

# QUALITY SERVICE REVIEW PROTOCOL

Case Name	Case Number
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**GENERAL INFORMATION**

**Directions:** The general information section is to be completed by the current caseworker prior to the beginning of the Quality Service Review (QSR). Fully complete this section to the best of your ability. You may need the case file for some information. This general information section may be completed in a separate "advance packet" section and then supplied to the QSR reviewer.

**CHILD'S INFORMATION**

Name – Child's (Last, First, MI)		Birthdate	Age
Race	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity	
Address (Street, City, State, Zip Code)		Telephone Number	

**CHILD'S HOME AND PRIMARY CAREGIVER INFORMATION**

**Child's Family of Origin**

Name – Caregiver (Last, First, MI)	Relationship to Child
Address (Street, City, State, Zip Code)	
Telephone Number – Home	Telephone Number – Cell

Not applicable, if parental rights are terminated and parent-child connections are not being maintained.

**Child's Current Placement Situation**

<input type="checkbox"/> Birth home	<input type="checkbox"/> Adoptive home	<input type="checkbox"/> Foster Family Home
<input type="checkbox"/> Relative / Kinship home	<input type="checkbox"/> Licensed Relative Foster Home	<input type="checkbox"/> Treatment Foster Home
<input type="checkbox"/> Group home / congregate home	<input type="checkbox"/> Residential treatment center	<input type="checkbox"/> Independent Living
<input type="checkbox"/> Detention / shelter	<input type="checkbox"/> Hospital / MHI	<input type="checkbox"/> Juvenile correctional facility
<input type="checkbox"/> Other – Specify:		

Child placed out of home with siblings  
 N/A – birth home     Some     Contra indicated     None     No siblings

Status  
 Voluntary     JIPS     CHIPS     Delinquent     Other – Specify:

**Child's Current Placement if Different from Family of Origin**

Name – Out-of-Home Caregiver (Last, First, MI)	Relationship to Child
Address (Street, City, State, Zip Code)	
Telephone Number – Home	Telephone Number – Cell

<b>Household Composition</b>	<b>Out-of-Home Caregiver</b>
Name	Relationship to Child

**Reason for Case Opening** (Check all that apply)

<input type="checkbox"/> Child <input type="checkbox"/> Adoption disruption <input type="checkbox"/> Physical abuse	<b>Family Issues (if applicable)</b> <input type="checkbox"/> Failure to protect <input type="checkbox"/> Absent parent
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- Sexual abuse
- Neglect
- Mental health issues
- Delinquency
- Truancy / status offense
- Other – Specify:

- Substance abuse
- Domestic violence
- Neglect
- Mental health issues
- Housing
- Other – Specify:

**Permanency Goals**

Current Permanency Goal	Proposed Permanence Goal
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Yes  No Does child have a Concurrent Plan?

**OUT-OF-HOME PLACEMENT HISTORY**

Date – Placement	Type – Placement	Begin Date	End Date	End Reason
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**CHILD ABUSE AND NEGLECT HISTORY**

Date – CPS Report (5 most recent)	Allegation	Finding	Opened for Service <input type="checkbox"/> Yes <input type="checkbox"/> No
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**CURRENT DIAGNOSIS AND MEDICATIONS**

Current Diagnosis	Date – Diagnosis Made
Emotional / Behavioral Disorders	

**Other Diagnosis Requiring Services / Treatment**

- Asthma
- Diabetes
- Vision impairment
- Hearing impairment
- Other – Specify:
- Chronic illness
- Seizures
- Substance abuse
- Developmental / physical disability (Specify below)

**Medication(s) Currently Taking**

Name – Medication	Reason	Monitoring / Supervising Physician

**CHILD'S SCHOOL INFORMATION**

Current School Name – School	
Address – (Street, City, State, Zip Code)	Telephone Number
Name – Teacher	<input type="checkbox"/> Regular Education <input type="checkbox"/> Special Education <input type="checkbox"/> Other – Specify:
Grade Level	Reading Level
Usual School (If different from current)	Number of Retentions

Name – School

Address (Street, City, State, Zip Code)

Telephone Number

Name – Teacher

**Type of Current School Placement** (Check all that apply)

- Early intervention services (under age 5 years)
- Regular education with no modification
- Section 504 special accommodations
- Special education services
- Yes  No  N/A Current IEP in record
- Apprenticeship / vocational rehabilitation
- Hospital / home tutoring
- Home schooled
- Alternative school – Name:
- Residential treatment center campus school
- Youth is expelled from school
- Youth has graduated or completed program
- Youth has dropped out of school
- BED
- College / technical school
- Other – Specify:

