes ☒ No
If yes, where?	
Has the Child/Youth had a Psychological Evaluation:	☐ Yes ☒ No
If yes, diagnosis, when, where?	
Has the Child/Youth been hospitalized for mental health problems/acute hospitalization?	☐ Yes ☒ No
If yes, diagnosis, when, where?	
Has the Child/Youth/Family received in-home services?	☐ Yes ☒ No

If yes, when, where?					
Has the Child/Youth previously been placed in a residential treatment facility?	☐ Yes ☒ No				
Child Name:	**Ariana Jones**	**Child DOB:**	**5/15**	**Person ID:**	

If yes, when, where?

Alcohol/Drug Abuse History

No	Now	Past	Frequency	(Xs per day/week/month)
☒	☐	☐		Alcohol
☒	☐	☐		Tobacco smoke/chew *(circle one or both)*
☒	☐	☐		E-cigarettes/vapor cigarettes
☒	☐	☐		Marijuana
☒	☐	☐		Narcotics
☒	☐	☐		Stimulants
☒	☐	☐		Methamphetamine
☒	☐	☐		Hallucinogens
☒	☐	☐		Steroids
☒	☐	☐		Huffing
☒	☐	☐		Ecstasy
☒	☐	☐		Street drugs, unknown
☒	☐	☐		Prescription drugs prescribed for another, specify:
☒	☐	☐		Over-the-counter medication, specify:
☒	☐	☐		Other, specify:

Has child been identified as high risk?	☐ Yes ☒ No
Has a Safety Plan been completed on child identified as high risk?	☐ Yes ☒ No ☐ N/A

Birth History (for all children)

Birth Weight:	6 lbs	**Birth Length:**	18"	☒ **Full term or** ☐ **Premature birth (<36 weeks)**	40	weeks

Did mother receive prenatal care:	☒ Yes ☐ No	**Month of pregnancy for 1st prenatal visit:**	3
Pregnancy/Birth complications:	Unknown		
Was there prenatal substance abuse:	☐ Yes ☒ No	**Substance and frequency:**	
Birth hospital and location:	Nashville, TN		

Minor Female

Age of 1st Period:	N/A	**Date of Last Period:**					
Pregnancies #		**Live births #**		**Full term**		**Premature (# weeks)**	
Miscarriages #		**Abortions #**		**Currently pregnant:**	☐ Yes ☐ No	**If yes, due date:**	

Gender and Sexual Identity

Does the Child/Youth identify him/herself as gay, lesbian, transgender, or intersex?	☐ Yes ☒ No
If yes, describe answer	

Sexual Activity

Is child sexually active?	☐ Yes ☒ No	**Use birth control?**	☐ Yes ☒ No	**Method:**	

Dating Violence					
Has Child/Youth experienced controlling, abusive or aggressive behavior in a dating relationship?	☐ Yes ☒ No				
If yes, explain:					
Child Name:	**Ariana Jones**	**Child DOB:**	**5/15**	**Person ID:**	

Medical			
Does the Child/Youth have a regular medical provider (pediatrician, family doctor, etc.)?	☒ Yes ☐ No		
If yes, name of medical provider:	Dr. Saywer	**Date of last visit:**	About 1 year ago

Immunizations			
Are immunizations up-to-date?	☒ Yes ☐ No	**Is the immunization record available?**	☐ Yes ☐ No
Religious/medical exemption?	☐ Yes ☒ No (parent/guardian must provide a notarized statement)		

Dental			
Does the Child/Youth have a regular dental provider?	☐ Yes ☒ No	**Does the Child/Youth wear braces?**	☐ Yes ☐ No
If yes, name of dental provider:		**Date of last exam:**	
If braces, name of orthodontist:		**Date of last exam:**	

Vision			
Does the Child/Youth wear glasses?	☐ Yes ☒ No	**Does the Child/Youth wear contacts?**	☐ Yes ☒ No
If yes, name of vision provider:		**Date of last visit:**	

This concludes the Well-Being Section

Child Name:	Ariana Jones	Child DOB:	5/15	Person ID:	

This information does not go to Health Care Provider

Education and Independent Living

Student graduated high school?	☐ Yes ☒ No ☐ GED ☐ HISET ☐ Student Home Schooled				
What school does the student attend? (name, city, county)	Gallatin Middle School Gallatin, TN				
Student's age	13	**Current grade**	8	**Student receives special education services?**	☐ **Yes** ☒ **No**
If yes, name the disability	None				

No	Yes	
☒	☐	Is the student taking GED classes
☒	☐	Does the student have a history of skipping school?
☒	☐	Is the student in an alternative school?
☒	☐	Is the student serving a zero tolerance expulsion (drugs, weapons and/or assault)?
☒	☐	Is the student serving a suspension for issues other than zero tolerance? If yes, what is the reason and duration of suspension?

Student strengths (check all that apply)	**Areas needing improvement (check all that apply)**
☐ Mathematics	☐ Mathematics
☐ Reading	☐ Reading
☐ Athletics	☐ Athletics
☐ Attendance in school	☒ Attendance in school
☐ Other, specify	☐ Other, specify

Other things you would like to share regarding your student's schooling?	

Presenting and Previous Court Actions on Youth (Unruly/Delinquent Youth only)

Current Dispositional Information			
Disposition Judge		**Special Judge**	
Current Disposition Court			
Current Disposition Decision		**Disposition Date**	
Have you been or are you currently on probation?	☐ Yes ☐ No	**If yes, where**	
Defense Attorney	N/A		
Current Adjudication Type		**Current Adjudication Date**	

Adjudicated Charge – Current and Previous	**Date Occurred**	**Disposition Date**	**Disposition**

Pending Charges	**Court Date Set**	**Date (if yes)**
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Violation of Probation (VOP) or Violation of Valid Court Order (VVCO) ***(explain if applicable)***

Child Name:	Ariana Jones	Child DOB:	5/15	Person ID:	

Narrative	

Legal/Probation Services Previously Offered to Child/Youth

Date	Type	Outcome

Safety (Unruly/Delinquent Youth only)

A) Maltreatment Allegations or Unruly Behaviors/Delinquency

Other *(explain)*	
Narrative	
Strengths *(Signs of Safety)*	
Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*	

B) Domestic Violence

Narrative	
Strengths *(Signs of Safety)*	
Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*	

FSW Name	Sandra Littleton	Contact #	
Office Address			
Supervisor		Contact #	

DCS / Provider Staff *Date*

I acknowledge receipt of the Intake, Placement, and Well-Being Information and History. I further acknowledge my legal duty to maintain confidentiality of this information and history and any additional information I may receive pursuant to Tennessee Code Annotated §37-2-415, The Foster Parent Rights Act.

Foster Parent *Date*

Foster Parent *Date*

Child Name:	Ariana Jones	Child DOB:	5/15	Person ID:	

Do not provide this section to the Foster Parent or the Health Care Provider

Has the child/Youth been adopted: ☐ Yes ☒ No: **Was the child/Youth in Permanent Guardianship:** ☐ Yes ☒ No
Receiving Adoption Assistance or Subsidized Permanent Guardianship: ☐ Yes ☒ No: If yes, **Amount:** ____
(If yes, immediately notify the Permanency Specialist, Child Welfare Benefits Counselor Regional and Central Office Fiscal Staff).

Adoption/Guardianship Completed by DCS: ☐ Yes ☒ No (If no List Name of the Agency)

Removal Date:	1/1	New Placement:	Nancy & Dan	Date of Placement:	1/1	Legal Custody Date:	1/1
Removal County:	Sumner	Adjudication Type: Brief Description:	☒ Dependent and Neglect ☐ Unruly ☐ Delinquent ☐ N/A Mother was incarcerated and the children were afraid of caregiver.				
Removal Reason:	☐ Alcohol Abuse (Child); ☐ Alcohol Abuse (Parent); ☐ Caretaker Inability to Cope due to Illness or Other: ☐ Child's Disability; ☐ Drug Abuse (Child); ☐ Drug Abuse (Parent); ☐ Inadequate Housing; ☒ Incarceration of Parents; ☐ NAS Prosecution (only select upon DCS attorney instruction); ☐ Physical Abuse (alleged/reported); ☐ Relinquishment; ☐ Sexual Abuse (alleged/reported); ☐ Truancy						

Removal Street Address	243 Blythe Ave						
City	Gallatin	County	Sumner	State	TN	Zip Code	37066
Kinship Exception Request							
Was KER approved?	☒ Yes ☐ No	If yes, by whom?	Sally Dykes				
Was the KER temporary or long term?	☒ temporary ☐ long term						
MSW Consult was completed with:	Melody Farmer						

Family Information

Both parents living?	☐ Yes ☒ No	If no, date(s) of death:	Unknown
Household income to determine IV-E eligibility: (including SS Benefits, SSI for child, AFDC, Foodstamps, Child Support, etc.) If additional supports are received, please indicate in whose name the payment/support is made.	Unknown		

Child/Youth Parent(s)/Caretaker(s)
Indicate Parent/Caregiver's Preferred Method for Receiving Documents

Birth Mother's Name	Renee Williams					Primary Caregiver	☒ Yes ☐ No
Email Address						☐ Yes ☐ No	
Maiden Name		Social Security No.	111-11-1111	DOB	3/15	Message Contact #	
Address	243 Blythe Ave					☐ Yes ☐ No	
City, State, Zip	Gallatin, TN 37066					Contact #	615-555-1567
Employer	N/A			Address			
City, State, Zip						Contact #	

Birth mother married when child/Youth was born?	☐ Yes ☐ No ☒ Unable to Determine		
Birth mother ever been married?	☒ Yes ☐ No ☐ Unable to Determine	**If so, where and to whom?**	Russ Williams
Birth mother ever been divorced?	☐ Yes ☐ No ☒ Unable to Determine	**If so, where and from whom?**	
Birth mother's race:	White/Caucasian		

Legal Father's Name	Timmy Jones			**Primary Caregiver**	☐ Yes ☒ No
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address	Deceased			☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	
Legal Father's Race:					
Marital Status of Parents	☐ **Married** ☐ **Separated** ☐ **Divorced** ☒ **Other**				
Putative/Alleged Father's Name	N/A				
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address				☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	
Putative/Alleged Father's Race:					
Caregiver's Name *(if different from above)*				**Relationship**	
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address				☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	

Relative Contact Person For Child/Youth (other than parent)

		Contact #	
Relationship			

Child Name:	Ariana Jones	Child DOB:	5/15	Person ID:	

Child/Youth Siblings:										In Custody
Name	Jewel Williams	SSN	111-11-1111	DOB	7/19	Sex	F	Race	Bi	☒ Yes ☐ No
Name	Justin Williams	SSN	111-11-1111	DOB	8/11	Sex	M	Race	Bi	☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No

Child Name:	Ariana Jones	Child DOB:	5/15	Person ID:	

Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No

Tennessee Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Initiated By: Angelo Midgett Title: CPS Date: 1/1

Revised By: Title: Date:

Person Providing Information to DCS: Ariana Jones Relationship to Child/Youth: Sister

Current insurance coverage ☐ Yes ☐ No ☒ Unknown **If yes, provide details:** Unknown

Child/Youth Information

Name of Child/Youth:	Jewel Williams			**E-mail Address:**				**SSN:**	111-11-1111		
DOB:	7/19	**Sex:**	F	**Race:**	White/Cauca	**Hispanic:**	☐ Yes ☒ No	**U.S. Citizen:**	☒ Yes ☐ No Provide Birth Certificate Verification		
Is Child/Youth of Native American Descent?	☐ Yes ☒ No ☐ Unable to Determine					**If "Yes" Tribal Affiliation**					
Child/Youth's Marital Status *(check one)*	☒ Never Married ☐ Divorced ☐ Widowed ☐ Married ☐ Separated										
Has Youth been placed in out of home care prior to this custody episode? If yes please list dates and placements:							☐ Yes ☒ No				

Current Description of the Child/Youth

Physical Description Date	January 1			**Primary Language Spoken**	English		
Height	3'2	**Weight**	48	**Hair Color**	Brown	**Eye Color**	Brown
Religion:	Baptist			**Identifying Marks or Tattoos:**	None		

Special Needs/Disabilities:	None			
Special Medical Equipment:	None			
Scheduled Appointments: (*date, provider, location, type of appt*)	Unknown			
Allergies:	☒ Yes ☐ No			
Allergic to:	**Medication:**		**Describe reaction:**	
	Food:		**Describe reaction:**	
	Insect Sting:		**Describe reaction:**	
	Other:	seasonal allergies	**Describe reaction:**	sneezing, coughing, runny nose
Medical modified/Religious diet?	☐ Yes ☒ No	**If yes, describe**		

Medications: Prescribed and Over the Counter

Current medications (*name, route, frequency, dosage & days of meds left)*	None

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Are meds given in school?	☐ Yes ☒ No	**Which meds?**	
Consent signed for psychotropic meds:	☐ Yes ☐ No ☒ N/A	**Next med appointment:**	
Has Foster Parent received medication:	☐ Yes ☒ No	**Explain:**	

Health History of Child Explain any items checked Now/Past in "COMMENTS" section

No	Now	Past		No	Now	Past	
☒	☐	☐	Birth defects	☒	☐	☐	Gastrointestinal problems
☒	☐	☐	Vision problems	☒	☐	☐	Kidney/urinary problems
☒	☐	☐	Hearing problems	☒	☐	☐	Hepatitis/liver problems
☒	☐	☐	Skin problems	☒	☐	☐	Cancer
☒	☐	☐	Head injuries	☒	☐	☐	Tuberculosis (TB)
☒	☐	☐	Headaches	☒	☐	☐	Autism/Asperger's (circle one)
☒	☐	☐	Sickle cell disease	☒	☐	☐	Developmental delays
☒	☐	☐	Anemia/blood disorder	☒	☐	☐	Learning disability
☒	☐	☐	Epilepsy/seizures	☒	☐	☐	Sleep problems
☒	☐	☐	Bedwetting	☒	☐	☐	Incontinence: ☐ Urine ☐ Stool
☒	☐	☐	Diabetes	☒	☐	☐	Other medical *(describe below)*
☒	☐	☐	Asthma/Respiratory Disease	☒	☐	☐	Accidents *(describe below)*
☒	☐	☐	Heart murmur	☒	☐	☐	Hospitalizations *(describe below)*
☒	☐	☐	Heart problems	☒	☐	☐	Surgeries *(describe below)*
☒	☐	☐	High blood pressure	☒	☐	☐	Problems with anesthesia
☒	☐	☐	Physical disabilities	☒	☐	☐	Other developmental disabilities

Child/Youth is currently hospitalized:	☐ Yes ☒ No	**If yes, where and why:**	

Comments/Additional health information/ongoing health related services:	None

Childhood Illnesses

No	Yes	Approx date		No	Yes	Approx date	
☒	☐		Measles	☒	☐		Chicken pox
☒	☐		German measles	☒	☐		Scarlet fever
☒	☐		Mumps	☒	☐		Rheumatic fever

Trauma Screening

Indicate *known* history of abuse/adverse experiences. Explain any yes answers in "COMMENTS" section

No	Yes		No	Yes	
☒	☐	Neglect	☒	☐	Domestic violence
☒	☐	Physical assault/abuse	☒	☐	School violence
☒	☐	Sexual assault/abuse	☒	☐	Community violence
☒	☐	Emotional abuse	☒	☐	Extreme interpersonal violence
☒	☐	Traumatic loss/separation	☒	☐	Natural disaster
☒	☐	Extended illness/medical trauma	☒	☐	Impaired caregiver (substance abuse/mental illness)
☒	☐	Serious injury	☐	☐	Other trauma, describe:

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Has abuse been reported? ☐ Yes ☒ No ***If no, call CPS 877-237-0026***

Comments/Additional health information:	

Behavioral/Mental Health History

No	Now	Past	
☒	☐	☐	Intense anger, if yes, describe
☒	☐	☐	Oppositional, if yes, describe
☒	☐	☐	Negative Peer Association, if yes, describe
☒	☐	☐	Extreme Attention Seeking, if yes, describe
☒	☐	☐	Makes False Statements, if yes, describe
☒	☐	☐	School Difficulties, if yes, describe
☒	☐	☐	Damage of Property, if yes, describe
☒	☐	☐	Habitual Lying, if yes, describe
☒	☐	☐	Stool Smearing, if yes, describe
☒	☐	☐	Stealing, if yes, describe
☒	☐	☐	Runaway, if yes, describe
☒	☐	☐	Hoarding, if yes, describe
☒	☐	☐	Problems with concentration and attention,if yes, describe
☒	☐	☐	Excessive Hyperactivity/does not respond to safety instructions, if yes, describe
☒	☐	☐	Requires Constant Supervision, if yes describe
☒	☐	☐	Anxiety, if yes, describe
☒	☐	☐	Depression, if yes, describe
☒	☐	☐	Seeing or hearing things that aren't there, if yes, describe
☒	☐	☐	Fire-setting, if yes, describe
☒	☐	☐	Animal cruelty, if yes, describe
☒	☐	☐	Animal fear, if yes, describe
☒	☐	☐	Self-injurious behavior/Other Self Harm, if yes, describe
☒	☐	☐	Aggressive, dangerous or destructive behaviors, if yes, describe
☒	☐	☐	Sexual aggression, if yes, describe
☒	☐	☐	Had homicidal thoughts, if yes, describe
☒	☐	☐	Had suicidal thoughts, if yes, describe
☒	☐	☐	Attempted suicide If yes, describe
☒	☐	☐	Had other mental health or behavioral problems, if yes, describe
☒	☐	☐	Other mental health diagnosis, if yes, describe

Has the Child/Youth received counseling or therapy?	☐ Yes ☒ No
If yes, where?	
Has the Child/Youth had a Psychological Evaluation:	☐ Yes ☒ No
If yes, diagnosis, when, where?	
Has the Child/Youth been hospitalized for mental health problems/acute hospitalization?	☐ Yes ☒ No
If yes, diagnosis, when, where?	
Has the Child/Youth/Family received in-home services?	☐ Yes ☒ No
If yes, when, where?	
Has the Child/Youth previously been placed in a residential treatment facility?	☐ Yes ☒ No

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

If yes, when, where?

