**REQUIRED CENTRAL STAFFING INFORMATION**

**Use of form:** This form is used to provide information so that placement decisions for children in need of out-of-home care placement can be made. Personally identifiable information is used only for that purpose. The Social Security Number is not mandatory, but may be needed to obtain a temporary medical card.

**Instructions:** A cover page summary describing the child and what the child’s needs are that may necessitate placement into a higher level of care must be attached.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name – Case Manager | | | | | | | | | | | | | | | | | | Region | | | | | | Telephone Number | |
| Name – Case Manager’s Supervisor | | | | | | | | | | | | | | | | | | | | | | | | Telephone Number | |
| Ongoing | | | IA | | | Other – Specify: | | | | |  | | | | | | | | | | | | | | |
| Date – Current Staffing | | | | | | | | | | | | | | | | | | Date – Central Staffing Form Completed | | | | | | | |
| Date – Internal Staffing Approval Signature From Program Manager | | | | | | | | | | | | | | | | | | Date – Target Date for Placement | | | | | | | |
| Provide statement of child’s needs and expected outcomes from higher level of care agency. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physical / Medical Information** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Child | | | | | | | | | | | | | | | | | | Birthdate | | | | Age | | Social Security Number | |
| Gender | | | | | | | | | Ethnicity | | | | | | | | | Height – Approximate | | | | | | Weight – Approximate | |
| Current Medication(s) and Dosage – Specify: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Prescribing Physician | | | | | | | | | | | | | | | | | | | | | | | | | |
| Significant Medical Conditions – Specify: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physical Limitations – Specify: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies – Specify: | | | | | | | | | | | | | | | | | | | | | | | Yes  No Child has Asthma | | |
| Name – Child’s Pediatrician | | | | | | | | | | | | | | | | | | Telephone Number | | | | | | Date – Last Physical Exam | |
| Yes  No | | | | Is child current on immunizations? | | | | | | | | | | | | If “No”, immunizations child needs – Specify: | | | | | | | | | |
| Date – TB test | | | | | | | Results of TB test | | | | | | | | | | | | | | | | | | |
| **Current Placement (Status)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Own home | | | | | Kinship relative | | | | | | | | Licensed relative | | | | | | | | | | | | |
| Foster care | | | | | Treatment foster care | | | | | | | | Hospital | | | | | | | | | | | | |
| Group care | | | | | RCCCY | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Name – Assessment center: | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Name – Stabilization center: | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Name – Assessment home: | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Name – Other – Specify: | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date – Placed in current placement: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Current placement: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address – Current placement: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone Number – Current placement: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| If child is not in own home, what date was the child removed from their home? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason child was removed from home – Specify: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date – Last CST: | | | | | | | | | | | | | | | Date – Next scheduled CST: | | | | | | | | | | |
| **Permanency Plan** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Return home | | | | | TPR / Adoption | | | | | Relative placement | | | | | | | Other – Specify: | | | | | | | | |
| Date – Last permanency plan review: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Decisions made at last permanency plan review: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child’s Legal Status** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family Case Number | | | | | | | | | | | | | | | | | | | | Child’s Court Number | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| CHIPS: Pending: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Current Order:       that expires on | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Name – Judge | | | | | | | | | | | | | | | | | | Next Court Date | | | | | Branch |
|  | | Name – District Attorney | | | | | | | | | | | | | | | | | | Name – Guardian ad Litem | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Delinquency: Pending: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Current Order:       that expires on | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Date – Next court appearance: | | | | | | | | | | | | | | | | | | | | | | | |
|  | | List offense(s): | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No  Don’t know Does the Indian Child Welfare Act (ICWA) apply? | | | | | | | | | | | | | | | | | | | | | | | | | |
| If “Yes”, what is the child’s tribal involvement? | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Placement History** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Indicate where and when the child was placed and why disruption occurred. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Foster Homes | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treatment Foster Homes | | | | | | | | | | | | | | | | | | | | | | | | | |
| Group Homes | | | | | | | | | | | | | | | | | | | | | | | | | |
| RCCCY | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inpatient Psychiatric Hospital | | | | | | | | | | | | | | | | | | | | | | | | | |
| Shelters / Assessment Centers / Stabilization Centers / Assessment Homes | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cognitive and Emotional Functioning** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No If child qualifies for SSI, has the child been referred? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe any intellectual and / or emotional challenges faced by this child and his / her caretakers; i.e., autistic / mentally ill / depressed / hyperactive / suicidal / self-mutilating / eneuretic and / or encopretic. | | | | | | | | | | | | | | | | | | | | | | | | | |