**Anticipated Transitions, Changes and / or Adjustments Over the Next 180 days (6 months)** (Check all that apply)

- Next grade level – new school
- Return home
- Move to a less restrictive environment
- Foster home placement change
- Adoption
- Child to adult services
- School to work in an employment situation
- Other – Specify:
- Discharge from [redacted] / care case closure
- Transition to independent living
- Discharge from independent living
- Discharge from juvenile justice supervision
- Discharge from extended physical illness / hospitalization
- Acute to residential treatment
- Graduation to post secondary school

**GENERAL FAMILY INFORMATION**

**Family of Origin Household Composition – Adult(s) over 18**

Name	Relationship to Child	Age	Gender	Race
[redacted]	[redacted]	[redacted]	<input type="checkbox"/> M <input type="checkbox"/> F	[redacted]
[redacted]	[redacted]	[redacted]	<input type="checkbox"/> M <input type="checkbox"/> F	[redacted]
[redacted]	[redacted]	[redacted]	<input type="checkbox"/> M <input type="checkbox"/> F	[redacted]
[redacted]	[redacted]	[redacted]	<input type="checkbox"/> M <input type="checkbox"/> F	[redacted]

**Family of Origin Household Composition – Children**

Name	Relationship to Child	Age	Gender	Race
[redacted]	[redacted]	[redacted]	<input type="checkbox"/> M <input type="checkbox"/> F	[redacted]
[redacted]	[redacted]	[redacted]	<input type="checkbox"/> M <input type="checkbox"/> F	[redacted]
[redacted]	[redacted]	[redacted]	<input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	[redacted]

**Children in Out-of-Home Placement**

Name	Placed with Siblings	Placed in County
[redacted]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[redacted]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[redacted]	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[redacted]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Family's Living Arrangement**

- Owns home
- Rents home
- Rents apartment
- Shelter
- Homeless
- With another family
- Other – Specify:

**Family's Income and Economic Benefits**

- Does any family member receive:
- SSI / Social Security
  - Wage or salary from current employer
  - TANF months remain of eligibility
  - Food stamps
  - Unemployment compensation
  - Other – Specify:
  - Military benefits
  - Child support

**TRANSITIONS / FAMILY ADJUSTMENTS ISSUES**

**Transitions Being Addressed by the Family**

Check all that have occurred in the past 90 days (3 months) or are anticipated in next 180 days (6 months)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> New job or work schedule     | <input type="checkbox"/> New member or baby             | <input type="checkbox"/> New residence             | <input type="checkbox"/> School change / suspension |
| <input type="checkbox"/> Lay-off or job loss          | <input type="checkbox"/> Family member reunification    | <input type="checkbox"/> Loss of home              | <input type="checkbox"/> Change of custody          |
| <input type="checkbox"/> Loss of TANF benefits        | <input type="checkbox"/> Loss of family member / death  | <input type="checkbox"/> Serious illness or injury | <input type="checkbox"/> Divorce of birth parents   |
| <input type="checkbox"/> Serious mental health crisis | <input type="checkbox"/> Incarceration of family member | <input type="checkbox"/> Victim of serious crime   | <input type="checkbox"/> Victim of natural disaster |
| <input type="checkbox"/> Other – Specify:             |   |  |   |