Alcohol/Drug Abuse History

No	Now	Past	Frequency	(Xs per day/week/month)
☒	☐	☐		Alcohol
☒	☐	☐		Tobacco smoke/chew *(circle one or both)*
☒	☐	☐		E-cigarettes/vapor cigarettes
☒	☐	☐		Marijuana
☒	☐	☐		Narcotics
☒	☐	☐		Stimulants
☒	☐	☐		Methamphetamine
☒	☐	☐		Hallucinogens
☒	☐	☐		Steroids
☒	☐	☐		Huffing
☒	☐	☐		Ecstasy
☒	☐	☐		Street drugs, unknown
☒	☐	☐		Prescription drugs prescribed for another, specify:
☒	☐	☐		Over-the-counter medication, specify:
☒	☐	☐		Other, specify:

Has child been identified as high risk?	☐ Yes ☒ No
Has a Safety Plan been completed on child identified as high risk?	☐ Yes ☒ No ☐ N/A

Birth History (for all children)

Birth Weight:	Unknown	**Birth Length:**		☒ **Full term or** ☐ **Premature birth (<36 weeks)**		weeks
Did mother receive prenatal care:	☐ Yes ☐ No	**Month of pregnancy for 1st prenatal visit:**				
Pregnancy/Birth complications:	Unknown					
Was there prenatal substance abuse:	☐ Yes ☐ No	**Substance and frequency:**				
Birth hospital and location:						

Minor Female

Age of 1st Period:	N/A	**Date of Last Period:**					
Pregnancies #		**Live births #**		**Full term**		**Premature (# weeks)**	
Miscarriages #		**Abortions #**		**Currently pregnant:**	☐ Yes ☐ No	**If yes, due date:**	

Gender and Sexual Identity

Does the Child/Youth identify him/herself as gay, lesbian, transgender, or intersex?	☐ Yes ☒ No
If yes, describe answer	

Sexual Activity

Is child sexually active?	☐ Yes ☒ No	**Use birth control?**	☐ Yes ☒ No	**Method:**	

Dating Violence

Has Child/Youth experienced controlling, abusive or aggressive behavior in a dating relationship?	☐ Yes ☒ No
If yes, explain:	

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Medical

Does the Child/Youth have a regular medical provider (pediatrician, family doctor, etc.)?	☒ Yes ☐ No		
If yes, name of medical provider:	Dr. Saywer	**Date of last visit:**	About 1 year ago

Immunizations

Are immunizations up-to-date?	☒ Yes ☐ No	Is the immunization record available?	☐ Yes ☐ No
Religious/medical exemption?	☐ Yes ☒ No (parent/guardian must provide a notarized statement)		

Dental

Does the Child/Youth have a regular dental provider?	☐ Yes ☒ No	Does the Child/Youth wear braces?	☐ Yes ☐ No
If yes, name of dental provider:		**Date of last exam:**	
If braces, name of orthodontist:		**Date of last exam:**	

Vision

Does the Child/Youth wear glasses?	☐ Yes ☒ No	Does the Child/Youth wear contacts?	☐ Yes ☒ No
If yes, name of vision provider:		**Date of last visit:**	

This concludes the Well-Being Section

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

This information does not go to Health Care Provider

Education and Independent Living

Student graduated high school?	☐ Yes ☒ No ☐ GED ☐ HISET ☐ Student Home Schooled				
What school does the student attend? (name, city, county)					
Student's age		**Current grade**		**Student receives special education services?** ☐ **Yes** ☐ **No**	
If yes, name the disability	None				

No	Yes	
☐	☐	Is the student taking GED classes
☐	☐	Does the student have a history of skipping school?
☐	☐	Is the student in an alternative school?
☐	☐	Is the student serving a zero tolerance expulsion (drugs, weapons and/or assault)?
☐	☐	Is the student serving a suspension for issues other than zero tolerance? If yes, what is the reason and duration of suspension?

Student strengths (check all that apply)	**Areas needing improvement (check all that apply)**
☐ Mathematics	☐ Mathematics
☐ Reading	☐ Reading
☐ Athletics	☐ Athletics
☐ Attendance in school	☐ Attendance in school
☐ Other, specify	☐ Other, specify

Other things you would like to share regarding your student's schooling?	

Presenting and Previous Court Actions on Youth (Unruly/Delinquent Youth only)

Current Dispositional Information			
Disposition Judge		**Special Judge**	
Current Disposition Court			
Current Disposition Decision		**Disposition Date**	
Have you been or are you currently on probation?	☐ Yes ☐ No	**If yes, where**	
Defense Attorney	N/A		
Current Adjudication Type		**Current Adjudication Date**	

Adjudicated Charge – Current and Previous	**Date Occurred**	**Disposition Date**	**Disposition**

Pending Charges	**Court Date Set**	**Date (if yes)**
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Violation of Probation (VOP) or Violation of Valid Court Order (VVCO) ***(explain if applicable)***

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Narrative	

Legal/Probation Services Previously Offered to Child/Youth

Date	Type	Outcome

Safety (Unruly/Delinquent Youth only)

A) Maltreatment Allegations or Unruly Behaviors/Delinquency

Other *(explain)*	
Narrative	
Strengths ***(Signs of Safety)***	
Risks, Needs and Concerns ***(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)***	

B) Domestic Violence

Narrative	
Strengths ***(Signs of Safety)***	
Risks, Needs and Concerns ***(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)***	

FSW Name	Sandra Littleton	Contact #	
Office Address			
Supervisor		Contact #	

DCS / Provider Staff *Date*

I acknowledge receipt of the Intake, Placement, and Well-Being Information and History. I further acknowledge my legal duty to maintain confidentiality of this information and history and any additional information I may receive pursuant to Tennessee Code Annotated §37-2-415, The Foster Parent Rights Act.

Foster Parent *Date*

Foster Parent *Date*

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Do not provide this section to the Foster Parent or the Health Care Provider

Has the child/Youth been adopted: ☐ Yes ☒ No: **Was the child/Youth in Permanent Guardianship:** ☐ Yes ☒ No
Receiving Adoption Assistance or Subsidized Permanent Guardianship: ☐ Yes ☒ No: If yes, **Amount:** ____
(If yes, immediately notify the Permanency Specialist, Child Welfare Benefits Counselor Regional and Central Office Fiscal Staff).

Adoption/Guardianship Completed by DCS: ☐ Yes ☒ No (If no List Name of the Agency)

Removal Date:	1/1	New Placement:	Nancy & Dan	Date of Placement:	1/1	Legal Custody Date:	1/1
Removal County:	Sumner	Adjudication Type: Brief Description:	☒ Dependent and Neglect ☐ Unruly ☐ Delinquent ☐ N/A Mother was incarcerated and the children were afraid of caregiver.				
Removal Reason:	☐ Alcohol Abuse (Child); ☐ Alcohol Abuse (Parent); ☐ Caretaker Inability to Cope due to Illness or Other: ☐ Child's Disability; ☐ Drug Abuse (Child); ☐ Drug Abuse (Parent); ☐ Inadequate Housing; ☒ Incarceration of Parents; ☐ NAS Prosecution (only select upon DCS attorney instruction); ☐ Physical Abuse (alleged/reported); ☐ Relinquishment; ☐ Sexual Abuse (alleged/reported); ☐ Truancy						

Removal Street Address	243 Blythe Ave						
City	Gallatin	County	Sumner	State	TN	Zip Code	37066
Kinship Exception Request							
Was KER approved?	☒ Yes ☐ No	If yes, by whom?	Sally Dykes				
Was the KER temporary or long term?	☒ temporary ☐ long term						
MSW Consult was completed with:	Melody Farmer						

Family Information

Both parents living?	☒ Yes ☐ No	If no, date(s) of death:	
Household income to determine IV-E eligibility: (including SS Benefits, SSI for child, AFDC, Foodstamps, Child Support, etc.) If additional supports are received, please indicate in whose name the payment/support is made.	Unknown		

Child/Youth Parent(s)/Caretaker(s)
Indicate Parent/Caregiver's Preferred Method for Receiving Documents

Birth Mother's Name	Renee Williams					Primary Caregiver	☒ Yes ☐ No
Email Address						☐ Yes ☐ No	
Maiden Name		Social Security No.	111-11-1111	DOB	3/15	Message Contact #	
Address	243 Blythe Ave					☐ Yes ☐ No	
City, State, Zip	Gallatin, TN 37066					Contact #	615-555-1567
Employer	N/A			Address			
City, State, Zip						Contact #	

Birth mother married when child/Youth was born?	☒ Yes ☐ No ☐ Unable to Determine		
Birth mother ever been married?	☒ Yes ☐ No ☐ Unable to Determine	**If so, where and to whom?**	Russ Williams
Birth mother ever been divorced?	☐ Yes ☐ No ☒ Unable to Determine	**If so, where and from whom?**	
Birth mother's race:	White/Caucasian		

Legal Father's Name	Russ Williams			**Primary Caregiver**	☐ Yes ☒ No
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address	Incarcerated			☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	
Legal Father's Race:					
Marital Status of Parents	☐ **Married** ☒ **Separated** ☐ **Divorced** ☐ **Other**				
Putative/Alleged Father's Name	N/A				
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address				☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	
Putative/Alleged Father's Race:					
Caregiver's Name *(if different from above)*				**Relationship**	
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address				☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	

Relative Contact Person For Child/Youth (other than parent)

		Contact #	
Relationship			

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Child/Youth Siblings:										In Custody
Name	Ariana Jones	SSN	111-11-1111	DOB	5/15	Sex	F	Race	C	☒ Yes ☐ No
Name	Justin Williams	SSN	111-11-1111	DOB	8/11	Sex	M	Race	Bi	☒ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No

Child Name:	Jewel Williams	Child DOB:	7/19	Person ID:	

Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No

Tennessee Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Initiated By: Angelo Midgett Title: CPS Date: 1/1

Revised By: Title: Date:

Person Providing Information to DCS: Ariana Jones Relationship to Child/Youth: Sister

Current insurance coverage ☐ Yes ☐ No ☒ Unknown **If yes, provide details:** Unknown

Child/Youth Information

Name of Child/Youth:	Justin Williams	E-mail Address:		SSN:	111-11-1111

DOB:	8/11	Sex:	M	Race:	White/Cauca	Hispanic:	☐ Yes ☒ No	U.S. Citizen:	☒ Yes ☐ No Provide Birth Certificate Verification

Is Child/Youth of Native American Descent?	☐ Yes ☒ No ☐ Unable to Determine	If "Yes" Tribal Affiliation	

Child/Youth's Marital Status *(check one)* ☒ Never Married ☐ Divorced ☐ Widowed ☐ Married ☐ Separated

Has Youth been placed in out of home care prior to this custody episode? If yes please list dates and placements: ☐ Yes ☒ No

Current Description of the Child/Youth

Physical Description Date	January 1	Primary Language Spoken	English

Height	2'3	Weight	30	Hair Color	Blonde	Eye Color	Brown

Religion:	Baptist	Identifying Marks or Tattoos:	None

Special Needs/Disabilities:	None
Special Medical Equipment:	None
Scheduled Appointments: (*date, provider, location, type of appt*)	Unknown

Allergies: ☐ Yes ☒ No

Allergic to:	Medication:		Describe reaction:	
	Food:		Describe reaction:	
	Insect Sting:		Describe reaction:	
	Other:		Describe reaction:	

Medical modified/Religious diet?	☐ Yes ☒ No	If yes, describe	

Medications: Prescribed and Over the Counter

Current medications (*name, route, frequency, dosage & days of meds left)*	None

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Are meds given in school?	☐ Yes ☒ No	**Which meds?**	
Consent signed for psychotropic meds:	☐ Yes ☐ No ☒ N/A	**Next med appointment:**	
Has Foster Parent received medication:	☐ Yes ☒ No	**Explain:**	

Health History of Child Explain any items checked Now/Past in "COMMENTS" section

No	Now	Past		No	Now	Past	
☒	☐	☐	Birth defects	☒	☐	☐	Gastrointestinal problems
☒	☐	☐	Vision problems	☒	☐	☐	Kidney/urinary problems
☒	☐	☐	Hearing problems	☒	☐	☐	Hepatitis/liver problems
☒	☐	☐	Skin problems	☒	☐	☐	Cancer
☒	☐	☐	Head injuries	☒	☐	☐	Tuberculosis (TB)
☒	☐	☐	Headaches	☒	☐	☐	Autism/Asperger's (circle one)
☒	☐	☐	Sickle cell disease	☒	☐	☐	Developmental delays
☒	☐	☐	Anemia/blood disorder	☒	☐	☐	Learning disability
☒	☐	☐	Epilepsy/seizures	☒	☐	☐	Sleep problems
☒	☐	☐	Bedwetting	☒	☐	☐	Incontinence: ☐ Urine ☐ Stool
☒	☐	☐	Diabetes	☒	☐	☐	Other medical *(describe below)*
☐	☒	☐	Asthma/Respiratory Disease	☒	☐	☐	Accidents *(describe below)*
☒	☐	☐	Heart murmur	☒	☐	☐	Hospitalizations *(describe below)*
☒	☐	☐	Heart problems	☒	☐	☐	Surgeries *(describe below)*
☒	☐	☐	High blood pressure	☒	☐	☐	Problems with anesthesia
☒	☐	☐	Physical disabilities	☒	☐	☐	Other developmental disabilities

Child/Youth is currently hospitalized:	☐ Yes ☒ No	**If yes, where and why:**	

Comments/Additional health information/ongoing health related services:	None

Childhood Illnesses

No	Yes	Approx date		No	Yes	Approx date	
☒	☐		Measles	☒	☐		Chicken pox
☒	☐		German measles	☒	☐		Scarlet fever
☒	☐		Mumps	☒	☐		Rheumatic fever

Trauma Screening

Indicate *known* history of abuse/adverse experiences. Explain any yes answers in "COMMENTS" section

No	Yes		No	Yes	
☒	☐	Neglect	☒	☐	Domestic violence
☒	☐	Physical assault/abuse	☒	☐	School violence
☒	☐	Sexual assault/abuse	☒	☐	Community violence
☒	☐	Emotional abuse	☒	☐	Extreme interpersonal violence
☒	☐	Traumatic loss/separation	☒	☐	Natural disaster
☒	☐	Extended illness/medical trauma	☒	☐	Impaired caregiver (substance abuse/mental illness)
☒	☐	Serious injury	☐	☐	Other trauma, describe:

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Has abuse been reported? ☐ Yes ☒ No ***If no, call CPS 877-237-0026***

Comments/Additional health information:	

Behavioral/Mental Health History

No	Now	Past	
☒	☐	☐	Intense anger, if yes, describe
☒	☐	☐	Oppositional, if yes, describe
☒	☐	☐	Negative Peer Association, if yes, describe
☒	☐	☐	Extreme Attention Seeking, if yes, describe
☒	☐	☐	Makes False Statements, if yes, describe
☒	☐	☐	School Difficulties, if yes, describe
☒	☐	☐	Damage of Property, if yes, describe
☒	☐	☐	Habitual Lying, if yes, describe
☒	☐	☐	Stool Smearing, if yes, describe
☒	☐	☐	Stealing, if yes, describe
☒	☐	☐	Runaway, if yes, describe
☒	☐	☐	Hoarding, if yes, describe
☒	☐	☐	Problems with concentration and attention,if yes, describe
☒	☐	☐	Excessive Hyperactivity/does not respond to safety instructions, if yes, describe
☒	☐	☐	Requires Constant Supervision, if yes describe
☒	☐	☐	Anxiety, if yes, describe
☒	☐	☐	Depression, if yes, describe
☒	☐	☐	Seeing or hearing things that aren't there, if yes, describe
☒	☐	☐	Fire-setting, if yes, describe
☒	☐	☐	Animal cruelty, if yes, describe
☒	☐	☐	Animal fear, if yes, describe
☒	☐	☐	Self-injurious behavior/Other Self Harm, if yes, describe
☒	☐	☐	Aggressive, dangerous or destructive behaviors, if yes, describe
☒	☐	☐	Sexual aggression, if yes, describe
☒	☐	☐	Had homicidal thoughts, if yes, describe
☒	☐	☐	Had suicidal thoughts, if yes, describe
☒	☐	☐	Attempted suicide If yes, describe
☒	☐	☐	Had other mental health or behavioral problems, if yes, describe
☒	☐	☐	Other mental health diagnosis, if yes, describe

Has the Child/Youth received counseling or therapy?	☐ Yes ☒ No
If yes, where?	
Has the Child/Youth had a Psychological Evaluation:	☐ Yes ☒ No
If yes, diagnosis, when, where?	
Has the Child/Youth been hospitalized for mental health problems/acute hospitalization?	☐ Yes ☒ No
If yes, diagnosis, when, where?	
Has the Child/Youth/Family received in-home services?	☐ Yes ☒ No
If yes, when, where?	
Has the Child/Youth previously been placed in a residential treatment facility?	☐ Yes ☒ No

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

If yes, when, where?

Alcohol/Drug Abuse History

No	Now	Past	Frequency	(Xs per day/week/month)
☒	☐	☐		Alcohol
☒	☐	☐		Tobacco smoke/chew *(circle one or both)*
☒	☐	☐		E-cigarettes/vapor cigarettes
☒	☐	☐		Marijuana
☒	☐	☐		Narcotics
☒	☐	☐		Stimulants
☒	☐	☐		Methamphetamine
☒	☐	☐		Hallucinogens
☒	☐	☐		Steroids
☒	☐	☐		Huffing
☒	☐	☐		Ecstasy
☒	☐	☐		Street drugs, unknown
☒	☐	☐		Prescription drugs prescribed for another, specify:
☒	☐	☐		Over-the-counter medication, specify:
☒	☐	☐		Other, specify:

Has child been identified as high risk?	☐ Yes ☒ No
Has a Safety Plan been completed on child identified as high risk?	☐ Yes ☒ No ☐ N/A

Birth History (for all children)

Birth Weight:	Unknown	**Birth Length:**		☒ **Full term or** ☐ **Premature birth (<36 weeks)**		weeks
Did mother receive prenatal care:	☐ Yes ☐ No	**Month of pregnancy for 1st prenatal visit:**				
Pregnancy/Birth complications:	Unknown					
Was there prenatal substance abuse:	☐ Yes ☐ No	**Substance and frequency:**				
Birth hospital and location:						

Minor Female

Age of 1st Period:		**Date of Last Period:**					
Pregnancies #		**Live births #**		**Full term**		**Premature (# weeks)**	
Miscarriages #		**Abortions #**		**Currently pregnant:**	☐ Yes ☐ No	**If yes, due date:**	

Gender and Sexual Identity

Does the Child/Youth identify him/herself as gay, lesbian, transgender, or intersex?	☐ Yes ☒ No
If yes, describe answer	

Sexual Activity

Is child sexually active?	☐ Yes ☒ No	**Use birth control?**	☐ Yes ☒ No	**Method:**	

Dating Violence

Has Child/Youth experienced controlling, abusive or aggressive behavior in a dating relationship?	☐ Yes ☒ No
If yes, explain:	

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Medical

Does the Child/Youth have a regular medical provider (pediatrician, family doctor, etc.)?	☒ Yes ☐ No		
If yes, name of medical provider:	Dr. Saywer	**Date of last visit:**	About 1 year ago

Immunizations

Are immunizations up-to-date?	☒ Yes ☐ No	**Is the immunization record available?**	☐ Yes ☐ No
Religious/medical exemption?	☐ Yes ☒ No (parent/guardian must provide a notarized statement)		

Dental

Does the Child/Youth have a regular dental provider?	☐ Yes ☒ No	**Does the Child/Youth wear braces?**	☐ Yes ☐ No
If yes, name of dental provider:		**Date of last exam:**	
If braces, name of orthodontist:		**Date of last exam:**	

Vision

Does the Child/Youth wear glasses?	☐ Yes ☒ No	**Does the Child/Youth wear contacts?**	☐ Yes ☒ No
If yes, name of vision provider:		**Date of last visit:**	

This concludes the Well-Being Section

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

This information does not go to Health Care Provider

Education and Independent Living

Student graduated high school?	☐ Yes ☒ No ☐ GED ☐ HISET ☐ Student Home Schooled				
What school does the student attend? (name, city, county)					
Student's age		**Current grade**		**Student receives special education services?** ☐ **Yes** ☐ **No**	
If yes, name the disability	None				

No	Yes	
☐	☐	Is the student taking GED classes
☐	☐	Does the student have a history of skipping school?
☐	☐	Is the student in an alternative school?
☐	☐	Is the student serving a zero tolerance expulsion (drugs, weapons and/or assault)?
☐	☐	Is the student serving a suspension for issues other than zero tolerance? If yes, what is the reason and duration of suspension?