| List the strategies that have proven most helpful in meeting the child’s cognitive / emotional needs at home, school and in the community. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Behavioral Functioning** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe any behavioral challenges faced by this child and his / her caretakers; i.e., uncontrollable / runaway / verbally aggressive / physically aggressive / sexually active / AODA issues. | | | | | | | | | | | | | | | | | | | | | | | | | |
| List the strategies that have proven most helpful in meeting the child’s behavioral needs at home, school and in the community. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Academic Functioning** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Current School | | | | | | | | | | | | | | | | | | | | | Grade Level | | | | |
| Name(s) – Previous School(s) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No In exceptional education? | | | | | | | | | | | | | | | | | | | | | | | | | |
| CD  ED  LD  Other – Specify: | | | | | | | | | | | | | |  | | | | | | | | | | | |
| List any behavioral issues at school; i.e., underachieving / truant / disruptive / child being sent home a significant amount of time. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No Current IEP? | | | | | | | | | | | | | | | | | | | | | | | | | |
| If “No” provide explanation: | | | | | | | | | | | | | | | | | | | | | | | | | |
| List identified academic strengths, needs, and the strategies that have proven to be the most helpful in meeting any identified special needs. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Services In Place** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Agency providing the service(s) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Whoever is transporting child to the desired service(s) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frequency of the service(s) | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Strengths and Talents of Child** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe child’s current and relevant strengths. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe some of what this child enjoys and does well. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Family Involvement** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide names, addresses and telephone numbers of parent(s) and / or guardian(s). | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No Has child’s parent been adjudicated? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide siblings names, birthdates, and where siblings are placed. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe any current contact (including family therapy and visitation) between child and parent(s), siblings, and relatives. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe child and family attitudes toward treatment foster care / group home care. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Visitation Schedule** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No Will visitation be supervised or not? | | | | | | | | | | | | | | | | | | | | | | | | | |
| List any court order requirements. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frequency of contact or no contact. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No Will biological parents support visitation? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No Will biological parents visit? | | | | | | | | | | | | | | Frequency of visits: | | | | |  | | | | | | |
| **Family History** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe relevant AODA, mental illness, domestic violence and corresponding treatment history of parents and adult family and how this may have or continues to influence this child and family. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe coping strategies, resiliency and resources, which have proven to be the most helpful to this family in meeting their challenges. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cultural / Spiritual Aspects of Child and Family** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe any child and / or family religious and cultural preferences. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Abuse / Neglect History** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe and provide date(s) of any substantiated incidents of physical, emotional, sexual abuse and neglect. | | | | | | | | | | | | | | | | | | | | | | | | | |
| List any current “No Contact” or restraining orders. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Placement Suggestions** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Check all that apply in describing the type of placement that will most likely meet the child’s needs. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Outside Milwaukee County  Within Milwaukee County | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Treatment Foster Home | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 2 parent | | | | | | | | | | | Younger children in home | | | | | | | | | | | | | |
|  | Single parent – female | | | | | | | | | | | Older children in home | | | | | | | | | | | | | |
|  | Single parent – male | | | | | | | | | | | No children in home | | | | | | | | | | | | | |
|  | Same gender partner households | | | | | | | | | | | No pets | | | | | | | | | | | | | |
| Describe what, if any, community / child **safety concerns** should be considered at present? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide suggestions on what might contribute to a smooth transition from the current placement into an approved higher level of care placement? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe what factors or interventions might prove most helpful and should be prioritized to increase the likelihood of a successful experience for this child (and his / her family) in placement. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Attach, if applicable, the most recent psychological reports / inpatient stays – with diagnoses / IEP summary page / Family Assessment / Case Plan | | | | | | | | | | | | | | | | | | | | | | | | | |