**SERVICES AND SUPPORTS FOR THE CHILD AND / OR FAMILY**

Type of Service (Provided now or any time in the past 90 days)	Date Started	On-going	Needed / Not Received	Provider
Family preservation / intensive in-home services		<input type="checkbox"/>	<input type="checkbox"/>	
Parent training and support		<input type="checkbox"/>	<input type="checkbox"/>	
Child care / protective daycare / babysitting		<input type="checkbox"/>	<input type="checkbox"/>	
After-school care services		<input type="checkbox"/>	<input type="checkbox"/>	
Wrap-around mental health services		<input type="checkbox"/>	<input type="checkbox"/>	
Early childhood intervention services (0 – 5)		<input type="checkbox"/>	<input type="checkbox"/>	
Diagnosis and assessment		<input type="checkbox"/>	<input type="checkbox"/>	
Child safety monitoring		<input type="checkbox"/>	<input type="checkbox"/>	
Therapeutic counseling (child / parent / family)				
Hospital / MHI		<input type="checkbox"/>	<input type="checkbox"/>	
Sub-acute mental health treatment facility		<input type="checkbox"/>	<input type="checkbox"/>	
Juvenile court services / detention / institution		<input type="checkbox"/>	<input type="checkbox"/>	
Youth offender diversion program		<input type="checkbox"/>	<input type="checkbox"/>	
Independent living		<input type="checkbox"/>	<input type="checkbox"/>	
Foster family care		<input type="checkbox"/>	<input type="checkbox"/>	
Group home / shelter care home		<input type="checkbox"/>	<input type="checkbox"/>	
Kinship care / relative's home / alternate		<input type="checkbox"/>	<input type="checkbox"/>	
Mentor / one-to-one services		<input type="checkbox"/>	<input type="checkbox"/>	
Tutoring / homework help		<input type="checkbox"/>	<input type="checkbox"/>	
Domestic violence services		<input type="checkbox"/>	<input type="checkbox"/>	
Substance abuse services		<input type="checkbox"/>	<input type="checkbox"/>	
Medical care		<input type="checkbox"/>	<input type="checkbox"/>	
Emergency food / cash for food		<input type="checkbox"/>	<input type="checkbox"/>	
Transportation		<input type="checkbox"/>	<input type="checkbox"/>	
Utility payments		<input type="checkbox"/>	<input type="checkbox"/>	
Housing		<input type="checkbox"/>	<input type="checkbox"/>	
Special education instruction		<input type="checkbox"/>	<input type="checkbox"/>	
Homebound services		<input type="checkbox"/>	<input type="checkbox"/>	
Alternative education services		<input type="checkbox"/>	<input type="checkbox"/>	
Transition services		<input type="checkbox"/>	<input type="checkbox"/>	
Vocational training / placement		<input type="checkbox"/>	<input type="checkbox"/>	
Academic counseling		<input type="checkbox"/>	<input type="checkbox"/>	
Crisis stabilization services		<input type="checkbox"/>	<input type="checkbox"/>	
Medication management services		<input type="checkbox"/>	<input type="checkbox"/>	
Other – Specify:		<input type="checkbox"/>	<input type="checkbox"/>	

**CO-OCCURRING CONDITIONS**

**Identify the special needs or co-occurring conditions** (Check all that apply)

None	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Orthopedic impairment	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Autism Spectrum Disorder	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Physical disability	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Behavioral disorder (of a serious nature or degree)	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Developmental disability	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Sensory impairment: <input type="checkbox"/> Vision <input type="checkbox"/> Hearing	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Trauma victim	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Mental illness	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Suicide risk	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Cognitive disability: Full Scale IQ	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Pregnant	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Neurological impairment / seizure disorder / TBI	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Substance exposed	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Specific learning disability	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Substance abuse / addiction	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Degenerative disease	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	HIV / AIDS	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Chronic health impairment	<input checked="" type="checkbox"/> Child	<input checked="" type="checkbox"/> Parent	Medically fragile / complex	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Other – Specify	<input checked="" type="checkbox"/> Child	<input checked="" type="checkbox"/> Parent			

**Identify Any Substantial Functional Limitations** (Check all that apply)

Communication	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Mobility	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Economic self-sufficiency	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Self direction	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Self care	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Independent living	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
Other – Specify:	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	Diminished capacity	<input type="checkbox"/> Child	<input type="checkbox"/> Parent

**LEGAL STATUS OF THE REVIEW CHILD**

**Court Hearing Information**

<input checked="" type="checkbox"/> – Last 2 Judicial Hearings	Date – Last 2 Permanency Hearings	Next Court Date and Reason
		,
		,

**Legal Status**

<input type="checkbox"/> Case not court involved	<input type="checkbox"/> Transfer of legal custody	<input type="checkbox"/> Guardianship
<input type="checkbox"/> Court ordered services	<input type="checkbox"/> Voluntary services	<input type="checkbox"/> Protective supervision

**Adoptive Activity Towards Adoption**

Date TPR petition requested:

Date TPR petition filed:

Date TPR granted / voluntary:

Date TPR granted / involuntary:

Date petition for adoption filed:

**FREQUENCY OF WORKER VISITS**

Visits with the CHILD over the last 12 months have been:  Weekly  Monthly  Bi-weekly  Less than monthly

Visits with the MOTHER over the last 12 months have been:  Weekly  Monthly  Bi-weekly  Less than monthly

Visits with the FATHER over the last 12 months have been:  Weekly  Monthly  Bi-weekly  Less than monthly

**PERMANENCY / SERVICE PLANS**

– Most recent CHILD plan: \_\_\_\_\_ Date – Most recent FAMILY plan: \_\_\_\_\_

Yes  No Was there a case / family plan in place within 30 days of case opening?

Yes  No Was the service plan developed using a team meeting including the family?

Yes  No  N/A Are permanency plan evaluations being done within 180 days, or more often, if needed?