Student strengths (check all that apply)	**Areas needing improvement (check all that apply)**
☐ Mathematics	☐ Mathematics
☐ Reading	☐ Reading
☐ Athletics	☐ Athletics
☐ Attendance in school	☐ Attendance in school
☐ Other, specify	☐ Other, specify

Other things you would like to share regarding your student's schooling?	

Presenting and Previous Court Actions on Youth (Unruly/Delinquent Youth only)

Current Dispositional Information			
Disposition Judge		**Special Judge**	
Current Disposition Court			
Current Disposition Decision		**Disposition Date**	
Have you been or are you currently on probation?	☐ Yes ☐ No	**If yes, where**	
Defense Attorney	N/A		
Current Adjudication Type		**Current Adjudication Date**	

Adjudicated Charge – Current and Previous	**Date Occurred**	**Disposition Date**	**Disposition**

Pending Charges	**Court Date Set**	**Date (if yes)**
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Violation of Probation (VOP) or Violation of Valid Court Order (VVCO) ***(explain if applicable)***

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Narrative	

Legal/Probation Services Previously Offered to Child/Youth

Date	Type	Outcome

Safety (Unruly/Delinquent Youth only)

A) Maltreatment Allegations or Unruly Behaviors/Delinquency

Other *(explain)*	
Narrative	
Strengths *(Signs of Safety)*	
Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*	

B) Domestic Violence

Narrative	
Strengths *(Signs of Safety)*	
Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*	

FSW Name	Sandra Littleton	Contact #	
Office Address			
Supervisor		Contact #	

DCS / Provider Staff *Date*

I acknowledge receipt of the Intake, Placement, and Well-Being Information and History. I further acknowledge my legal duty to maintain confidentiality of this information and history and any additional information I may receive pursuant to Tennessee Code Annotated §37-2-415, The Foster Parent Rights Act.

Foster Parent *Date*

Foster Parent *Date*

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Do not provide this section to the Foster Parent or the Health Care Provider

Has the child/Youth been adopted: ☐ Yes ☒ No: **Was the child/Youth in Permanent Guardianship:** ☐ Yes ☒ No
Receiving Adoption Assistance or Subsidized Permanent Guardianship: ☐ Yes ☒ No: If yes, **Amount:** ____
(If yes, immediately notify the Permanency Specialist, Child Welfare Benefits Counselor Regional and Central Office Fiscal Staff).

Adoption/Guardianship Completed by DCS: ☐ Yes ☒ No (If no List Name of the Agency)

Removal Date:	1/1	New Placement:	Nancy & Dan	Date of Placement:	1/1	Legal Custody Date:	1/1
Removal County:	Sumner	Adjudication Type:	☒ Dependent and Neglect ☐ Unruly ☐ Delinquent ☐ N/A				
		Brief Description:	Mother was incarcerated and the children were afraid of caregiver.				

Removal Reason: ☐ Alcohol Abuse (Child); ☐ Alcohol Abuse (Parent); ☐ Caretaker Inability to Cope due to Illness or Other: ☐ Child's Disability; ☐ Drug Abuse (Child); ☐ Drug Abuse (Parent); ☐ Inadequate Housing; ☒ Incarceration of Parents; ☐ NAS Prosecution (only select upon DCS attorney instruction); ☐ Physical Abuse (alleged/reported); ☐ Relinquishment; ☐ Sexual Abuse (alleged/reported); ☐ Truancy

Removal Street Address	243 Blythe Ave						
City	Gallatin	County	Sumner	State	TN	Zip Code	37066
Kinship Exception Request							
Was KER approved?	☒ Yes ☐ No	If yes, by whom?	Sally Dykes				
Was the KER temporary or long term?	☒ temporary ☐ long term						
MSW Consult was completed with:	Melody Farmer						

Family Information

Both parents living?	☒ Yes ☐ No	If no, date(s) of death:	
Household income to determine IV-E eligibility: (including SS Benefits, SSI for child, AFDC, Foodstamps, Child Support, etc.) If additional supports are received, please indicate in whose name the payment/support is made.	Unknown		

Child/Youth Parent(s)/Caretaker(s)
Indicate Parent/Caregiver's Preferred Method for Receiving Documents

Birth Mother's Name	Renee Williams					Primary Caregiver	☒ Yes ☐ No
Email Address						☐ Yes ☐ No	
Maiden Name		Social Security No.	111-11-1111	DOB	3/15	Message Contact #	
Address	243 Blythe Ave					☐ Yes ☐ No	
City, State, Zip	Gallatin, TN 37066					Contact #	615-555-1567
Employer	N/A	Address					
City, State, Zip						Contact #	

Birth mother married when child/Youth was born?	☒ Yes ☐ No ☐ Unable to Determine		
Birth mother ever been married?	☒ Yes ☐ No ☐ Unable to Determine	**If so, where and to whom?**	Russ Williams
Birth mother ever been divorced?	☐ Yes ☐ No ☒ Unable to Determine	**If so, where and from whom?**	
Birth mother's race:	White/Caucasian		

Legal Father's Name	Russ Williams			**Primary Caregiver**	☐ Yes ☒ No
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address	Incarcerated			☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	
Legal Father's Race:					
Marital Status of Parents	☐ **Married** ☒ **Separated** ☐ **Divorced** ☐ **Other**				
Putative/Alleged Father's Name	N/A				
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address				☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	
Putative/Alleged Father's Race:					
Caregiver's Name *(if different from above)*				**Relationship**	
Email Address				☐ Yes ☐ No	
Social Security No.		**DOB**		**Message Contact #**	
Address				☐ Yes ☐ No	
City, State, Zip				**Contact #**	
Employer		**Address**			
City, State, Zip				**Contact #**	

Relative Contact Person For Child/Youth (other than parent)

		Contact #	
Relationship			

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Child/Youth Siblings:										In Custody
Name	Ariana Jones	SSN	111-11-1111	DOB	5/15	Sex	F	Race	C	☒ Yes ☐ No
Name	Jewel Williams	SSN	111-11-1111	DOB	7/19	Sex	F	Race	Bi	☒ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No

Child Name:	Justin Williams	Child DOB:	8/11	Person ID:	

Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No

Additional Intake Documents

State of Tennessee

Child Welfare Benefits Application

Date Received:

IDENTIFYING INFORMATION:

Child's Last Name	First	Middle	Date of Birth	Social Security Number
Jones	Ariana		**5/15**	**111-11-1111**
Race: W	Sex: F	Child's County of Venue		Date of Custody **1/1**
Mother's Last Name: Williams	First: Renee	Middle	Date of Birth 3/15	Social Security Number: 111-11-1111
Father's Last Name: Jones	First Timmy	Middle	Date of Birth	Social Security Number

REMOVAL HOME (From whose home the foster child was removed):

Name of Person from whose home the child was removed?	Relationship of person to child:

PLACEMENT INFORMATION (Where the child is placed, outside of the home, because of this situation):

Name of Placement:	Date Entered Placement:
Dan and Nancy	1/1

ELIGIBILITY/REIMBURSABILITY:

1. Is the child a U.S. Citizen or Qualified Alien?	2. Is the child a Tennessee resident?	3. Is the child a Native American?
Yes ☒ No ☐	Yes ☒ No ☐	Yes ☐ No ☒

4. DEPRIVATION OF PARENTAL SUPPORT BY CHILD'S LEGAL AND/OR BIOLOGICAL PARENTS:

	MOTHER	**FATHER**
a. Parent living in the home from which the child was removed?	Yes ☒ No ☐	Yes ☐ No ☒
b. Is the child's parent(s) deceased?	Yes ☐ No ☒	Yes ☒ No ☐
	If "yes", date death occurred:	**If "yes", date death occurred:** unknown
c. Parent(s) **disabled (physically/ mentally)?**	Yes ☐ No ☒	Yes ☐ No ☐
d. Parent(s) **unemployed?**	Yes ☒ No ☐	Yes ☐ No ☐

The primary wage earner is the parent with the most earnings over the past 24 months. Who is the primary wage earner?
Mother ☐ Father ☐ Check here if neither parent was a wage earner: ☒

Is the primary wage earner currently unemployed or employed less than 100 hours per month? Yes ☒ No ☐

4A. Was the child living with either or both parents during the month the court proceedings were initiated or the month of the Voluntary Placement was signed? Yes ☒ No ☐

If no, list all living arrangements for the six months prior to the month the court proceedings initiated or the month that the Voluntary Placement Agreement was signed, beginning with the child's most recent living arrangements prior to placement and working back.

From	To	Name and Address	Relationship

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: CWB Case File, Copy Child's Record *RDA 2984*

Date Received:			

4B. Give the following information on **all** persons (including the foster child) who were living in the home from which the foster child was removed (removal home).

Name	Birth Date	Relationship to Foster Child	Social Security Number
Ariana **Jones**	**5/15**	**self**	**111-11-1111**
Renee Williams	**3/15**	**mother**	
Frank Smith		**mother's boyfriend**	
Justin Williams	**8/11**		**111-11-1111**
Jewel Williams	**7/19**		**111-11-1111**

5. **Financial Resources:** Enter information about the foster child's financial resources and income in sections 5 thru 10 below. If the foster child's parent(s), a stepparent or foster child's sibling (whole, half, step sibling) age 18 or younger were also living in the removal home, enter their resources and income in sections 5 thru 10. Do not enter for other persons in the removal home.

Source	Balance	Owner	Bank Name and Address	Account Number
Cash	**324**	**Renee Williams**		
Checking/ Savings	**0.00**			
IRA/CD	**0.00**			
Stocks/Bonds	**0.00**			
Trust Accounts	**0.00**			
Other	**0.00**			

6. List any real estate family members or child owns other than their home:

Value/Amount/Owed: 0.00	Owner:	Location:
Value/Amount/Owed: 0.00	Owner:	Location:

7. List any vehicles family member or child owns:

Value/Amount/Owed: 0.00	Owner:	Model/Year:
Value/Amount/Owed: 0.00	Owner:	Model/Year:

8. Income other than wages (Monthly amount or equivalent): Check the (Step box) if the income below is received by a stepparent in the removal home.

	Foster Child	Mother (Step ☐)	Father (Step ☐)	Sibling (Step ☐)	Sibling (Step ☐)
Social Security	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
SSI	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Veteran's Benefits	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
UC/WC	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Railroad Retirement	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Pension	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Military	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Child Support	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Date Received:					
Other	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
9. Indicate the child's payee for the above benefits:	Name:		Type of Benefits:		
	Name:		Type of Benefits:		

10. Current Employer: Check the box in the (Step) column if the wages are received by a stepparent or step sibling.

	(Step)	From	To	Employer Name and Address	Gross Wages (amount before deductions)	Frequency (weekly, bi-weekly, semi-monthly, yearly)	# Hours Worked Per Week
Child	☐						
Mother	☐						
Father	☐						
Sibling	☐						
Sibling	☐						

Child Care Expenses:

Did the child's parent pay for someone to care for the child so that the child's parent could get to work, training, or look for a job? Yes ☐ No ☒

If "yes", **Amount Paid**: **Frequency: Weekly** ☐ **Monthly** ☐

Child Care Provider Name and Address:

Phone Number:

Date Received:

11. **Does the child have any physical, emotional, or mental disabilities? Attach copies of the child's Individual Education Plan and psychological report from the child's case manager concerning possible disability.** Yes ☐ No ☒ None

If yes, briefly describe:

12. Is the child attending school? Yes ☒ No ☐ N/A ☐ Name of school: Gallatin Middle School Gallatin, TN
If yes, is the attendance: Full Time ☒ Part Time ☐ Grade 8

13. If the child is 18 and in school, is he/she expected to complete the course of study by age 19? Yes ☐ No ☒ N/A ☐
Expected graduation date:

14. Is the home from which the child was removed receiving adoption support payments on behalf of the child? Yes ☐ No ☒

15. Does the child receive or expect an inheritance or settlement? Yes ☐ No ☒

16. Child Support Information-Non-Custodial Parent Data: (Confirm the parent/foster child relationship is reflected in TFACTS.)

Foster Child's Mother:		Does a "Good Cause" reason exist to not pursue child support from the mother?: No ☒ Yes ☐				
Race W	Date of Birth 3/15	Place of Birth Nashville	Height 5'6"	Weight 125	Hair blonde	Eyes brown

Street Address 243 Blythe Avenue	City Gallatin	State TN	Zip 37066	Telephone Number 615-555-1567
Is this address valid? Yes ☒ No ☐	Last date at above address 1/1	Parental Abandonment Date		

Employer Name and Address	City	State	Zip	Last date employed
Is there a Court Order for support? Yes ☐ No ☒ If so, Date of Order:	County of Jurisdiction	Amount	Frequency	Paid To

Military-Branch	Date Entered	Date Discharged	Type/Amount of Federal Benefits (SS,VA)

Date/Place of Marriage (mother's marriage to the foster child's father)	Date/Place of Divorce (mother's divorce from the foster child's father)
Health Insurance- Name and Address	Policy Number
Is the child covered by this insurance? Yes ☐ No ☒	
Does the mother have a criminal record? Yes ☐ No ☐ If yes, provide details:	

Is mother making child support payments? Yes ☐ No ☐	If yes, indicate: Amount:	Frequency	Last date support was paid

Foster Child's Father:	Does a "Good Cause" reason exist to not pursue child support from the father?: No ☐ Yes ☐ Legal Parent ☐ Alleged Parent ☐					
Race	Date of Birth	Place of Birth	Height	Weight	Hair	Eyes

Street Address Deceased	City	State	Zip	Telephone Number
Is this address valid? Yes ☐ No ☐	Last date at above address	Parental Abandon Date		

Employer Name and Address	City	State	Zip	Last date employed
Is there a Court order for support? Yes☐ No☐ If so, Date of Order:	County of Jurisdiction	Amount	Frequency	Paid To

Military-Branch	Date Entered	Date Discharged	Type/Amount of Federal Benefits (SS,VA)

Date/Place of Marriage (father's marriage to the foster child's mother)	Date/Place of Divorce (father's divorce from the foster child's mother)
Health Insurance- Name and Address	Policy Number
Date Received:	
Is the child covered by this insurance? Yes ☐ No ☐	
Does the father have a criminal record? Yes ☐ No ☐ If yes, provide details:	

Is father making child support payments? Yes ☐ No ☐	If yes, indicate: Amount:	Frequency	Last date support was paid

17. Group Health Insurance: Current Coverage and Access to Availability

a. **Does the foster child currently have medical insurance or any group health insurance (including TennCare, Medicaid, Champus, military health insurance, federal employee health plans, individual health insurance plans)? Yes ☐ No ☒** Unknown
If yes, Policyholder Name:
Name of Carrier: Policy # Effective Start Date:

b. **If the foster child's parent(s) is employed and does not have current group health insurance, does the foster child and/or foster child's parent have ACCESS to employer offered group health insurance, i.e., does the employer off group health insurance? Yes ☐ No ☒**

c. **If yes,** can the foster child's parent(s) apply for health insurance coverage at any time? Yes ☐ No ☐

Understanding of DCS Family Services Worker/Authorized Representative/Court Liaison

I understand that information may be submitted to the United States Citizenship and Immigration Services (USCIS) for verification. If the child receives Medicaid, as the child's representative, I assign to the State any other medical benefits the child has as long as the child receives Medicaid. I will cooperate with the Department of Children's Services, the Department of Human Services, the Department of health, and the Tennessee Bureau of Investigation. I authorize the release of information to recover the benefits and investigate fraudulent claims for benefits.

I understand that I will be responsible for reporting changes in living arrangements and other criteria as required within ten (10) days. I certify under penalty of perjury that the information provided is true and correct to the best of my knowledge.

I understand that if I disagree with action taken on this application I may appeal the decision within 90 days of the date notified.

USE OF SOCIAL SECURITY NUMBERS AND COMPUTER MATCHING: An individual applying for benefits must have a Social Security Number or apply for one, as required by PL 97-98. We use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. If those records do not match the information provided on behalf of the child, it may affect whether the child qualifies for benefits.

Family Services Worker/Authorized Representative/Court Liaison Angelo Midgett	Telephone No	Date **1/1**

ATTACH APPROPRIATE COURT ORDER(S) AND ALL OTHER PERTINENT INFORMATION

Including copies of: Court Orders, Voluntary Placement Agreements, petitions, birth certificates, and social security card, plus child's Individual Education Plan, psychological reports, Procedure to Establish Good cause, and health insurance card.

Additional comments or information may be added below:

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO or FROM the Department of Children's Services and Notification of Release

A. AUTHORIZATION FOR RELEASE TO DCS

☐ I, _____ hereby authorize release of the information specified on page 2, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.

B. AUTHORIZATION FOR DCS TO RELEASE

☐ I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 2, to the person/entity specified on page 2.

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

Authorizing Signature	*Print Name*	1/1 *Date*

Name of Client's Representative (Print)	*Signature of Client's Representative*	1/1 *Date*

Angelo Midgett *Name of Witness (Print)*	*Signature of Witness*	1/1 *Date*

Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Jones	Ariana		**5/15**	**111-11-1111**	F
Name*: (Last)*	*(First)*	*(Middle)*	*Date of Birth*	*Social Security*	*Gender*

Other Legal Names: _____ Address: _____ Place of Birth: Nashville, TN

Home Telephone No.	*Cellular Telephone*	*Work Telephone*	*Alternate Telephone*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Original Child's case File *RDA 2982*
CS-0559 Rev: 12/19

Type of Information Requested (check ONLY one):

1. ☐ Education records, including transcripts, GED, TCAP, Special Education
2. ☐ Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.
3. ☐ Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.
4. ☐ Background/Criminal History Checks, including Polygraph, and Fingerprint Results
5. ☐ Employment Records
6. ☐ Personal Finance/Credit History/Insurance Records (as applicable)
7. ☐ Other

Authorization Expires: **☐ in one year** **☐ in 90 days** **☐ On_____/_____/**
(Authorization not to exceed one year.)

Name of Provider/School/Entity <u>Releasing Info to DCS</u> or <u>Receiving info from DCS</u>: Gallatin Middle School Gallatin, TN

Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ Arrange/Access Services ☐ CPS Investigation ☐ Juvenile Court Case
☐ Other: _____

		1/1
Authorizing Signature	*Print Name*	*Date*
		1/1
Name of Client's Representative (Print)	*Signature of Client's Representative*	*Date*
Angelo Midgett		1/1
Name of Witness (Print)	*Signature of Witness*	*Date*

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me.** _____
Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

The Following form titled Informed Consent for Psychotropic Medication may be removed and destroyed if the child is not on any Psychotropic medication.

