BestforBabies

CHECKLIST OF ESSENTIAL SERVICES

Last revised 1/9/19

This checklist applies to all children ages birth to 5 who are subject to a dependency case. It should be completed and filed with the court as an attachment to the Court Report, Permanency Planning Report or Addendum Report prior to **EACH** hearing (including all Report and Review, Status and Permanency hearings).

Child's Name:	**JD#**	**Name of Person Filling In Checklist & Date:**
Child's DOB:	**Age: ____ Yrs. _____ Mos.**	**Date of Hearing:**

DCS CASE MANAGER RESPONSIBILITIES | Within 30 Days of Placement

72-Hour Rapid Response Referral: ☐ YES **Date:** _____ ☐ NO (Maricopa: Mercy Care AZ, dispatch@crisisnetwork.org; Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz & Yuma: Arizona Complete Health, AzCHDCSRR@azcompletehealth.com; Apache, Coconino, Gila, Mohave, Navajo & Yavapai: Steward Health Choice, UrgentResponseDispatch@crisisnetwork.org)

Current Placement: ☐ Kinship ☐ Foster Care ☐ In-Home Dependency ☐ Other

Case Plan Goal: ☐ Reunification ☐ Severance/Adoption ☐ Remain with Family

If non-relative placement, date of last inquiry for appropriate kin: ___ / ___ /___ Follow-up dates: _____

Concurrent Plan: Severance/Adoption: ☐ Kinship ☐ Non-Kinship

☐ Case manager follow-up with caregiver/foster parent to assure all necessary medical, dental and nutritional appointments are made and attended (note follow-up dates and results): _____

_____

Initial Progress Mediation date: ___ / ___ /___ **Initial Child & Family Team (CFT) meeting date:** ___ / ___ /___

SOCIAL / EMOTIONAL / BEHAVIORAL

Are the attachment and emotional needs of this baby being met?

1. Does the baby exhibit any red flags for emotional / health problems? ☐ Excessive fussiness

☐ Chronic sleeping or feeding disturbances ☐ Inconsolable crying ☐ Feeding challenges

☐ Substance exposure ☐ Experienced family violence ☐ Suspected developmental delay / autism spectrum

☐ Multiple foster care placements ☐ Failure to Thrive ☐ Other: _____

2. Has the baby demonstrated attachment to a caregiver? ☐ Yes ☐ No Name: _____
   As evidenced by:

3. Has the child had more than one placement? ☐ Yes ☐ No If yes, when and why?

4. Is parenting time being provided in a developmentally appropriate way? ☐ Yes ☐ No
   Frequency: _____ Duration: _____ Location: _____
   Who is providing transportation? _____ Is foster parent present to comfort child? ☐ Yes ☐ No
   Are parenting skills being increased? ☐ Yes ☐ No

5. Is this child receiving behavioral health services? ☐ Yes Provider: _____
   ☐ No Why not? _____
   Referred for __ BH Birth to 5 Assessment __ ASQ3 __ ASQ-SE Provider: _____
   Was AzEIP referral indicated? ☐ Yes ☐ No Should AzEIP be considered in the future? ☐ Yes ☐ No

HEALTH / DEVELOPMENT – Within 30 Days:

6. Obtained medical / dental / birth records / birth certificate / Social Security number? ☐ Yes ☐ No

If no, date of last request: _____ If yes, copies given to caregiver? ☐ Yes ☐ No

7. Requested immunization history (records or ASIIS)? ☐ Yes ☐ No

Copies given to foster parents and primary care provider? ☐ Yes ☐ No

8. List any health problems and risks identified in the baby's birth and medical records (e.g. low birth weight, prematurity, prenatal exposure to toxic substances): _____

_____

9. Does the baby/child have any of the following health problems? ☐ Substance exposure

☐ Fetal Alcohol Syndrome ☐ Failure to Thrive ☐ Hearing and vision problems ☐ Sensory Issues

☐ Respiratory Issues / Asthma ☐ Ear Infections ☐ Allergies ☐ Feeding Issues ☐ Cavities

☐ Congenital infections - HIV, hepatitis, syphilis ☐ Other: _____

How are the issues being addressed? _____

10. Child must receive EPSDT (Early Periodic Screening Diagnosis & Treatment) within 7 days of placement and at the following ages. Enter date of initial pediatric appointment and follow-up appointments:

2-4 days ____/____/____ 1 mo ___/___/___ 2mo ___/___/___ 4mo ___/___/___ 6mo ___/___/____

9mo ___/___/____ 12 mo ___/___/___ 15 mo ___/___/___ 18 mo ___/___/____

2 yrs. ___/___/____ 3 yrs. ___/___/____ 4 yrs. ___/___/____ Vision exam required? ☐ Yes ☐ No

If yes, date:

11. Child must have initial pediatric dental exam within 30 days of placement (after age 1): ___/___/____

And every 6 months for follow-up visits (enter dates): ___/___/___ ; ____/___/___/ ; ___/___/____

CAREGIVER RESOURCES

What resources are available to enhance this baby's healthy development and prospects for permanency?

12. Have the baby and caregiver been referred to Early Head Start or another quality early childhood program?
Program: _____

13. Is the baby enrolled in childcare? ☐ Yes ☐ No If yes, where? _____
How many hours in childcare a day? _____ Are there any concerns?_____

14. Has the caregiver been given Neurosequential Model in Caregiving webinar information? ☐ Yes ☐ No
List any other advanced training / resources offered:

15. Has a public health nurse home visitor been referred? ☐ Yes ☐ No