

SAFETY ANALYSIS AND PLAN

Case Name	Case Number
Date of Safety Assessment and Plan	Worker Name

CHILD INFORMATION

Child Name	Date of Birth
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PARENT / CAREGIVER INFORMATION

Parental Role Name	Date of Birth
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A. Safety Threat Description

Specifically describe the family conditions that support the safety threats identified. If any evaluations such as psychological, medical or AODA evaluations are needed to understand the conditions that affect safety, describe those here.

B. Parent/Caregiver Protective Capacity

Can and will the non-maltreating parent or another adult in the home protect the child(ren)?

Yes
 No
 N/A

If you answered "Yes", describe how the parent's / caregiver's protective capacities can and will manage the identified safety threats. This justification demonstrates that the child is safe no further safety intervention is needed. If you answer "No", continue with analysis and plan.

C. Analysis

1. An In Home Safety Plan is necessary to ensure safety of the child(ren) and control threats which would otherwise result in imminent risk of placement.

Yes
 No

2. In-home services work for the family?

- No
 The parents are willing for services to be provided and will cooperate with service providers.
 The home environment is calm enough for services to be provided and for the service providers to be in the home safely.
 Safety services that control all of the conditions affecting safety can be put in place without the results of any scheduled evaluations.
 Parents / caretakers are residing in the home.

3. Safety Services

The Identified Safety Threat and the associated Safety Service / Action Type, Safety Service Provider and the specific identified the safety service / action and how it will control the threat identified are listed below:

Identified Safety Threat	Safety Service / Action Type	Safety Service Provider	Specifically explain the safety service / action and how it will control the threat identified

4. Can available resources keep the child(ren) safe in his / her home?

- Yes
 No
 All needed services / activities exist.
 All needed services / activities / providers are currently available at the level / time required.

D. Comments (Including Trial Reunification plan, if applicable, and any other pertinent information)

E. Signatures

SIGNATURE –Family Member

Date Signed

SIGNATURE –Family Member

Date Signed

SIGNATURE –Family Member

Date Signed

Name – Worker

SIGNATURE - Worker

Date Signed

Name - Supervisor

SIGNATURE - Supervisor

Date Signed