Tennessee Department of Children's Services

Informed Consent for Psychotropic Medication

Appointment Date _____ TFACTS Person ID# _____

Child's Name Ariana **Jones** DOB **5/15**

Home County _____ DCS FSW Sandra Littleton

Placement ☐ Foster home ☐ Congregate care facility Facility name _____

☐ Child entering custody on the medication(s) listed below

PLEASE ATTACH PSYCHOTROPIC MEDICATION EVALUATION Form CS-0629 OR EQUIVALENT FORM

Medication (dose, frequency, route) _____

None

For the treatment of None

Allergies None

Any other medication child is taking _____

Prescribing Provider's Name None Telephone # _____

Clinic Name None

Address _____

I have been informed of the recommendation that medication be prescribed as part of my/my child's treatment program. I have been informed of the nature of my/my child's condition, the risks and benefits of treatment with the above medication, of other forms of treatment, as well as the risks of no treatment. My signature below indicates that I have received information explaining the most common side effects of this/these medication(s), but understand that there may be other side effects.

I understand that medication is only one aspect of my/my child's overall treatment, and that success and improvement depends on my active involvement and participation in all aspects of the treatment plan developed for me/my child. I also understand that although this medication is expected to be helpful in the treatment of my/my child's condition, there is no absolute guarantee as to the results.

For females: Because this/these medication(s) could be harmful to a developing fetus, I will notify the medical staff immediately if I suspect pregnancy or have plans to attempt pregnancy.

Based on the information provided to me:

☐ I give **PERMISSION/CONSENT** to the administration of the above listed medications(s).

☐ I **REFUSE** to allow the administration of the above listed medication(s).

Youth age 16 or older signature_____ Date__ 1/1 _

Parent/Legal Guardian signature_____ Date___1/1 ____

Print name_____ Relationship_____

Witness #1 Verbal Consent_____ Date_____

Witness #2 Verbal Consent_____ Date_____

Reason parent cannot sign_____

DCS Health Nurse Signature _____ Date_____

Print name_____ Region _____

☐ I have been **NOTIFIED** that consent was given by DCS for the above listed medications(s).

Parent/Legal Guardian signature_____ Date_____

Print name_____ Relationship_____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Child's Group Home File

Tennessee Department of Children's Services

Medication Transfer

Name_____Ariana _ _ **Jones** _____ DOB_____ **5/15** _____

Date_____ **1/1** _____

The following medications are being sent with this child/youth to a new placement:

Medication and Dosage:	Instruction:	Count:	# Refills
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications collected/counted by: _____

Medication has been sealed by: _____

Signature #1_____ Signature #2_____

Medication has not been sealed ☐

By signing below you are agreeing that all medications and counts are accurate as listed

_____ _____
Signature of Person releasing medications Date

_____ _____
Signature of Transport Person Date

_____ ____ _____
Signature of Person or Parent/Guardian receiving medication Date

Medication has been sealed by medical staff and is being released to parent/guardian. By signing below you are agreeing that you are receiving sealed medications

_____ _____
Signature of parent/guardian receiving sealed medication Date

Note: Some medication may not be in "child proof" containers. Please keep all medications out of the reach of children.

Youth released from a *Youth Development Center* may receive a one month supply of prescription medication sent directly from the pharmacy via UPS. Please check the medication you receive to make sure the type of medication and the dose is correct. Report any errors directly to the pharmacy.

In case of questions, please contact:

_____ Sandra Littleton _ Angelo Midgett _____ _____ _____
Sending Staff/Facility/FSW Phone

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Child /Youth Record

Tennessee Department of Children's Services

Authorization for Routine Health Services for Minors

Name of Child: _Ariana _ **Jones** ___ __ Date of Birth: __ **5/15** ___Social Security Number: __ **111-11-1111** __

Date of Custody: **1/1** County of Custody: __ _____ Region of Custody: __ _____

This document verifies that __Ariana _ _ **Jones** _____ **is in the legal custody of the Tennessee Department of Children's Services. The Department of Children's Services, by virtue of the court's order granting legal custody, is authorized to consent to ordinary and/or necessary medical care.**

Child/Youth

(The information below must be fully explained to the minor; minor does not sign form)

Routine health services may be provided while you are within the custody of the Tennessee Department of Children's Services. Examples of routine health services are: routine dental procedures including extractions, pelvic exams, blood draws and samples, immunizations, treatment of communicable disease(s), routine suturing or minor lacerations, x-rays, and other medical procedures not listed generally governed by implied consent guidelines in the community setting. If you choose not to consent, the Department of Children's Services, by virtue of the court's order granting the department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or treatment.

Parent/Guardian

I, ___ __ _____, understand that it may be necessary for the Tennessee Department of Children's Services to provide routine health care to my child while he/she is in the custody of the Department. I understand the meaning of routine with regard to health services as generally outlined above and hereby give my permission to such care. I have also been informed that if I choose not to consent, the Department of Children's Services, by virtue of the court's order granting the department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or treatment.

_____ 1/1 _____

Parent's or Legal Guardian's Signature *Date*

_____ 1/1 _____

Witness' Signature *Date*

Based upon refusal of the above named minor's parent or legal guardian to consent to the routine treatment of his/her child while in custody of the Department of Children's Services or because, after diligent efforts to locate, the parent or legal guardian cannot be located, the Department of Children's Services due to its rights and responsibilities as legal custodian is authorized to consent to ordinary and/or necessary medical care and/or treatment.

*** parent refused to sign paperwork at time of removal

☐ No parent available at time of removal

_____ _____

DCS Staff Signature Date

This is the current version of this form. Please disregard all previous versions prior to the date listed below.

Tennessee Department of Children's Services

Penalty for Harboring Notice

Ariana Jones — ***Child's Name***

5/15 — ***Date of Birth***

You are advised that ***IF*** the above named child, who is in the custody of the Department of Children's Services (DCS), runs away from DCS custody, you are legally obligated to report any known information regarding the whereabouts of this child/youth. You are hereby notified that harboring a juvenile offender is a criminal offense punishable by up to ***11 months, 29 days in jail and $2, 500 in fines***. I understand this law and consequences if I choose to harbor any child/youth who has run away from DCS custody.

I confirm by my signature below that if I have ***any*** information that would help locate this child/youth in the event of running away from DCS custody I will share it immediately with my DCS worker or supervisor and/or law enforcement.

Any child/youth who runs away is at risk of harming themselves, other persons and the community at large. Your cooperation in bringing this child back into custody is very important.

Print Name | *Date*

Signature | *Relationship to Child/Youth*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Youth's Case File
Recipient

Tennessee Department of Children's Services

Request for Certification/Verification of Birth, Death, Marriage or Divorce

The purpose of this request is to:

- ☐ File TPR and/or finalize adoption
- ☐ 17-year-old about to age out of care or transitioning to EFCS
- ☐ Newborn in need of TennCare benefits
- ☐ Severe abuse
- ☒ Other: Records

(Requests will be prioritized by Vital Records in the order listed above)

Requestor's Name	Sandra Littleton	Title		Date	1/1

For **TN Records Requests**		For **Records From Other States**	
E-mail ***vragencysupport@tdhs.zendesk.com***		Dept. of Children's Services	
Call 615-442-7744 for questions		Sandra Littleton	Sandra Littleton
		Jayhawk Avenue	
		Address 2 (if applicable)	
		Murfreesboro, TN	
		Fax Number	

This agency needs	☒ birth certificate	Case Name and Number	
	☐ death verification	County	
	☐ marriage certificate	FSW's Signature	
	☐ divorce verification	FSW's Telephone Number	

INFORMATION REQUIRED FOR SEARCH: BIRTH - DEATH

Full Name	Ariana **Jones**			Sex	F	Race	W
	First	Middle	Last				

Place of	☐ Birth Nashville, TN	Date of	☐ Birth **5/15**
	☐ Death		☐ Death

Requesting copy of the birth certificate of and a copy, if available, of the Voluntary Acknowledgment of Paternity

B	Birth Certificate Number			
I	Mother's full Maiden Name	Renee	Williams	
R		First	Middle	Last(Maiden)

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Case File, Vital Records Office

RDA 2982

Requestor's Name	Sandra Littleton	Title		Date	1/1

T	Father's Full Name	Timmy	Jones	
H		First	Middle	Last
D	Name of Funeral Director, if known			
E				
A				
T	Cause and Date of Death			
H				

FOR BIRTH OF CHILD UNDER ONE YEAR

Name of Hospital		Name of Attendant	
Address of Hospital			

INFORMATION REQUIRED FOR SEARCH: MARRIAGE - DIVORCE

Name of Groom/Husband					
	First	Middle	Last	Age	Race
Name of Bride/Wife					
	First	Middle	Last	Age	Race

Date of Marriage or Divorce		Place of Marriage	
County in which license was issued		County of Divorce	
Name of court			
Other data			

Please Note: Attached you will find a release of information authorizing this request

For Vital Records Office use Only – Do Not write below this Section

This is to certify that our files show:

Verification / Certificate No.		☐ Birth ☐ Marriage	☐ Death ☐ Divorce	File Date:	Attached (Yes/No)
Verification / Certificate No.		☐ Birth ☐ Marriage	☐ Death ☐ Divorce	File Date:	Attached (Yes/No)

Processed by: _____ Date: _____
Signature of Vital Records Staff

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Case File, Vital Records Office

RDA 2982

Tennessee Department of Children's Services

Case Intake Packet Documents Verification

Date	TFACTS Case ID	County	Case Worker
1/1			Angelo Midgett

Native American Heritage Veto/Verification
Native America/Tribal Affiliation includes:

- An Indian child under the age of 18;
- A member of an Indian tribe;
- Eligible for membership in an Indian tribe; or
- The biological child of a member of an Indian tribe.

Child Name	DOB	Child is **NOT** Native American or affiliated with a tribe	Is Native American or has Tribal Affiliation
Ariana **Jones**	**5/15**	☒	☐ with: _____
		☐	☐ with: _____
		☐	☐ with: _____
		☐	☐ with: _____
		☐	☐ with: _____

Note: If the family reports having Native American heritage, form letter **Confirmation of Native American Heritage** must be completed to capture tribal information. Form letter **Determination of Tribal Affiliation** must be completed if it is believed or confirmed that the child or parents are Native American, but the tribe or registration information is not known as outlined in **DCS Policy 16.24 Children of Native American Heritage**.

Mother/ Caregiver Initials	Father/ Caregiver Initials	Youth Initials	Name of Document
			Client's Rights Handbook (7/15)
			Notification of Equal Access to Programs and Services and Grievance Procedures CS-0158 (7/15) I have read the above procedure of how to file a Title VI complaint. This procedure was explained to me in detail and a copy was issued to me for my records. I was advised that this form is available in other languages.
			Notice of Privacy Practices CS-0699 (6/09), which describes how DCS may use my health information, my rights to privacy regarding my health information, and how I can exercise those rights.
			Independent Living Youth Handbook/A Guide for Teens in Foster Care (For youth ages 14 and older *who are in state custody*) *Must be printed/separate from packet

By providing my initials and signature below, I acknowledge that I received the following paperwork, the case worker has reviewed the paperwork with me, I verify that the information I provided regarding Native American Heritage is correct and I had the opportunity to review and ask questions.

Parent/Caregiver Signature	1/1 Date	Parent/Caregiver Signature	1/1 Date
Youth over age 14 Signature	1/1 Date	Witness	1/1 Date

Client's Rights Handbook

Tennessee Department of Children's Services | Policy and Procedures | Dec. 2016

Table of Contents

A Note about this Handbook

The information inside is very important. It spells out how the Department of Children's Services (DCS) process works in Tennessee. It describes what happens when DCS gets called, what we will seek to do and how we work to keep a child's best interests at heart.

We know that this can be very hard on families and very hard on children. But we also know that when we remember to do what is best for the children, we are often very successful in making this a positive turning point in a child's life.

DCS works closely with the courts; there are specific laws that describe how we do what we do. For many people, these laws and procedures are long and confusing. This handbook is designed to help you understand better.

DCS staff will also work with clients and families to accommodate special needs as listed below, including but not limited to:

- Bilingual personnel or translators or arrange for the use of communication technology;
- Sign language needs;
- Methods for the hearing impaired clients and persons;
- Communication assistance for persons with special needs who have difficulty making their service needs known, and
- Consideration of literacy levels of clients and family.

A Case Worker will review all of these rights and expectations with you in person and will be happy to go back over it with you if you wish. If you require any special accommodations as listed above, please let the Case Worker know your specific needs.

Still, many families find it useful to have it all in writing so they can review it later. If you need help understanding anything here, please ask for help. Feel free to go through it with your lawyer or someone you trust.

Contact Information

DCS Staff	Name	Telephone Number
DCS Case Worker	Sandra Littleton	
Team Leader/Lead Investigator		
Team Coordinator/Investigative Coordinator		( ) -
Regional Administrator/Regional Investigative Director		( ) -

DCS hours of operation are 8:00 a.m. – 4:30 p.m. If you have an emergency after hours, please contact: _____ **Telephone Number:** _____

The Tennessee Child Abuse Hotline, 1-877-237-0004, is available twenty-four (24) hours per day, seven (7) day per week**.**

Rights and Responsibilities

You Have the Right to:

- Available services, regardless of your age, race, ethnicity, gender, religious or political affiliation, sexual orientation, sexual identity, physical or mental disability, or infectious disease, and the right to referral, as appropriate, to other service providers.
- Competent professional services, including an individualized written treatment or service plan, services based on the plan, periodic review and assessment of needs, and revisions to the plan including a description of services that may be needed for follow-up.
- Ongoing participation in the planning of services and in the development and periodic revision of the treatment or service plan, including the right to an explanation of all aspects of one's own condition and treatment.
- Refuse services and/or treatment in accordance with State and Federal laws.
- Appeal adverse actions (delays, denials, reductions, suspensions, or terminations) of TennCare services (if you are TennCare eligible).
- Services and treatment under conditions that support your personal liberty, and restrict such liberty only as necessary, to comply with treatment needs, including the right to freedom from restraint or seclusion.
- Confidentiality of your records and protected health information.
- Review, upon request, your own records.
- Information regarding client's rights including a copy of this document and/or an explanation of client's rights in a language of your choice, to the extent possible, and access to an advocate to understand, exercise, and protect your rights.
- Assert complaints with respect to infringement of these rights, including the right to have such complaints considered in a fair, timely and impartial procedure. You may contact the DCS Customer Relations Unit at 1-800-861-1935 Monday through Friday between the hours of 8:00 a.m. – 4:00 p.m. CST, or by email at: DCS.Custsrv@tn.gov .

Your Responsibilities are:

- To provide all relevant information to DCS.
- Inform your Case Worker and court, if applicable, of any special needs. This includes current or chronic health conditions, information about school and education and any family customs or cultural practices important to your family or your child.
- Attend all Court hearings and team meetings.
- Cooperate with your Case Worker.
- Participate in developing your child's permanency plan.
- Participate in the services that are offered and work on your child's permanency plan, including all activities and services the Court may order you and other family members to complete.
- Attend health and medical appointments with your child when feasible. Consent to medical treatment for your child. Attend family therapy when prescribed and participate in your child's treatment plan.
- Stay in touch with your Case Worker. Be sure that the worker always has your current address and telephone number.
- Provide you child's Case Worker with information about your progress towards the goals stated in your child's permanency plan and any changes in your life.
- Visit and communicate with your child as agreed upon.
- Communicate any concerns that you have to the Case Worker or to your lawyer.
- Pay child support if ordered by the court.

Case Worker's Responsibilities

- Contact you for more information and to ask you some questions.
- Visit you and your child regularly.
- Help you understand the problems that brought you and your child to Court.
- Schedule a Child and Family Team Meeting (CFTM) to develop a plan which lists the steps you must take to have your child returned to you. This meeting should happen within thirty (30) days after your child is removed from you.
- Assist you in obtaining the services that are listed in the permanency plan. This is called **"reasonable efforts."** Reasonable efforts may include assisting you in obtaining counseling, parenting classes, transportation and/or other services that are necessary.
- Inform you of health and medical appointments and assist with attendance and transportation when feasible.

Resolution of Grievances

If you are dissatisfied with an action taken by DCS you should discuss the situation with your case worker. If the action is one taken by DCS pursuant to a court order or one which is the subject of pending judicial proceedings, DCS is obligated to follow the court's decision and cannot change the decision without going back to court. In such a situation, you should contact your attorney to discuss your concerns.

Grievances should first be addressed through the Child and Family Team Meeting (CFTM) process. If the issue cannot be resolved by through a CFTM, you can contact the DCS Customer Relations Hotline:

- By e-mail at DCS.Custserv@tn.gov,
- By phone at 1-800-861-1935, or
- By mail at Department of Children's Services

DCS Customer Relations
Unit 315 Deaderick St.
10th Floor, UBS Building
Nashville, TN 37243

A customer relations representative who has not been involved in your case can review your case and help work through grievances.

Indian Child Welfare Act (ICWA)

Indian tribes have jurisdiction over Indian child custody proceedings. If your child is either (a) a member of an Indian tribe, or (b) is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe, you must inform your DCS Case Worker.

Confidential Child Specific Information

All information created or collected, directly or indirectly, in any medium, which identifies you and/or your child, shall be kept confidential in order to protect your privacy, and will not be shared except as provided for by law. Child case files and related information are official records which have been designated as confidential by law.

Equal Access to Programs

You will receive notification of your right to equal access to services (Form ***Notification of Equal Access to Programs and Services and Grievance Procedures,*** CS-0158) and will be asked to sign a form indicating you received that notification. If you do not receive notification of your right to equal access, please notify your caseworker.

Child Abuse Hotline

At the Tennessee Department of Children's Services, we are serious about keeping kids safe.
We receive about 169,000 calls to our Child Abuse Hotline annually. *To report child abuse or neglect in Tennessee call the state* ***Child Abuse Hotline at 877-237-0004.*** *Reports also can be made online through a form our secure site (https://apps.tn.gov/carat/).*

Our experienced staff members will guide Hot Line callers through a series of questions. It's OK if callers don't know all of the details. The staff uses the information you provide to determine the severity of the situation and how best to intervene.

Abuse and Neglect Allegations

The Department utilizes a Multiple Response System for allegations of child abuse and neglect. This approach assists the Department in:

- ensuring children are safe;
- working in partnership with parents to identify the family's strengths and needs; and
- asserting that families are the experts at solving their own problems.

The Multiple Response System begins when the Department receives an allegation of child abuse or neglect through the Child Abuse Hotline. Allegations may be received by way of telephone, fax, web, or in person. The Child Abuse Hotline guides concerned citizens through the referral process, gathering important information to assist in making a determination regarding DCS involvement. Possible levels of involvement include connecting families to resources, opening an assessment case, or opening an investigation.

What to Expect During an Investigation

If the allegation meets criteria for investigation, a Child Protection Services investigator will be assigned to investigate the allegation(s). This investigator will inform you of your rights and responsibilities, the allegation(s) being investigated, and outline investigative process. This process may involve the assistance of Child Advocacy Centers, Law Enforcement, Medical Personnel and/or Prosecutors to ensure the safety and wellbeing of your child.

At the onset of the investigation, the investigator will hold an initial interview with your child to determine their immediate safety. This interview will take place away from the alleged abuser either at home, school or in another safe location. Your consent is not required for an interview to take place.