Yes  No  N/A Is a concurrent permanency goal in effect?

Yes  No  N/A Is a safety place in plan? Current with \_\_\_\_\_ months.

Yes  No  ICWA  N/A Are the plan's strategic goals related timelines, and current implementation status consistent with provisions of the ASFA?

What other agencies have plans for this child / family?

<input type="checkbox"/> Education: IEP	<input type="checkbox"/> Education: special accommodation(s)
<input type="checkbox"/> MH provider	<input type="checkbox"/> Early intervention IFSP
<input type="checkbox"/> Juvenile court / program	<input type="checkbox"/> Independent living programs
<input type="checkbox"/> Vocational rehabilitation	<input type="checkbox"/> Collaborative / community partners
<input type="checkbox"/> Substance abuse treatment plan	<input type="checkbox"/> Multidisciplinary team
<input type="checkbox"/> Family Safety Review Protocol	

Other – Specify:

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**CASEWORKER INFORMATION**

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How long have you been employed with the child welfare agency?

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How long have you been in your current position?

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How long have you been assigned to this case?

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How many caseworkers have been assigned to this case before you (if any)?

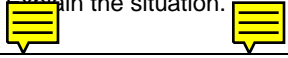
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How many open cases do you currently have? Out-of-home care: In-home: Investigation:

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From your perspective, are there any barriers or limitations that prevent you from providing good casework in this case?

Explain the situation.



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**SIGNATURE – Caseworker** \_\_\_\_\_ **Date Signed**

**CASEWORKER END HERE**



## REVIEWER'S ASSESSMENT OF THE CHILD'S GLOBAL ASSESSMENT OF FUNCTIONING

The level reported below represents the REVIEWER'S ASSESSMENT, based on interviews, records, and direct observation, when possible. The reviewer should consider the child's level of functioning reported at HOME, at SCHOOL, and PRESENT LEVEL ACROSS SETTINGS. Rate actual functioning regardless of treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular level of functioning. This scale applies to children age five years and older. Rely on interview results obtained from the parent / caregiver; teacher; service coordinator; service provider; and child, if age ten and older, in rating the child's general level of functioning.

- | <u>Level</u>             | <u>Levels of functioning to be used by the reviewer in determining the child's general level of functioning</u>  |
|--------------------------|--|
| <input type="checkbox"/> | <b>100 Superior functioning</b> in all areas (at home, at school, with peers, in the community); involved in a wide range of activities and has many interests (e.g. has hobbies, participates in extracurricular activities, belongs to an organized group such as the Scouts); likable, confident; "everyday" worries never get out of hand; doing well in school; getting along with others; behaving appropriately; no symptoms.   |
| <input type="checkbox"/> | <b>90 Good functioning</b> in all areas: secure in family, in school, and with peers; there may be transient difficulties but "everyday" worries never get out of hand (e.g., mild anxiety about an important exam; occasional "blow-ups" with siblings, parents / caregivers, or peers).  |
| <input type="checkbox"/> | <b>80 No more than slight impairment in functioning</b> at home, at school, with peers, and in the community; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental / caregiver separation, death, birth of a sibling), but these are brief and interference with functioning is transient; such youth are only minimally disturbing to others and are not considered deviant by those who know them.   |
| <input type="checkbox"/> | <b>70 Some difficulty in a single area, but generally functioning pretty well</b> (e.g., sporadic or isolated antisocial acts, such as occasional truancy or committing petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties that do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the youth well would not consider him / her deviant but those who know him / her well might express concern. |
| <input type="checkbox"/> | <b>60 Variable functioning with sporadic difficulties or symptoms in several but not all social areas;</b> disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the youth in other settings.   |
| <input type="checkbox"/> | <b>50 Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area,</b> such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.  |
| <input type="checkbox"/> | <b>40 Major impairment in functioning in several areas and unable to function in one of these areas;</b> i.e., disturbed at home, at school, with peers, or in society at large; e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either thought or mood disturbance, suicidal attempts with clear lethal intent. Such youth are likely to require special schooling and / or hospitalization (but this alone is not a sufficient criterion for inclusion in this category).             |
| <input type="checkbox"/> | <b>30 Unable to function in almost all areas,</b> e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).   |
| <input type="checkbox"/> | <b>20 Needs considerable supervision to prevent hurting self or others</b> (e.g., frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication (e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor).   |
| <input type="checkbox"/> | <b>10 Needs constant supervision (24-hour care)</b> due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.   |
| <input type="checkbox"/> | <b>0 N/A Not available or not applicable due to age of the young child.</b>  |