

Report to the Court
Congregate Care Placement Recommendation

Child Name:

DOB:

Docket Number:

Hearing Type:

Hearing Date:

Permanency Goal:

Type of placement request:

Entering (has never lived in a Congregate Care Facility)

Re-entering (has previously lived in a Congregate Care Facility)

Transfer (moving from one Congregate Care to another Congregate Care)

Ongoing (remain in current Congregate Care Facility)

Current Placement:

Home

Kinship Care

Relative Care-Maternal

Relative Care-Paternal

Pre-Adoptive Home

**Kinship Non-Relative
Care**

Foster Care

Foster Home

**Pre-Adoptive Home
(Non-Kinship)**

**Supervised
Independent Living**

Congregate Care

Shelter Care

Group Home

Residential Facility

**Residential
Treatment Facility**

Hospitalization

**Medical Care
Facility**

**Psychiatric
Facility**

Reason for congregare care placement request (be specific regarding why this level of care is the best placement option):

Safety Threat(s) that prevents youth from being in home:

Community Services/Treatment provided prior to request being made (be specific):

Family finding (identify all efforts made to locate and involve family/kin in the child's network, the resolution of safety threats or general concerns):

Youth's opinion regarding proposed placement (use his/her words, if possible):

Mother's opinion regarding proposed placement (use her words, if possible):

Father's opinion regarding proposed placement (use his words, if possible):

Guardian's opinion regarding proposed placement (use his/her words, if possible):

Family Meeting: Was a family meeting held? Yes No

**If yes,
Date of Meeting:**

Attendees (name and relationship)

What was decided by the family (attach a copy of the family plan):

Previous Placements:

Placement:

Reason previous placement is not an option:

Kinship Placement Options Explored:

Name:	Relationship:	Reason unable to be placed:
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Proposed Placement Facility:

Reason this specific facility is being recommended:

Critical Incident History of this Facility (list all critical incidents, child line complaints, licensing violations and results of investigations within the past 2 years):

Above information proved by (facility staff person name/title/date):

Facility distance from youth's family/home county:

Services to be provided by the facility that cannot be provided in the community (be specific):

Service: _____ **Frequency:** _____ **Provider/Credentials:** _____

Counseling & Treatment Services to be provided (be specific):

Type: _____ **Frequency:** _____ **Duration:** _____ **Provider/Credentials:** _____

Trauma Treatment youth will receive:

Type: _____ **Frequency:** _____ **Duration:** _____ **Provider/Credentials:** _____

Medications: **None** **See attached** **See below (list medication name, dosage, purpose, side-effects)**

Visitation Plan (address mother, father, siblings, kin, friends, etc...)

Name/Relationship	Frequency	Location	Transportation Assistance Needed?
			Yes No
			If yes, how will transportation need be met?

Telephone Contact Plan:

Name/Relationship:

Frequency:

Duration:

Current Education Placement:

Grade Level:

Public School in community

Public School on facility grounds

Non-public School on facility grounds

Youth has GED or HS Diploma

Vocational Program/Higher Education

Other (explain):

Does child have an IEP or 504 Plan? If so, how will this plan be implemented in the placement setting?

Community Extra-Curricular activities in which youth will be involved (list specific activities not run by the provider, in which the youth will participate off campus grounds in each of the categories below...list activity and frequency):

Physical activities:

Social activities:

Arts

Other:

Special dietary needs of youth:

Other youth needs not addressed above (religious, cultural, language, etc.):

Discharge Plan (what needs to occur for youth to leave facility placement):

Recommended by:

Caseworker Name/Signature

Date

The above recommendation was reviewed and approved by:

CYS Agency Administrator/Designee

Date