During the initial interview the investigator may identify the need for a:

- Forensic Interview- a second interview which takes place at a Child Advocacy Center.
- Medical evaluation to assess any injuries.
- Mental health evaluation.

If any of the above services are needed, the investigator will accompany your child or follow up with you to ensure completion of the interview or evaluation(s). The investigator will consult with a DCS attorney to determine how to proceed if any of the above services are refused, which could lead to court involvement.

If during the investigation, the investigator determines there is no immediate risk of harm, your family may be offered services before the closure of the case. However, if the investigator determines there is an immediate risk of harm to your child, the investigator may:

- Engage you in a voluntary Immediate Protection Agreement, placing the child with a temporary caregiver; or
- Remove the child into the Department's custody.

If the investigator engages you in a voluntary Immediate Protection Agreement, you and the investigator will agree to who the temporary caregiver is and where the caregiver(s) and/or child will reside and any restrictions involving contact with the caregiver or others. In addition to these agreements, a Family Permanency Plan will be developed. The Family Permanency Plan outlines the actions to be completed by the child, caregiver(s), and/or the investigator prior to the child returning home and/or the closing of the investigation.

In addition to interviewing your child and determining their immediate safety needs, the investigator will:

- Interview the alleged abuser;
- Interview anyone who may be able to provide additional information about the abuse;
- Interview you and other caregivers in the home;
- Interview siblings, if applicable;
- Make a visit to your home; and
- Make a visit to the location where the abuse occurred, if it differs from the home.

After all interviews are conducted and other evidence is collected, the investigator will evaluate the information and make a determination to substantiate or unsubstantiate the allegations. This process is called classifying the case. A classification of substantiated means there was enough evidence to say the child was abused or neglected. If the classification is unsubstantiated, this means there was not enough evidence to say the child was abused or neglected.

In addition to determining the classification, the investigator may also recommend or require services for the family prior to closing the case.

Appeal Rights

For CPS Investigations, if the alleged abuser is substantiated they will receive a letter notifying him or her of the substantiation and their appeal rights. The abuser has the right to request a review of the substantiation by the DCS Commissioner, or designee. This review will determine if the investigation was properly classified. Written notice of the request for review must be received by the Commissioner, or designee, within twenty (20) business days of the date noted on the letter.

What to Expect During an Assessment Case

If the allegation meets criteria for and Assessment case, a Child Protection Services Assessment worker will be assigned to work with your family. This Assessment worker will inform you of your rights and responsibilities, the allegation(s) that brought your family to the attention of DCS, and outline the service delivery process. This process may involve the assistance of Child Advocacy Centers, Law Enforcement, Medical Personnel and/or Prosecutors to ensure the safety and wellbeing of your child.

At the onset of the Assessment case, the Assessment worker will hold an initial interview with your child to determine their immediate safety. This interview will take place away from the alleged abuser either at home, school or in another safe location. Your consent is not required for an interview to take place.

In addition to interviewing your child and determining their immediate safety needs, the Assessment worker will:

- Interview the alleged abuser;
- Interview anyone who may be able to provide additional information about the abuse;
- Interview you and other caregivers in the home;
- Interview siblings, if applicable;
- Make a visit to your home; and
- Make a visit to the location where the abuse occurred, if it differs from the home.

If during the case, the Assessment worker determines there is no immediate risk of harm, but that services may benefit your family before the closure of the case. In this case, the Assessment worker will work with you and your family to identify the supports and services needed to eliminate the concerns and potential safety risks to your child.

After all interviews are conducted and other evidence is collected, the Assessment worker will evaluate the information and make a determination to classify the allegations as 1) No Services Needed, 2) Services Recommended or 3) Services Required. A classification of Services Required means there was enough evidence to say the child was at risk. At this point, the family must comply with services, or the department can seek a court order to ensure the services are completed. If the services were recommended, then the family can choose whether or not they wish to accept services and support from DCS.

However, if the Assessment worker determines there is an immediate risk of harm to your child, the Assessment worker may:

- Engage you in a voluntary Immediate Protection Agreement, placing the child with a temporary caregiver of your choosing; or
- Remove the child into the Department's custody.

Non-Custodial Interventions

Family Crisis Intervention Program (FCIP) and Family Support Services (FSS)

A **Family Crisis Intervention Program** (FCIP) is a brief intervention with families who have unruly children at risk for state custody. The intervention is designed to help the family and child through the present crisis period so they can access less intrusive community services without requiring further Court intervention and/or custodial care from the Department of Children's Services.

A **Family Support Services** (FSS) case is one that is transferred to a social services case worker after Child Protective Services has determined there is a need for ongoing services with the family that would extend beyond CPS's limited timeframes.

Juvenile Probation

Juvenile probation is court-ordered and includes supervision of the youth and treatment services to address the problems the youth is encountering. Probation may be used at the "front end" of the juvenile justice system for first-time, low-risk offenders or at the "back end" as an alternative to institutional confinement for more serious offenders. In some cases probation may be voluntary, in which the youth agrees to comply with a period of informal probation in lieu of formal adjudication. More often, once adjudicated and formally ordered to a term of probation, the juvenile must submit to the probation conditions established by the court. Among the services provided, youth on probation can expect to follow a curfew, announced and unannounced home and school visits from the DCS worker, as well as random drug screening when applicable.

If Your Child Enters DCS Custody

There are three (3) main paths to state custody called a "committal status" under which a child can be placed into the legal and physical custody of DCS:

- If the child is found to be **neglected or abused**;
- If the child is found to be **delinquent**, also referred to as a juvenile justice child who has been found by the Court to have committed an offense which would be considered a crime if it had been committed by an adult; or
- The child is **unruly**, which refers to a child who is in need of treatment or rehabilitation and who habitually, and without justification, is truant from school; is habitually disobedient to the degree that his or her health and safety is endangered; and/or is a runaway.

The protocols set out here apply to all children committed to DCS, no matter their committal status.

If your child has been committed to the department, DCS will be completing various assessments on your child to identify the areas that the child and the family need to address in order to obtain permanency for your child. DCS honors your role as parent and will make every effort to involve you in the decision making process involving the care of your child. You can expect the following to occur during your child's placement with the department:

The intake process usually occurs in Court following the Judge's decision. Basic information will be gathered such as family information, address and telephone numbers. You will be asked to sign releases of information to enable DCS to obtain items such as school records, medical records, insurance or TennCare information. DCS will request that you provide basic health information about your child and provide a copy of your child's Social Security card and health insurance card.

A home visit will be scheduled. The purpose of the home visit is to obtain information for the functional assessment of the child and family. You can expect this visit to last approximately one (1) hour and at least one (1) parent or guardian needs to be present.

An initial child and family team meeting (CFTM) will be held (within 7 days of commitment) and will include the parents and/or guardians, DCS staff, the child, attorneys and any others who may have a significant influence in the child's life. Within thirty (30) days, an initial permanency planning CFTM will be held. In this meeting, concerns, risks, and goals for the child and/or family will be identified and a permanency plan created. Everyone's responsibilities will be outlined in that document. The responsibilities will be reasonably related to the goal, to remedy the conditions which necessitated foster care, and must be in the best interests of the child. The plan will then be sent to the Court for ratification and will then become a legal document.

The DCS Case Worker will maintain contact with you to ensure all needs are being met. Either the Court or a Foster Care review board will review your child's case at least every six (6) months.

Your child will be released from custody when ordered by the Court. The release date depends on the circumstances at the home that the child will be returning to and progress of the parents or guardians toward their plan.

Foster Care

When children are not able to stay safely in their own homes and there isn't a relative who can take them in, they often have to come into state custody.

In Tennessee, we place a strong emphasis on keeping children in a family-like setting. The Tennessee Department of Children's Services strives to keep sibling groups together and our staff does everything it can to keep kids as close to their home communities as possible.

DCS recruits foster families, who we call Resource Parents, to provide safe and supportive homes in which the children's emotional, physical and social needs can be met.
Foster care is a temporary service until the family and in some cases, the child, can address the problems which made placement necessary.

When parents cannot, or will not, make their home safe for the child's return, other permanent options are sought. These include adoption or, for older youth, independent living arrangements.

Kinship Foster Care

We at DCS believe strongly that children who must leave their homes do the best when they are able to live with people they already know or have an established relationship or connection. Kinship care refers to cases in which the children are placed in the legal custody of the State by a judge, and DCS then places the children with grandparents or other kin (strong relationship, not necessarily relatives).

In these situations, DCS, acting on behalf of the State, has legal custody and must answer to the court, but the kin have physical custody. DCS, in collaboration with the family, makes the legal decisions about the children, including deciding where they live. DCS is also responsible for ensuring that the children receive medical care and attend school. If the court has approved visitation with parents, DCS is responsible for making sure that the visits occur between parents and children. In kinship care, the child's relative caregivers have rights and responsibilities similar to those of nonrelative foster parents.

All relative caregivers must complete Foster Parent training (PATH) and the home study process within 120 days of a child/children being placed in their home. It is only after this training is complete that DCS can provide regular financial support through foster care board contracts.

Juvenile Justice

In Tennessee, young people who are adjudicated delinquent after breaking the law are placed with DCS. Many of them have been victims of trauma, abuse and neglect themselves. DCS offers a range of mental-health services, treatment programs, in addition to highly effective educational programs and vocational training.

DCS is required to place these youth in the least restrictive setting possible. Many of our students participate in programs that are operated by our network of private providers. These populations of young people often have mental-health issues and substance-abuse problems that department staff and providers work to address.

Those with more serious crimes on their records — generally at least two felonies or crimes against a person — are housed at one of our secure-care facilities. Tennessee operates three youth development centers (YDC). They operate as year-round schools and offer a wide range of case management and therapeutic services, but unlike other schools, they are hardware-secure facilities. The students' movements are largely managed by children's services officers, and the grounds are surrounded by tall anti-climb fences.

If a youth's behavior becomes out of control at the YDC and he is at risk of harming himself or others, staff may use Restrictive Behavior Management techniques to protect the youth and others from harm. Restrictive Behavior Management includes methods such as physical restraint, handcuffs, leg shackles, or placing a youth in confinement. These methods are only used in emergency situations. As soon as the youth calms down and is no longer a threat to himself or others, he will be released from confinement and/or the restraints. You will be notified within 24 hours if any of these methods are used with your child.

It is DCS's job to try to get these young people back on track. Each student has a case worker who follows his or her progress. Regular child and family team meetings are held so that parents and guardians can discuss concerns and monitor a student's progress.

Often, these students are far behind their peers in school. Our education specialists determine each student's needs and get them back on track for educational success.

Permanency Planning

Permanency plans are created to ensure that you and your child's needs are met while he or she is temporarily in the custody of DCS and that he or she is safely and permanently placed back in the care of a family/relative/kin in a timely manner. The plan shall include all necessary actions to be completed by the parents, child and/or DCS to facilitate the child achieving his or her permanency goal.

Permanency plans will be developed during a CFTM and, to the extent possible, will reflect the consensus of the meeting's participants while still meeting DCS' responsibility to ensure safety, permanency and well-being for your child.

Unless parental rights have been terminated, all known parents, including legal, biological, and alleged fathers shall be included in the permanency planning process. Your child's participation will be requested if he or she is 6-years-old and capable and required at age 12 and older.

You may identify and invite outside resources, such as extended family members or other support persons, to help develop the plan and to and support you throughout your involvement with DCS.

If your child will temporarily live in a foster home, or receives residential treatment, this will be discussed and determined at the CFTM. You will be a part of this decision making process.

If your child is on TennCare you have a right to appeal decisions made about TennCare funded services provided by DCS. You will be provided a notice of appeal rights, called a *Notice of Action*, and a TennCare Medical Appeal form at the CFTM. The permanency plan can be revised when new issues that hinder accomplishment of the permanency goal arise, when there is a change in the time frame for meeting the goals, or when there is a need for changes in services or treatment for you or your child, but never less often than annually. The permanency plan can also be revised when accomplishments and successes are occurring that will aid in achieving permanency sooner. A Permanency Plan review Child and Family Team Meeting should occur at least every three months.
The permanency plan must be approved by the Juvenile Court.

If you do not agree with the plan or the revised plan, you have the right to present your concerns at the court during the hearing for approval of the plan.

Informed Consent

As indicated in the parent responsibilities section, a child's parent, unless or until parental rights are terminated, has the legal right and responsibility to consent to medical treatment for his/her child in most circumstances. DCS will have the child's parent sign an Authorization for Routine Health Services for Minors form at the time the child enters state custody or no later than the initial CFTM. The form allows for the child to receive general medical treatment and Early Periodic Screening, Diagnosis and Treatment (EPSD&T) and follow-up. DCS is authorized by virtue of the Court's order granting DCS legal custody to consent to ordinary and/or necessary medical care and/or treatment and may provide consent without parental permission if absolutely necessary. Further treatment or psychotropic medication require a separate informed consent once the parent or legal guardian have received sufficient information about the risks and benefits of taking and not taking a prescribed or recommended treatment by the health care provider.

If the parent refuses to consent to medical treatment or procedures, DCS will consult with the prescribing health care provider. If it is determined that the treatment is "ordinary and necessary" to protect the child from harm and receiving the treatment is in the best interest of the child, DCS will give consent for the treatment. If the treatment is determined to be necessary but beyond the scope of authority outlined by the Court then DCS will ask the Court to decide what should be done.

Tennessee law presumes that a child age fourteen (14) and older has the maturity to consent to medical treatment, but it must be determined on a case-by-case basis by the prescribing health care provider. Because of that presumption, some providers may require both parental consent and the consent of the older minor.

The decision by a mature fourteen (14) year old or older child to refuse medical treatment or tests shall not be overridden by DCS or a parent giving consent for refused treatment if the provider has determined the child is mature enough to make the decision.

Children with serious emotional disturbances or mental illness who are sixteen (16) years old or older have the same rights as adults with respect to outpatient and inpatient mental health treatment, medication decisions, confidential information and participation in conflict resolution procedures.

If a child fourteen (14) years old or older refuses to consent to medical treatment or procedures, DCS will consult with the prescribing health care provider. If it is determined that the treatment is necessary to protect the child from harm and having the treatment is in the best interest of the child, DCS will ask the Court to decide what should be done. .

Your child has the right to practice the religion of his or her choice within reason and will be provided opportunities to do so.

Behavior Management and Restrictive Interventions for Children in Custody

DCS requires that all DCS staff and all facilities serving children in state custody use positive behavior management techniques that provide positive incentives for good behavior and minimize reliance on intrusive and restrictive disciplinary measures. DCS policy prohibits the use of any form of corporal punishment on any child in custody.

DCS seeks to prevent and eliminate the use of physical restraint and to protect the child/youth's health and safety while preserving his or her dignity. Restrictive interventions such as physical restraint will be used only in circumstances in which a child or youth poses an imminent risk of harm to self or others.

Restrictive interventions will never be used as a means of punishment, discipline, coercion, and absence of treatment or programming, or due to staff convenience or retaliation by staff.

TennCare Appeals

If your child needs a health screening, or a prescribed health service, and there is a delay, denial, reduction, termination or suspension of that service, you have the right to file an appeal regarding this determination (adverse action). DCS Case Workers and DCS Child Health staff will assist you in accessing TennCare services for your child and in filing an appeal if there is an adverse action.

As indicated above, if DCS is responsible to provide a TennCare funded placement service, you have the right to appeal that determination (adverse action). If a placement decision is made involving a TennCare funded placement, a Notice of Action and TennCare Medical Appeal form will be provided at the CFTM or mailed to you if you did not attend the CFTM.

Credit Checks & Independent Living

All youth who enter custody and are 14+ years of age will have an annual credit history check completed on Transunion, Experian and Equifax to address any inaccuracies in their credit report. Youth will be engaged in this process in order to learn valuable independent living skills regarding credit and credit reporting. If any inaccuracies are found in your child's credit report, your case worker will be sure to address those with you.

Termination of Parental Rights: Voluntary & Involuntary

You may voluntarily surrender your parental rights by appearing before the Judge of Chancery, Circuit or Juvenile Court and signing a voluntary surrender form. If you decide that you would like to surrender your rights, you should discuss it with your Family Service

Worker. DCS can refuse to accept the surrender of a child. Birth parents can access counseling and legal assistance if they are considering surrendering their parental rights. Please contact your Family Service Worker for more information.

Parental rights may be terminated involuntarily if the Judge of a Chancery, Circuit or Juvenile Court finds on the basis of a petition alleging that statutory grounds for termination have been established and that termination is in the child's best interest. You will be appointed an attorney to represent you in the court proceedings, if the Court determines you cannot afford to hire your own attorney. Conditions that can justify termination of parental rights against a parent include: abandonment, wanton disregard, lack of concern, substantial non-compliance with the permanency plan, conditions which led to removal have not been remedied or other conditions prevent return, severe child abuse, ten-year prison sentence and/or mental incompetence. Birth parents can request a referral for counseling and support to cope with voluntary and involuntary termination of parental rights, grief, separation, loss, and the life-long implication of placing a child for adoption when appropriate.

If a parent's parental rights have been terminated (either voluntarily or involuntarily), it means that the parents are no longer legally responsible for that child. He and/or she cannot make medical, educational, or any other type of decisions regarding the care of the child. The parent will not be notified of any future legal proceedings for the child. Once all parents' rights are terminated on a child, that child becomes eligible for adoption.

"Open adoption" typically refers to an adoption in which the birth parent maintains some legal rights to visit and obtain information about the child after the adoption is finalized. The State of Tennessee does **not** have an "open adoption". However, there are times when an adoptive parent is willing to work with the birth parent to maintain contact and/or visits. DCS can facilitate these conversations, but it is the decision of the adoptive parent whether contact with the birth parent is allowed.

In the State of Tennessee, birth parents have the following rights after their child has been adopted:

- Once an adopted child reaches the age of twenty-one (21), eligible parties (including birth parents) can request access to the child's adoption record if that child gives written consent. ***T.C.A. 36-1-127***.
- The state can release non-identifying information to a birth parent without the consent of the adopted child. ***T.C.A. 36-1-133***.
- The Contact Veto Registry is available to a parent that voluntarily surrenders their parental rights. This Registry allows parents, siblings, spouses, grandchildren and legal representatives of the adopted child to maintain a record of their contact information. If an adopted child wants to make contact with a person on the registry after they turn 21, they will have access to this information if they request it. ***T.C.A. 36-1-128*** through ***36-1-129***.

You may call 615-253-4676 and ask to speak with someone regarding the Contact Veto Registry.
You may also mail requests for information to:

Department of Children's Services
Attn: Access to Sealed Records
315 Deaderick St.
10th Floor UBS Building
Nashville, TN 37243

Once an adoption has been finalized, the foster care and adoption record is sealed and cannot be accessed except in the situation described above. Parents' confidentiality is maintained as described in the "Confidentiality" Section of this handbook.

Birth parents have the right to participate in the CFTM until their parental rights have been terminated. These meetings can include discussions regarding DCS plans on filing a petition to terminate a parent's rights, adoption placement, TPR process, assistance available to parents, the child's progress, and any other concerns. DCS encourages all parents to participate in CFTM's so they can provide input regarding their child.

When Your Child Exits Custody

If your child is returning to your care, you have the right to information about their reapplication for TennCare benefits, which can be done at your local Department of Human Services (DHS) office. You Family Service Worker should provide this information.

Glossary

Adjudication: The outcome of the Court's process to determine the validity of allegations made in a petition or complaint. The process consists of the presentation of witnesses and evidence by oral testimony or written statements, and arguments by counsel or the parties. The court decides the case based on the proof presented by the parties and their arguments. For example, the court determines whether or not a child is dependent and neglected and then makes a disposition of the child either immediately or at a later

date. (See Disposition Hearing).

Allegation: A charge or claim of fact in a report of child abuse or neglect or in a petition. It must be proven if the report or petition is to be found true. The abuse report lists specific events, injuries, or threats (such as cuts, bruises, welts, or medical neglect) referred to as the report allegations. The report also suggests the type of allegation (such as physical abuse, neglect, sexual abuse, or emotional abuse as an introduction to the report's specific allegations.

Child's Attorney: The attorney appointed by the Court, or retained by the child or his/her family to represent the wishes of the child. The child's attorney differs from the Guardian ad Litem in that the Guardian ad Litem represents the child's best interests to the Court even if the child's best interests differ from what the child wants. Under most circumstances when a child is alleged to be unruly or delinquent, that child is entitled to an attorney prior to adjudication and disposition as long as that constitutional right is not waived. However, in a dependent, neglected or abused allegation, a Guardian ad Litem must be appointed by the Court for that child.

Caretaker: Person responsible for a child's care, whether that person is a parent, legal guardian, or an adult temporarily in a parent's role, as in institutional or out-of-home settings.

Classification Staffing: A meeting called for the purpose of discussing diagnostic data, identifying problems and strengths, formulating recommendations and deciding a youth's placement.

Custody: The control of actual physical care of the child and includes the right and responsibility to provide for the physical, mental and morale well-being of the child TCA 37-1-102 (b) (8).

Child Support: Court ordered or voluntary money payments made to or on behalf of a child by the parent(s) (legal or natural parent(s) who admit(s) paternity). Child support paid while a child is in the custody of the Department of Children's Services may be used to reimburse the State for the child's board payment and other costs of care in compliance with applicable state and federal laws and regulations.

Disposition Hearing: A juvenile Court hearing during which arguments are made as to what should be done with a child already adjudicated to have been abused, neglected, unruly, or delinquent. This hearing is often combined with the adjudicatory hearing, but it may be scheduled up to 15 days later if the child is in custody (or 90 days if the child is not in custody). Further evidence is presented at this time to determine if the child will be placed in foster care, will remain in foster care or some other placement, or will remain with the parents.

Early Periodic, Screening, Diagnostic and Treatment Services (EPSD&T): A Medicaid entitlement program for children under the age of 21. In Tennessee, EPSD&T benefits are provided by TennCare, the State's Medicaid agency. EPSD&T includes periodic screenings to provide preventive (early) health care for children and youth, as well as any medically necessary care even if the service is something that would not be covered for an adult on TennCare.

Ex Parte Review: A chance for a Judge to hear only one party's side at that time. However, a Judge will set a later time for all parties to be included. While fairness and the law dictate that all sides get an equal hearing before a Judge, this isn't always possible. For example, if parents who pose a risk to a child are threatening to flee, a Judge may hold an ex parte review to hear Family Service Workers' concerns without alerting the people who are threatening to leave with the child.

Family Crisis Intervention Program (FCIP): A brief intervention with families who have unruly children at risk for state custody. The intervention is designed to help the family and child through the present crisis period so they can access less intrusive community services without requiring further Court intervention and/or custodial care from the Department of Children's Services. TCA 37-1-168

Foster Care Review Board (FCRB): An advisory body appointed by the Juvenile Court Judge, which reviews the status of each child's care in DCS custody at least once within the first ninety (90) days of initial placement and least every six (6) months thereafter.

Family Service Worker: A DCS employee responsible for providing case management services to children under the State's supervision, in State custody, or at risk of State custody and their families.

Guardian: Parents are natural guardians of a child. The Court may appoint a guardian for a child whose parent(s) is (are) deceased. The Court may give guardianship to DCS following a termination of parental rights. DCS may, pursuant to TCA, act as guardian when there is no natural guardian or when a minor has been abandoned. The guardian of a child, if appointed by the Court or if acting under statute, has all the duties of a parent to provide for the child's support, education, and medical care, subject only to the parent's, if any, remaining rights.

Guardian ad Litem (GAL): The attorney appointed to represent the best interests of the child in Court proceedings. The Guardian Ad Litem's role differs from that of an attorney for the child, in that the child's attorney is bound to do what the child, his client, directs, while the Guardian Ad Litem must represent the child's best interests to the Court, even if the child's best interests differ from what the child wants. The Guardian Ad Litem represents the child in litigation only but is not responsible for the child's care on a daily basis.

Group Home: A home operated by any person, agency, corporation, or institution or any group which receives 7 to 12 children under 17 years of age for full-time care outside their own homes in facilities owned or rented and operated by the organization.

Informed Consent: The agreement to treatment given after the patient, legal custodian, and/or legal guardian has received sufficient information about the risks and benefits of taking and not taking a prescribed or recommended treatment.

Interpreter: A person who translates orally for parties conversing in different languages.

Juvenile Court: A Court with jurisdiction under Tennessee statutes to hear and decide matters pertaining to children.

Permanency Planning: The process of intervention and decisive casework on the part of the case manager. Such intervention focuses on choosing the least restrictive permanent outcome for the child, i.e., return to parent, relative placement, adoption, independent living or permanent foster care, in a timely manner.

Petition: A formal written application to the Court requesting judicial action on a certain matter.

Reasonable Efforts: The department's obligation under state and federal law and as a part of sound casework practice, to attempt risk reduction services prior to removing children from their homes and subsequent to removal, to make it safe for the child to return home. If DCS must remove the child, the Court's disposition order must include documentation of the reasonable efforts that DCS exhausted in order to prevent foster care or to prove that services could not reasonably be expected to protect the child.

Magistrate: An attorney appointed by the Juvenile Court Judge to hear cases. A magistrate serves at the pleasure of the appointing Judge and has the same authority as the Juvenile Court Judge to issue any and all process. In the conduct of the proceedings, the magistrate has the powers of a trial Judge. Most findings made by a referee are appealable to the Juvenile Court Judge upon a motion by any party. For more specific information, see T.C.A. § 37-1-107.

Restitution: A legal action serving to make good of, or give back an equivalent for some injury or deed.

Staffing: A team composed of at least three (3) professional personnel and the youth who meet for the purpose of discussing diagnostic data, identifying problems and strengths, and formulating recommendations including the youth's placement(s).

Tennessee Department of Children's Services

Notification of Equal Access to Programs and Services and Grievance Procedures

Title VI of the Civil Rights Act of 1964 makes it illegal for people to be discriminated against on the basis of their race, color or national origin in all programs, benefits, and services provided by the Department of Children's Services (DCS) which receives Federal Financial Assistance. The Americans With Disabilities Act Amendment of 2008 (ADA) and the Rehabilitation Act of 1973 makes it illegal for people to be discriminated against on the basis of disability in all programs, benefits, and services provided by DCS that receives Federal Financial Assistance."

It is the policy of the State of Tennessee, Department of Children's Services, to ensure that all management staff, contractors, and service beneficiaries are aware of the provisions of Title VI of the Civil Rights Act of 1964 and the Americans With Disabilities Act Amendment of 2008 (ADA) as well as the Rehabilitation Act of 1973. If you feel that you have received disparate treatment based on race, color, national origin, disability or any other classification protected by Federal and/or Tennessee State Law, you are encouraged to file a complaint with the DCS Office Civil Rights. To file such complaint, you should do the following:

1. You must file a written complaint within one hundred-eighty (180) days to the date of the alleged discrimination. You are encouraged to file your complaint as soon as possible in order to allow sufficient time to file an appeal with an external agency if you are not satisfied with the results of the DCS investigation.
2. In your complaint, be sure to include your name, address, and telephone number.
3. The complaint should contain the name and address of the agency, institution, or department you believe discriminated against you.
4. Indicate how, why, and when you believe you were discriminated against. Include as much specific detailed information as possible about the alleged acts of discrimination and any other information that you deem relevant to your complaint.
5. If known, provide the names of any persons who the DCS Office of Civil Rights could contact for clarity regarding your allegations.
6. Please sign your written complaint and then submit it to:

Office of Civil Rights
Department of Children's Services
UBS Tower, 12th Floor
315 Deaderick Street
Nashville, TN 37243
Telephone: (615) 532-5552
Fax: (615) 532-7602

7. You may also file your complaint in writing to the offices listed below:

Director
Tennessee Human Rights Commission
Attention: Title VI Compliance
William R. Snodgrass Building/Tennessee Tower
312 Rosa L. Parks Blvd, 23rd Floor
Nashville, TN 37243
Telephone: (615) 741-5825
Fax: (615) 253-1886

or

Director
Office for Civil Rights
U.S. Department of Health & Human Services
61 Forsyth Street, S.W.
Suite 3B70
Atlanta, GA 30323
Telephone: (404) 562-7886
Fax: (404) 562-7881

You should file a complaint under this procedure if you feel you have been excluded from participation in, denied the benefit of a service or subjected to discrimination under a program or activity receiving federal financial assistance from the Department of Children's Services.

☐ I have read the above procedure of how to file a Title VI or ADA complaint. This procedure was explained to me in detail and a copy was issued to me for my records. I was advised that this form is available in other languages.

_____ _____
Signature *Date*

_____ _____

_____ _____
Witness *Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Child/Youth's Case File
Copy: Client

Tennessee Department of Children's Services
Notice of Privacy Practices

This notice is only for your information. You do not have to do anything with this information.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of This Notice: October 2, 2017

Information About Your Health is Confidential

The Department of Children's Services (DCS) is required by law to maintain the privacy of information about your health and your child's health. DCS is required to give you this notice which describes the rules of the privacy law that we must follow to keep information about you r health and your child's health confidential. These rules are subject to change by the federal government, and our Department is obligated and committed to tell you about any important changes which may be made in the future. DCS reserves the right to change its privacy practices described in this notice and apply those changes to any health information DCS maintains. We will give you a copy of any revised privacy notice while you are receiving services from DCS. DCS is required to follow the Privacy Notice currently in effect. DCS is required to notify you if there is a breach of your unsecured health information. Everyone who works with our Department must agree to keep health information private. The people who work with us include, but are not limited to:

- Department of Children's Services (DCS) employees
- Foster Parents
- DCS contract providers and their employees
- TennCare and TennCare health plans
- The State of Tennessee
- The Federal government
- Companies that have contracts with the State of Tennessee or the Federal government
- Health care providers, like a doctor or therapist

How DCS Uses Information About Your Health or Your Child's Health

When you and your child begin receiving services from DCS, we obtain health information about you and your child in order to provide those services. DCS is involved in providing services such as Family Support Services or Family Crisis Intervention for children who are not in DCS custody. DCS is also involved in providing court-

ordered probation and aftercare services. The health information that DCS obtains in providing these services may include things such as the need for counseling, therapy, or substance abuse treatment.

When a child comes into DCS custody, the court will give DCS the authority to consent to any necessary and routine medical care for that child. DCS may need to consent to medical care for a child in custody because the parent or legal guardian is not available or is unwilling to consent to medical care for the child. DCS needs as much information as possible about the child's health to make sure the child gets proper health care. This would include such things as:

- Notes or records from the child's doctor, drugstore, hospital or other health care providers
- Lists of illnesses the child and family members now have or have had before
- Lists of the medicines the child takes now or has taken before
- Results from x-rays and lab tests

DCS Shares Information About You and Your Child Only as the Law Allows

DCS would share information about you or your child to:

Make sure that you get the treatment you need;
Pay health care providers;
Check on our program to ensure you are receiving quality health care;
Help if anyone's health or safety is in danger;
Prove that your child is enrolled in TennCare with your child's doctors or other providers;
Check how health programs are working. Your information may help us find insurance fraud;
Report cases of abuse or neglect;
Tell you about appointments and other health information. We may send you or your child reminders for your child's check-ups. We may also send you information about health services that may be available to you;
Obey laws on workers' compensation.

DCS may share information about you and your child with:

Your family, foster families, or others who are involved in your child's care;
The Court when the law says we must or we are ordered to do so;
Schools or school nurses so they can treat your child or watch for any signs and symptoms of an illness or condition your child may have;
TennCare Consumer Advocates or attorneys who represent your child on a TennCare appeal or are trying to help your child access services;
Law enforcement;
Public health agencies to update records for births and deaths or to track diseases;
A coroner, funeral home, or people dealing with organ transplants;
Medical research organizations. They must keep information about you and your child private.

DCS may share information for research if we take out the identifying information that tell who you and your child are;

Government agencies involved in military and veteran's activities, national security activities or correctional institutions.

DCS May Need Written Approval to Share Private Health Information

When we need approval to share private health information, we must ask for it on a written authorization form. You can take back your approval at any time, but you must tell us in writing.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

See and get copies of your health records. If you want a copy, you must ask for it in writing. We may charge a fee for the cost of copying and mailing. DCS has the right to refuse to disclose certain information. If we cannot give you the information you want, we will send you a letter that tells you why.

Ask questions about how we share your health information or ask questions about the information in this notice.

Complain about how we share your health information. Please refer to the section in this notice entitled,

Contact DCS with Questions or Complaints Regarding Your Rights to Privacy.

Ask us to change health information that is wrong. You must ask us in writing. You must give us a reason why we need to change it. We may not be able to agree to the change. If we cannot make the change, we will send you a letter that tells you why.

Ask us for a list of who got your health information. The list will tell you who got your information. You must ask us in writing for a copy. The law says that we do not have to give you a list when:

- We have your written authorization to give out your health information;
- We use it to help you get health care;
- We use it to help with payment for your care;
- We use it to operate our programs.

Ask us not to share certain information about your health. You must ask us in writing. You must tell us what information you do not want shared, and with whom you do not want us to share that information. There may be some cases when we cannot agree to your request. If we cannot agree to your request, we will send you a letter that tells you why.

Take back your approval for us to share your health information. If we ask you to sign an authorization form, you can take it back at any time. You must do it in writing (to the

appropriate DCS office or facility that is maintaining your records). This will not change any information that we have already shared.

Ask us to contact you in a different way or at a different address. You must ask us in writing, and tell us why we need to change.

Ask for another copy of this notice or copies of any new notices.

The Rights Listed Above Apply to the Following Persons

Persons 18 years old or older and emancipated minors, regarding their own health information;

Persons 16 years old or older who have mental illness or serious emotional disturbance, regarding their own mental health information;

Persons who have the legal authority to make health care decisions for another individual, regarding the health information of the individual. Note*: The law defines this being someone's "personal representative". DCS will have to verify that you are authorized to be someone's personal representative. DCS may also decide to not treat you as the personal representative of someone with regard to their private health information, if we believe that you have abused, neglected, or subjected that person to domestic violence, that treating you as their personal representative could put that person in danger, and that it is not in the best interest of the person to treat you as their personal representative;*

Persons under the age of 18 in specific situations where they consent to treatment that does not require parental consent, or when the doctor has determined that the minor is mature enough to consent to treatment and the doctor does not require parental consent. In these situations, the minor has privacy rights about their own health information related to such treatment.

How to Contact DCS with Questions or Complaints Regarding Your Rights to Privacy

Do you have questions or a complaint about your right to privacy? You can send your question or complaint to one of the following offices below. Asking questions or making a complaint will not have any affect on the services that you or your child receives. Be sure to include in your letter the name, birth date and social security number of yourself, your child or the person you are representing and keep a copy for your records.

Send complaints or questions to:	You may also send complaints to:
Customer Relations Unit **Department of Children's Services** **315 Deaderick St., UBS Tower, 7th Floor** **Nashville, TN 37243-1290**	**Office for Civil Rights** **U.S. Department of Health and Human Service** **Atlanta Federal Center, Ste 3B70, 61 Forsyth Street, SW** **Atlanta, GA 30303-8909**

Toll free telephone number: 1-800-861-1935 **E-Mail: *DCS.Custsrv@tn.gov***	**Voice phone (404) 562-7886** **FAX (404) 562-7881** **TDD (404) 331-2867** **For complaints filed by email send to:** ***OCRComplaint@hhs.gov***

THIS NOTICE AND THE INFORMATION CONTAINED HEREIN DOES NOT APPLY TO THE RELEASE OF SEALED ADOPTION RECORDS, PURSUANT TO TENNESSEE CODE ANNOTATED, TITLE 36.

Tennessee Department of Children's Services

HIPAA Notice of Privacy Practices – Client Acknowledgement

The purpose of the *Notice of Privacy Practices* information that you have been given and asked to read is to inform you about the law protecting your health information and how the Department of Children's Services may use your health information.

This *Notice* describes your privacy rights regarding your health information and how you may exercise those rights. This *Notice* also gives you information about where to direct your questions or comments about the policies and procedures the Department of Children's Services uses to protect the confidentiality of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Client Acknowledgement

I have received the Department of Children's Services (DCS) *Notice of Privacy Practices*, which describes how DCS may use my health information, my rights to privacy regarding my health information, and how I can exercise those rights.

_____	_____
Signature - Client (or Personal Representative)	*Date*

Note: Department of Children's Services retains this signed page. The Client retains the Notice of Privacy Practices information attached.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO or FROM the Department of Children's Services and Notification of Release

A. AUTHORIZATION FOR RELEASE TO DCS

☐ I, _____ hereby authorize release of the information specified on page 2, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.

B. AUTHORIZATION FOR DCS TO RELEASE

☐ I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 2, to the person/entity specified on page 2.
I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

_____	_____	1/1
Authorizing Signature	*Print Name*	*Date*

_____	_____	1/1
Name of Client's Representative (Print)	*Signature of Client's Representative*	*Date*

Angelo Midgett	_____	1/1
Name of Witness (Print)	*Signature of Witness*	*Date*

Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Jones	Ariana		**5/15**	**111-11-1111**	F
Name*: (Last)*	*(First)*	*(Middle)*	*Date of Birth*	*Social Security*	*Gender*

Other Legal Names: _____ Address: _____ Place of Birth: Nashville, TN

_____	_____	_____	_____
Home Telephone No.	*Cellular Telephone*	*Work Telephone*	*Alternate Telephone*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Original Child's case File *RDA 2982*
CS-0559 Rev: 12/19

Type of Information Requested (check ONLY one):

1. ☐ Education records, including transcripts, GED, TCAP, Special Education
2. ☐ Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.
3. ☐ Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.
4. ☐ Background/Criminal History Checks, including Polygraph, and Fingerprint Results
5. ☐ Employment Records
6. ☐ Personal Finance/Credit History/Insurance Records (as applicable)
7. ☐ Other

Authorization Expires: **☐ in one year** **☐ in 90 days** **☐ On_____/_____/**
(Authorization not to exceed one year.)

Name of Provider/School/Entity <u>Releasing Info to DCS</u> or <u>Receiving info from DCS</u>:

Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ Arrange/Access Services ☐ CPS Investigation ☐ Juvenile Court Case
☐ Other: _____

		1/1
Authorizing Signature	*Print Name*	*Date*
		1/1
Name of Client's Representative (Print)	*Signature of Client's Representative*	*Date*
Angelo Midgett		1/1
Name of Witness (Print)	*Signature of Witness*	*Date*

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me. _____**
Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO or FROM the Department of Children's Services and Notification of Release

A. AUTHORIZATION FOR RELEASE TO DCS

☐ I, _____ hereby authorize release of the information specified on page 2, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.

B. AUTHORIZATION FOR DCS TO RELEASE

☐ I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 2, to the person/entity specified on page 2.

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

Authorizing Signature	*Print Name*	1/1 *Date*
Name of Client's Representative (Print)	*Signature of Client's Representative*	1/1 *Date*
Angelo Midgett *Name of Witness (Print)*	*Signature of Witness*	1/1 *Date*

Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Jones	Ariana		**5/15**	**111-11-1111**	F
Name*: (Last)*	*(First)*	*(Middle)*	*Date of Birth*	*Social Security*	*Gender*

Other Legal Names: _____ Address: _____ Place of Birth: Nashville, TN

Home Telephone No.	*Cellular Telephone*	*Work Telephone*	*Alternate Telephone*

Type of Information Requested (check ONLY one):

1. ☐ Education records, including transcripts, GED, TCAP, Special Education
2. ☐ Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.
3. ☐ Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.
4. ☐ Background/Criminal History Checks, including Polygraph, and Fingerprint Results
5. ☐ Employment Records
6. ☐ Personal Finance/Credit History/Insurance Records (as applicable)
7. ☐ Other

Authorization Expires: **☐ in one year** **☐ in 90 days** **☐ On_____/_____/**
(Authorization not to exceed one year.)

Name of Provider/School/Entity <u>Releasing Info to DCS</u> or <u>Receiving info from DCS</u>:

Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ Arrange/Access Services ☐ CPS Investigation ☐ Juvenile Court Case
☐ Other: _____

		1/1
Authorizing Signature	*Print Name*	*Date*
		1/1
Name of Client's Representative (Print)	*Signature of Client's Representative*	*Date*
Angelo Midgett		1/1
Name of Witness (Print)	*Signature of Witness*	*Date*

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me.** _____
Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

EDUCATION PASSPORT

COMPLETE THIS FORM FOR EACH NEW SCHOOL

The Education Passport is designed to compile needed school enrollment records in one location. All forms and documentation listed below should be kept with the passport. Information contained on this passport is subject to confidentiality laws.

PREPARED FOR NEW SCHOOL **ENROLLED DATE**

School

STUDENT'S INFORMATION

Child's Name Ariana **Jones**

Foster Parent Dan and Nancy

Address

City/ST/ZIP

Telephone ( ) -

MOTHER'S INFORMATION

Name Renee Williams

Address 243 Blythe Avenue

City/ST/ZIP Gallatin TN 37066

Telephone 615-555-1567

Parental Rights Terminated? ☐ **Yes** ☒ **No**

FATHER'S INFORMATION

Name Timmy Jones

Address Deceased

City/ST/ZIP

Telephone

Parental Rights Terminated? ☐ **Yes** ☐ **No**

FAMILY SERVICE WORKER'S INFORMATION

Name Sandra Littleton

Address

City/ST/ZIP

Telephone

Email

RECORDS CHECKLIST (REQUIRED)	Enclosed	Not Applicable
1. Immunization Records		
2. Most recent grade card with attendance data		
3. Current transcript (for high school students)		
4. Current IEP (if applicable)		
5. Current 504 Student Services Plan (if applicable)		
6. TEIS screening results and Family Services Plan (if applicable)		

ADDITIONAL SCHOOL ENROLLMENT INFORMATION	Yes	No
1. Has this student been officially withdrawn from previous school?		
2. Is this student currently suspended or expelled from public school?		
3. Are any medications needed during the school day?		
If yes, list :		

LIST THE MOST RECENT SCHOOLS THE STUDENT HAS ATTENDED

School System Name	School Name	Withdrawn Date
1. Gallatin, TN	Gallatin Middle School	
2.		
3.		

Child/Youth's Status: Check one box for each numbered item below.

1. ☐ School Age ☐ Under 3 yrs old ☐ Ages 3 to 5 (not in school) ☐ Ages 3 to 5 (receiving Sp. Ed)

2. ☐ Copy of H.S. Diploma enclosed ☐ Copy of GED/HiSET Enclosed ☐ Not Applicable
☐ Copy of other diploma enclosed (List type of diploma:)

Compiled by: Sandra Littleton **Date:** 1/1

Distribution: Child/Youth's File

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STATE OF TENNESSEE -- DEPARTMENT OF CHILDREN'S SERVICES
Division –UBS Tower 10th Floor, 315 Deaderick Street – Nashville TN 37243
Education
(615) 360-4350

CS-0657, Revised 01/17
RDA 10223

Tennessee Department of Children's Services

School Enrollment Letter

To: School Where Child is to Be Enrolled
Re: Ariana **Jones**
Date: **1/1**

Through an agreement with the Department of Children's Service (DCS), Ariana **Jones** has been placed in the custody of Foster parent(s) Name/Name of Contact and provider agency. This is your primary point of contact for routine education issues and for the daily support for this student.

Please assist us with enrolling Ariana in school. Attached to this letter are all the prior school records we have. Please send a record request to the last school for the official education records. Ariana last attended Gallatin Middle School Gallatin, TN .

I am the Family Service Worker for this child. Do not hesitate to notify me or my supervisor if you are unable to reach the primary contact(s) listed above. Please also notify me of any education matters concerning the child's well-being including disciplinary actions, special education meetings, health and behavioral concerns.

Please invite the parent/guardian(s) listed on the Education Passport to all special education meetings and also include:

	Name	Address	Phone	E-Mail
Family Service Worker:	Sandra Littleton			
Team Leader:				
Foster Parent Name:			( ) -	
Contract Name at Provider Agency:			( ) -	
Other Title			( ) -	

Thank you for your assistance,

Sandra Littleton

Distribution: Child/Youth's File

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CS-0657, Revised 01/17
RDA 10223

Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

I hereby authorize representatives of the Tennessee Department of Children's Services, to include only the Health Advocacy Unit, Fiscal Team, Child-Benefit workers and case managers with applicable authority, bearing this release, or a copy of same, to obtain ONLY confidential TennCare **eligibility** information from your files. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services within the scope of providing services to children.

I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information and that by signing this authorization only my eligibility status in TennCare will be released – no other TennCare records will be released for me. I can revoke my consent at any time. Should I choose to revoke this consent, I understand that the revocation must be in writing to be effective. I also understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization is valid until such request is fulfilled, but not to exceed one year from date of my signature. I understand that I may ask and receive a copy of this authorization. I hereby request and authorize the release of ONLY confidential TennCare **eligibility** information.

Identifying Information of Individual to Whom this Release Pertains:

Name: Last	**Jones**	**First**	Ariana	**Middle**	
Address					
City		**State**		**Zip Code**	
SSN	**111-11-1111**	**DOB**	**5/15**	**Place of Birth**	Nashville, TN ☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
This form is effective from:	**Date:** 1/1	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** 1/1

Signature of Authorized Representative*: _____

Witness: Angelo Midgett **Date:** 1/1

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person	Sandra Littleton	**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: Sandra Littleton **Date:** 1/1

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Child/Youth's Case File, Information Recipient

Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

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I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

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Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**	☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	
This form is effective from:	**Date:** 1/1	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** 1/1

Signature of Authorized Representative*: _____

Witness: Angelo Midgett **Date:** 1/1

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person	Sandra Littleton	**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: Sandra Littleton **Date:** 1/1

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Child/Youth's Case File, Information Recipient

Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

I hereby authorize representatives of the Tennessee Department of Children's Services, to include only the Health Advocacy Unit, Fiscal Team, Child-Benefit workers and case managers with applicable authority, bearing this release, or a copy of same, to obtain ONLY confidential TennCare **eligibility** information from your files. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services within the scope of providing services to children.

I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information and that by signing this authorization only my eligibility status in TennCare will be released – no other TennCare records will be released for me. I can revoke my consent at any time. Should I choose to revoke this consent, I understand that the revocation must be in writing to be effective. I also understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization is valid until such request is fulfilled, but not to exceed one year from date of my signature. I understand that I may ask and receive a copy of this authorization. I hereby request and authorize the release of ONLY confidential TennCare **eligibility** information.

Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**		☐ **Male** ☐ **Female**	
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	
This form is effective from:	**Date:** 1/1	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** 1/1

Signature of Authorized Representative*: _____

Witness: Angelo Midgett **Date:** 1/1

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

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☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person	Sandra Littleton	**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: Sandra Littleton **Date:** 1/1

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

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Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

I hereby authorize representatives of the Tennessee Department of Children's Services, to include only the Health Advocacy Unit, Fiscal Team, Child-Benefit workers and case managers with applicable authority, bearing this release, or a copy of same, to obtain ONLY confidential TennCare **eligibility** information from your files. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services within the scope of providing services to children.

I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

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Identifying Information of Individual to Whom this Release Pertains:

Name: Last	Williams	**First**	Renee	**Middle**	
Address	243 Blythe Avenue				
City	Gallatin	**State**	TN	**Zip Code**	37066
SSN	111-11-1111	**DOB**	3/15	**Place of Birth**	☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	615-555-1567
This form is effective from:	**Date:** 1/1	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** 1/1

Signature of Authorized Representative*: _____

Witness: Angelo Midgett **Date:** 1/1

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person	Sandra Littleton	**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: Sandra Littleton **Date:** 1/1

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

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Identifying Information of Individual to Whom this Release Pertains:

Name: Last	Jones	**First**	Timmy	**Middle**	
Address	Deceased				
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**	☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	
This form is effective from:	**Date:** 1/1	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** 1/1

Signature of Authorized Representative*: _____

Witness: Angelo Midgett **Date:** 1/1

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Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**		☐ **Male** ☐ **Female**	
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
This form is effective from:	**Date:** 1/1	**to**	**Date:**		

Date not to exceed one year from begin date.

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Witness: Angelo Midgett **Date:** 1/1

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Address							
City		**State**		**Zip Code**			
SSN		**DOB**		**Place of Birth**		☐ **Male** ☐ **Female**	
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -		
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Name: Last	**Williams**	**First**	**Justin**	**Middle**	
Address					
City		**State**		**Zip Code**	
SSN	**111-11-1111**	**DOB**	**8/11**	**Place of Birth**	**Nashville, TN** ☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
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Date not to exceed one year from begin date.

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Identifying Information of Individual to Whom this Release Pertains:

Name: Last	**Williams**	**First**	**Jewel**	**Middle**	
Address					
City		**State**		**Zip Code**	
SSN	**111-11-1111**	**DOB**	**7/19**	**Place of Birth**	**Nashville, TN** ☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
This form is effective from:	**Date:** 1/1	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** 1/1

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Witness: Angelo Midgett **Date:** 1/1

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Tennessee Department of Children's Services

Kinship Exception Request

PART 1---FAMILY INFORMATION

Date: **1/1** Family Case Name: Case #:

Child's Name	Date of Birth	Race	Sex	Special Needs
Ariana **Jones**	**5/15**	W	F	None
Jewell Williams	7/19	Bi	F	None
Justin Williams	8/11	Bi	M	None

PART 2---PARTIES RESPONSIBLE FOR COMPLETING KINSHIP EXCEPTION REQUEST

Requesting Case Manager:	Angelo Midgett	☐ CPS	☐ FSW
Region:	Mid Cumberland	County: Sumner	Sandra Littleton
Reviewing Team Leader/Team Coordinator:		Date Reviewed:	1/1

☒ KER APPROVED ☐ KER DENIED

Date consult note/form entered into TFACTS:				
Signature of KER Approver:			Date:	
Other Information/Regional Protocol Requirements:				

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution:

RDA 2982

Tennessee Department of Children's Services

Contact Sheets for Genogram

Child Name:	Ariana **Jones**	DOB:	**5/15**
Initiated by:	Angelo Midgett	Date:	**1/1**

Genogram

Parent Relationship	Name	Phone	Address	Diligent Search Searching, Notified, or N/A	Comments (Include dates of Marriages and Divorces)		
Birth Mother	Renee Williams	615-555-1567	243 Blythe Avenue Gallatin TN 37066				
Birth Father	Timmy Jones		Deceased				
Legal Parent							
Putative Father							
Other Parent							
Family Relationship	**Name**	**Phone**	**Address**	**Diligent Search Searching, Notified, or N/A**	**Placement Option? Permanent, Temporary, or Not Option**	**Barrier Code**	**Comments**
Step Mother							
Step Father							
Paramour	Frank Smith					1	
Maternal Grandmother							
Maternal Grandfather							
Maternal Aunt/Uncle							
Maternal Aunt/Uncle							
Maternal Aunt/Uncle							
Maternal Aunt/Uncle							
Maternal Cousin							

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Distribution:

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RDA 2982

Maternal Cousin							
Paternal Grandmother							
Paternal Grandfather							
Paternal Aunt/Uncle							
Paternal Aunt/Uncle							
Paternal Aunt/Uncle							
Paternal Aunt/Uncle							
Paternal Cousin							
Paternal Cousin							
Adult Sibling							
Adult Sibling							
Sibling's Parents							
Other Relatives	Russ Williams					20	

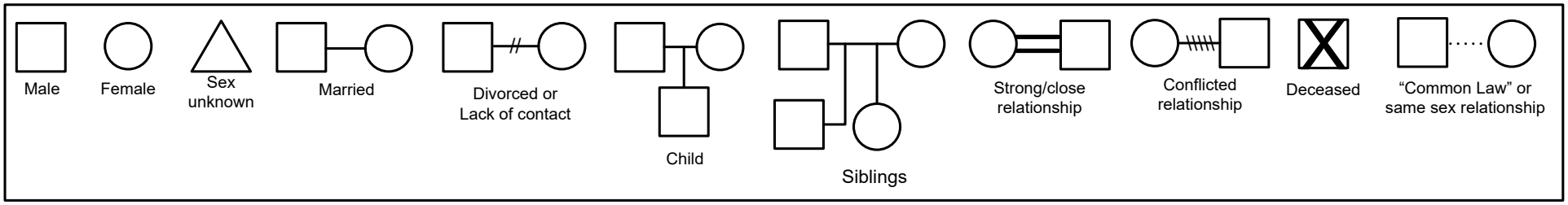
Barrier	Code	Barrier	Code	Barrier	Code
Removal Home/Failure to Protect	1	Failed Expedited Study (Policy 16.20)	9	Lives Out of State/Country	17
Domestic Violence	2	Inadequate Finances, Space, Housing	10	Undocumented Immigrant	18
Alleged Child Perpetrator	3	Lack of Transportation	11	Deported	19
Verified/Reported Sexual Offender	4	Serious Health/Mental Health Issue	12	Incarcerated	20
Failed Backgrond Checks	5	Unable to Provide Adequate Supervision	13	Unable to Locate	21
Unwaivable DCS/Criminal History	6	Under Age 18	14	Deceased	22
Court Order Restriction or Violation	7	Waivable DCS/Criminal History	15	Resource Unwilling	23
Failed Drug Screen/Abuse/Addiction	8	No Significant Relationship to Child	16	Other: Specify	24

Ecomap

Community Support	Name/Agency	Phone	Address	Contacts/Important People to child/youth/family	Dates Attended/Services Delivered
Neighbors					
Neighbors					
Neighbors					
Neighbors					
School Personnel					
School Personnel					
School Personnel					

School Personnel					
Church Friends					
Church Friends					
Church Friends					
Church Friends					
Community Friends					
Community Friends					
Community Friends					
Community Friends					
Others					
Others					

Genogram Drawing (Optional)



BlueCare Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bluecare.bcbst.com

SelectKids TennCare*Select*

IMMEDIATE ELIGIBILITY FORM

What Is the Purpose of This Form?
The purpose of this form is to determine whether a child entering the custody of Tennessee's Department of Children's Services (DCS) is eligible for immediate access to TennCare benefits. This form is to be filled out by a DCS Representative. It must be completed in full and faxed to: SelectKids Unit at 1-800-330-2842. Need help? Call 1-800-451-9147.

1/1

Date of DCS Custody: _____ ☐ YDC

PART 1: DCS Health Advocate Rep Information

Name: _____ Phone Number: _____

Fax Number: _____

Address: (Street/City/State/ZIP) _____

PART 2: Child/Applicant Information

111-11-1111

Social Security number: _____ Name: Ariana Jones

Primary Language English

Race:

☐ Black/African-American ☐ Alaskan Native ☐ Other Pacific Islander
☐ White ☐ Asian ☐ Decline
☐ American Indian ☐ Native Hawaiian ☐ Unavailable/Unknown

Is the child/applicant Hispanic/Latino? ☐ Yes ☐ No

Date of Birth: 5/15 Sex: ☐ Female ☐ Male

County of Commitment: _____ County of Placement: _____

PART 3: Immediate Needs (check all that apply)

☐ Pharmacy, lack of medication
☐ Durable medical equipment (wheelchair, C-Pap, etc.)
☐ Neonatal Abstinence Syndrome
☐ Physical therapies
☐ Member is at risk of harm to self or others
☐ Behavioral health services
☐ Member has been hospitalized within the last three (3) months
☐ Other (please specify)

Note: A TennCare*Select* Case Manager will call you to discuss the specific needs requested above.

PART 4: Provider and Other Insurance Information

Primary Care Provider of Choice: _____ Provider Number: _____

Other Insurance (besides TennCare): ☐ Yes ☐ No

Name of Insurance Carrier: _____ Effective Date: _____

Name of Policy Holder: _____ ID Number: _____

CERTIFICATION: *I certify that the information on this form is true and correct to the best knowledge of DCS. I understand that the eligibility must still be processed through the Child Benefit Worker. The Bureau of TennCare determines the eligibility.*

1/1

Signature: _____ Date: _____
(month/day/year)

**DCS stands for the Department of Children's Services* *+YDC stands for Youth Development Center*

17TCS104806 (2/17)

Family Advocacy Support Tool

FAMILY ADVOCACY AND SUPPORT TOOL					TENNESSEE VERSION 2.1
Case Name: **Williams**			Case Number:		
Assessor:			Date of Assessment:	m m d d y y	
Form Status:	Initial	Subsequent	Annual	Discharge	
Caregiver 1:	**Renee Williams (Mother)**		Youth 1:	**Ariana**	
Caregiver 2:	**Frank (Paramour)**		Youth 2:	**Jewell**	
Caregiver 3:			Youth 3:	**Justin**	
Caregiver 4:			Youth 4:		
			Youth 5:		
			Youth 6:		

THE FAMILY TOGETHER	Family					
Financial Resources	**1**					
Residential Stability	**0**					
Physical Condition of Home	**0**					
Home Maintenance	**0**					
Natural Supports	**1**					
Family Conflict	**2**					
Resiliency	**2**					
Family Safety	**3**					
CAREGIVER (Primary = 1)	Caregiver 1 (Mom)	Caregiver 2 (Frank)	Caregiver 3	Caregiver 4		
Adjustment to Traumatic Experiences	**1**	**0**				
Medical/Physical	**0**	**0**				
Developmental	**0**	**0**				
Mental Health	**1**	**2**				
Substance Use	**2**	**3**				
Criminal Activity	**3**	**0**				
Supervision	**2**	**2**				
Discipline	**0**	**1**				
Involvement in Care	**1**	**1**				
Knowledge of Family and Child Needs	**2**	**1**				
YOUTH (Score from oldest to youngest)	Youth 1	Youth 2	Youth 3	Youth 4	Youth 5	Youth 6
Sexual Abuse (if score 1-3, complete Trauma Exposure Module below)	**0**	**0**	**0**			
Physical Abuse	**0**	**0**	**0**			
Emotional Abuse	**1**	**0**	**0**			
Neglect	**2**	**2**	**2**			
Traumatic Grief	**1**	**0**	**0**			
Witness to Family, School, Community Violence	**2**	**0**	**0**			
Relationship with Primary Caregiver	**0**	**0**	**0**			
School	**0**	**N/A**	**N/A**			
Medical/Physical	**0**	**1**	**0**			
Developmental/Intellectual	**0**	**0**	**0**			
Mental Health	**0**	**0**	**0**			
Substance Use	**0**	**0**	**0**			
High Risk Behavior	**0**	**0**	**0**			
Runaway	**0**	**0**	**0**			
TRAUMA EXPOSURE MODULE	Youth 1	Youth 2	Youth 3	Youth 4	Youth 5	Youth 6
Commercial Sexual Exploitation (CSE)	**No**	**No**	**No**			

NOTE: All ratings are on a 4-point scale with the following action levels: '0' (no evidence of need or clear strength), '1' (history, suspicion of need; opportunity for strength building), '2' (action needed), '3' (disabling, dangerous, immediate action needed).

Initial Child and Adolescent Needs and Strengths

Child and Adolescent Needs and Strengths (CANS) Score Sheet								TENNESSEE VERSION
Child Name: Ariana Williams-Initial CANS	Caregiver (s) Renee Williams (Mother)							
Assessor:	Date of Assessment:	m	m	d	d	y	y	

CAREGIVER RESOURCES & NEEDS	Score
Adjustment to Trauma Experiences	1
Medical/Physical	0
Developmental	0
Mental Health	1
Substance Use	2
Parental Criminal Activity	3
Supervision	1/2
Discipline	1/2
Involvement in Caregiving Functions	1/2
Knowledge	1
Safety	3
Organization	1
Social Resources	1
Residential Stability	0
YOUTH TRAUMATIC EXPERIENCES	Score
Sexual Abuse	0
Physical Abuse	0
Emotional Abuse	1
Neglect	2
Medical Trauma	0
Witness to Family, Comm, School Violence	2
Natural or Manmade Disaster	0
War/Terrorism Affected	0
Victim/Witness to Criminal Activity	0
Disruptions in Caregiving/Attachment Losses	2
YOUTH STRENGTHS	Score
Family Strengths/Support	1
Interpersonal/Social Connectedness	1
Educational Setting	2
Vocational	3
Optimism	3
Talents and Interests	3
Spiritual/Religious	3
Cultural Identity	2
Community Life	2
Relationship Permanence	2
Resiliency	2
Natural Supports (excluding family)	2

YOUTH LIFE FUNCTIONING	Score
Family Functioning	2
Living Situation	0
Social Functioning	0
Developmental/Intellectual	0
Recreational	0
Legal	0
Medical/Physical	0
Sleep	0
Sexual Development	0
School Attendance	0
School Behavior	0
School Achievement	0
CULTURAL FACTORS	Score
Language	0
Traditions and Rituals	0
Cultural Stress	0
YOUTH BEHAVIORAL/EMOTIONAL NEEDS	Score
Psychosis (Thought Disorder)	0
Attention/Concentration	0
Impulsivity/Hyperactivity	0
Depression	1
Anxiety	1
Oppositional Behavior	0
Conduct	0
Substance Use	0
Attachment Difficulties	0
Eating Disturbances	0
Anger Control	0
YOUTH RISK BEHAVIORS	Score
Suicide Risk	0
Non-Suicidal Self-Injurious Behavior	0
Other Self-Harm (Recklessness)	0
Danger to Others	0
Runaway	0
Fire Setting	0
Sexually Reactive Behavior	0
Sexual Aggression	0
Delinquent Behavior	0
Decision-Making (Judgment)	0
Intentional Misbehavior	0
Bullying Others	0
Victimization/Exploitation	0

Needs:

0=no evidence
1=history, watch/prevent
2=recent, act
3=acute, act immediately

Strengths:

0=centerpiece
1=useful
2=identified
3=not yet identified

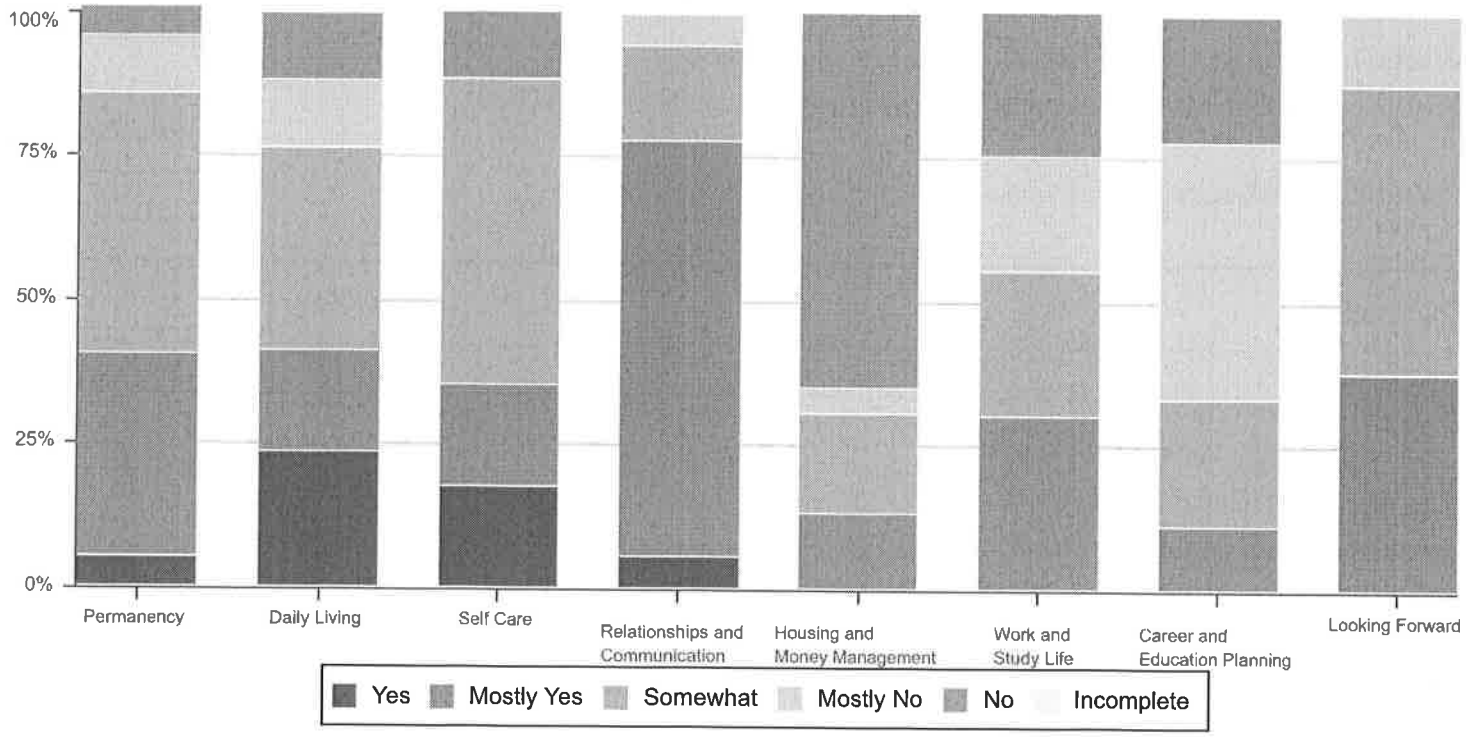
Life Skills Assessment

Casey Life Skills Assessment 11/03/2020

Ariana Jones (Y-1201288) DCS (P-95510)

Overall average **2.91**

	Yes	Mostly Yes	Somewhat	Mostly No	No	Incomplete
Permanency	5%	35%	45%	10%	5%	0%
Daily Living	23%	17%	35%	11%	11%	0%
Self Care	17%	17%	52%	0%	11%	0%
Relationships and Communication	5%	72%	16%	5%	0%	0%
Housing and Money Management	0%	13%	17%	4%	65%	0%
Work and Study Life	0%	30%	25%	20%	25%	0%
Career and Education Planning	0%	11%	22%	44%	22%	0%
Looking Forward	0%	37%	50%	12%	0%	0%



Permanency

Average **3.25**

STATEMENTS	RESPONSES
TN Dept. of Children's Services Ver. 20.11	93

STATEMENTS	RESPONSES
There is at least one adult I trust who would be legally allowed to make medical decisions for me and advocate for me if I was unable to speak for myself.	YES
I am a part of a family and we care about each other. I have friends or family to spend time with on holidays and special occasions. I know an adult who could be a grandparent, aunt or uncle to my children now or my future children. I know what my legal permanency goal is. I have information about my family members. I know an adult I can go to for financial advice. I have an adult in my life who cares about how I am doing at school or work.	MOSTLY YES
I know at least one adult, other than my worker, who would take my call in the middle of the night if I had an emergency. I have at least one trusted adult who would visit me if I were in the hospital. I can get in touch with at least one family member when I want to. I know at least one adult I can depend on when I exit care. I know an adult who would help me if I had a financial emergency. I know an adult I could live with for a few days or weeks if I needed to. There is at least one adult that I have regular contact with, other than my case manager or other professional, who lives in stable and safe housing. I know an adult who will go with me if I need to change schools. I have talked about my education plans with an adult who cares about me.	SOMEWHAT
An adult I trust, other than my worker, checks in with me regularly. I know an adult who will help me apply for training or education after high school	MOSTLY NO
I have recently talked to an adult who works in a job I would like to have.	NO

Daily Living

Average 3.29

STATEMENTS	RESPONSES
I know where to go to get on the Internet I can find what I need on the Internet. I know how to use my email account. I would not post pictures or messages if I thought it would hurt someone's feelings.	YES
If someone sent me messages online that made me feel bad or scared, I would know what to do or who to tell. I know how to do my own laundry. I keep my living space clean.	MOSTLY YES

STATEMENTS	RESPONSES
I can create, save, print and send computer documents. I know the risks of meeting someone in person that I met online. I know at least one adult, other than my worker, who would take my call in the middle of the night if I had an emergency. I can make meals with or without using a recipe. I think about what I eat and how it impacts my health. I know the products to use when cleaning the bathroom and kitchen.	SOMEWHAT
An adult I trust, other than my worker, checks in with me regularly. I understand how to read food product labels to see how much fat, sugar, salt, and calories the food has.	MOSTLY NO
When I shop for food, I take a list and I compare prices. I know how to use a fire extinguisher.	NO

Self Care

Average 3.29

STATEMENTS	RESPONSES
There is at least one adult I trust who would be legally allowed to make medical decisions for me and advocate for me if I was unable to speak for myself. I can turn down a sexual advance. I know how to prevent getting pregnant or getting someone else pregnant.	YES
I can take care of my own minor injuries and illnesses. I brush my teeth daily. I know how to get myself away from harmful situations.	MOSTLY YES
I can get medical and dental care when I need it. I know how to make my own medical and dental appointments. I know when I should go to the emergency room instead of the doctor's office. I know my family medical history. I have at least one trusted adult who would visit me if I were in the hospital. I bathe (wash up) daily. I have a place to go when I feel unsafe. I know ways to protect myself from sexually transmitted diseases (STDs). I know where to go to get information on sex or pregnancy.	SOMEWHAT
I know how to get health insurance when I am older than 18. I know how to get the benefits I am eligible for, such as Social Security, Medicaid, Temporary Assistance for Needy Families (TANF), and Education and Training Vouchers (ETV) .	NO

Relationships and Communication

Average 3.7

STATEMENTS	RESPONSES
I show others that I care about them.	YES
I can speak up for myself. I know how to act in social or professional situations. I know how to show respect to people with different beliefs, opinions, and cultures. I have friends I like to be with who help me feel valued and worthwhile. I am a part of a family and we care about each other. I have friends or family to spend time with on holidays and special occasions. I know an adult who could be a grandparent, aunt or uncle to my children now or my future children. My relationships are free from hitting, slapping, shoving, being made fun of, or name calling. I know the signs of an abusive relationship. I know what my legal permanency goal is. I have information about my family members. I think about how my choices impact others. I can deal with anger without hurting others or damaging things.	MOSTLY YES
I can describe my racial and ethnic identity. I can get in touch with at least one family member when I want to. I know at least one adult I can depend on when I exit care.	SOMEWHAT
I can explain the difference between sexual orientation and gender identity.	MOSTLY NO

Housing and Money Management

Average 1.78

STATEMENTS	RESPONSES
I know what can happen if I break my rental lease. I know an adult I can go to for financial advice. I know what happens in my state if I am caught driving without car insurance or a driver's license.	MOSTLY YES
I know an adult who would help me if I had a financial emergency. I know an adult I could live with for a few days or weeks if I needed to. There is at least one adult that I have regular contact with, other than my case manager or other professional, who lives in stable and safe housing. I know how to use public transportation to get where I need to go.	SOMEWHAT
I can explain why people need renter'□s or homeowner□'s insurance.	MOSTLY NO

STATEMENTS	RESPONSES
I understand how interest rates work on loans or credit purchases.	NO
I understand the disadvantages of making purchases with my credit card.	
I know the importance of a good credit score.	
I know how to balance my bank account.	
I put money in my savings account when I can.	
I use online banking to keep track of my money.	
I know the advantages and disadvantages of using a check cashing or payday loan store.	
I know how to find safe and affordable housing.	
I can figure out the costs to move to a new place, such as deposits, rents, utilities, and furniture.	
I know how to fill out an apartment rental application.	
I know how to get emergency help to pay for water, electricity, and gas bills.	
I plan for the expenses that I must pay each month.	
I keep records of the money I am paid and the bills I pay.	
I can explain how to get and renew a driver's license or state ID card.	
I can figure out all the costs of car ownership, such as registration, repairs, insurance, and gas.	

Work and Study Life

Average 2.6

STATEMENTS	RESPONSES
I have an adult in my life who cares about how I am doing at school or work.	MOSTLY YES
I can take criticism and direction at school or work without losing my temper.	
I know how to prepare for exams and/or presentations.	
I look over my work for mistakes.	
I get to school or work on time.	
I get my work done and turned in on time.	
I know what sexual harassment and discrimination are.	SOMEWHAT
I know the reasons why my personal contacts are important for finding a job.	
I know an adult who will go with me if I need to change schools.	
I know how to get help from my school's mental health services.	
I know where I can get tutoring or other help with school work.	
I know how to prepare for a job interview.	MOSTLY NO
I know what employee benefits are.	
I know how to get the documents I need for work, such as my Social Security card and birth certificate.	
I know how and when I can see my child welfare or juvenile justice records.	

STATEMENTS	RESPONSES
I know how to develop a resume. I know how to fill out a job application I know what the information on a pay stub means. I can fill out a W-4 payroll exemption form when I get a job. I know where I can get help with an income tax form.	NO

Career and Education Planning

Average 2.22

STATEMENTS	RESPONSES
I can explain the benefits of doing volunteer work.	MOSTLY YES
I know what type (college, trade school) education I need for the work I want to do. I have talked about my education plans with an adult who cares about me.	SOMEWHAT
I know where to find information about job training. I know how to get into the school, training, or job I want after high school. I know how to find financial aid to help pay for my education or training. I know an adult who will help me apply for training or education after high school	MOSTLY NO
I know how to find work-related internships. I have recently talked to an adult who works in a job I would like to have.	NO

Looking Forward

Average 3.25

STATEMENTS	RESPONSES
I believe I can influence how my life will turn out. I can describe my vision for myself as a successful adult. I believe my relationships with others will help me succeed.	MOSTLY YES
I have a good relationship with a trusted adult I like and respect. I feel I am ready for the next phase of my life. Most days, I am proud of the way I am living my life. Most days, I feel I have control of how my life will turn out.	SOMEWHAT
I would like to use my experience to help other youth.	MOSTLY NO

Updated Child and Adolescent Needs and Strengths

Child and Adolescent Needs and Strengths (CANS) Score Sheet							TENNESSEE VERSION
Child Name: Ariana Williams-Update CANS	Caregiver (s) Renee Williams (Mother)						
Assessor:	Date of Assessment:	m	m	d	d	y	y

CAREGIVER RESOURCES & NEEDS	Score
Adjustment to Trauma Experiences	1
Medical/Physical	0
Developmental	0
Mental Health	1
Substance Use	3
Parental Criminal Activity	2
Supervision	1/2
Discipline	1/2
Involvement in Caregiving Functions	2
Knowledge	0
Safety	2
Organization	1
Social Resources	0
Residential Stability	2
YOUTH TRAUMATIC EXPERIENCES	**Score**
Sexual Abuse	0
Physical Abuse	0
Emotional Abuse	1
Neglect	2
Medical Trauma	0
Witness to Family, Comm, School Violence	2
Natural or Manmade Disaster	0
War/Terrorism Affected	0
Victim/Witness to Criminal Activity	0
Disruptions in Caregiving/Attachment Losses	2
YOUTH STRENGTHS	**Score**
Family Strengths/Support	0
Interpersonal/Social Connectedness	1
Educational Setting	2
Vocational	3
Optimism	3
Talents and Interests	3
Spiritual/Religious	3
Cultural Identity	2
Community Life	2
Relationship Permanence	2
Resiliency	2
Natural Supports (mentor)	1

YOUTH LIFE FUNCTIONING	Score
Family Functioning	2
Living Situation	2
Social Functioning	2
Developmental/Intellectual	0
Recreational	1
Legal	2
Medical/Physical	0
Sleep	0
Sexual Development	0
School Attendance	0
School Behavior	2
School Achievement	0
CULTURAL FACTORS	**Score**
Language	0
Traditions and Rituals	0
Cultural Stress	0
YOUTH BEHAVIORAL/EMOTIONAL NEEDS	**Score**
Psychosis (Thought Disorder)	0
Attention/Concentration	0
Impulsivity/Hyperactivity	0
Depression	1
Anxiety	0
Oppositional Behavior	1
Conduct	0
Substance Use	0
Attachment Difficulties	0
Eating Disturbances	0
Anger Control	2
YOUTH RISK BEHAVIORS	**Score**
Suicide Risk	0
Non-Suicidal Self-Injurious Behavior	0
Other Self-Harm (Recklessness)	0
Danger to Others	0
Runaway	0
Fire Setting	0
Sexually Reactive Behavior	0
Sexual Aggression	0
Delinquent Behavior (probation)	2
Decision-Making (Judgment)	1
Intentional Misbehavior	1
Bullying Others	0
Victimization/Exploitation	0

Needs:

0=no evidence
1=history, watch/prevent
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Strengths:

0=centerpiece
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