

Interagency Family Preservation Program

Fact Sheet for Parents

- Interagency Family Preservation Program is *intensive, home-based* services, designed to serve families who are in crisis. **Intensive** means we will provide service on an as needed basis on days and times that meet the demanding schedules of families. We make a commitment to provide a minimum of 5 hours of face-face and phone contact with family members and appropriate, involved professionals per week. **Home-based** means we make a commitment to serve families in their homes and in their communities. There may be times that families need to come into the office to receive services.
- Interagency Family Preservation Services are **voluntary**. This means families must choose to accept these services. You may choose to discontinue the services at any time during the period of service delivery. Should you decline or discontinue services, we will notify the referring worker/agency of your decision, which may result in legal or other consequences for you and your child(ren). However, if there are safety issues for your child(ren) that we believe requires attention, we may recommend Court intervention to address these safety concerns and request in-home intervention services. By law, alleged reports of child abuse, neglect or sexual abuse have to be reported.
- Interagency Family Preservation Services utilize a **team** approach to serve your family. A team of workers will be assigned to your family upon receipt of the referral. This IFP team consists of a Social Worker and Family Support Worker.

The IFP Team will soon begin to rally resources on your behalf. A Team Meeting will occur soon after you begin your work with the IFP Team. You will discuss the purpose of this meeting and who will be in attendance with your Team.

At the first Team Meeting, you and all of the people involved with helping your family will decide on a plan of service. The **plan of care** will serve as a blueprint for: **what needs your family has...what services you need...who will provide these services...when and for how long...and what each person/group/agency involved will do to help your family.**

- The Interagency Family Preservation Program is **family focused**. This means we will look at the strengths and needs of all family members and we will try to help all members of your family. To do this, we will ask a lot of questions and spend a lot of time talking with you about what has happened in your family's past and what is going on now. We ask that you help us understand your family and make time to share this very important information with us.

The Interagency Family Preservation staff is available to you 24 hours a day, 7 days a week to help with any emergencies your family may encounter during our work together.

**Baltimore County Department of Social Services
Interagency Family Preservation Services Referral Form**

**Fax completed form to Margie Koretzky at 410-887-3786
(Baltimore County Dept. of Health, Bureau of Behavioral Health). She will convey to the program.**

Date: _____

I. Referral Source:

_____ DSS _____ DJS _____ Health Dept. _____ Public School
_____ Mental Health _____ Self Referral _____ Other

Contact Name: _____ Email: _____
Agency Name: _____
Phone Number: _____ Other Number: _____

Will you (referral source) be a part of the Team? Y/N If No, name another alternate: _____
Has the family agreed to be referred for IFPS? Y/N Date Family Agreed to Services: _____

II. Primary Caregiver (PCG):

Last Name First Name Role/Relationship to identified child(ren)

DOB Social Security Number Race Gender

Street Address City State Zip Code

Home Phone Number Work Phone Cell Phone

Is an interpreter needed? Y/N Language: _____

Permanent/Temporary Address (circle one) Risk of Eviction/Homeless? Y/N

III. Family Members/Household/Significant Others - - - - - Include at risk child(ren)

1. _____
Last Name First Name Middle Name Gender Race
SSN: _____ DOB: _____ Team Member? Yes or No Is child AT-RISK? **Yes or No**
Relationship to PCG: _____ Name of School/Grade: _____ IEP? Yes or No
Private Insurance or Medical Assistance Numbers: _____

2. _____
Last Name First Name Middle Name Gender Race
SSN: _____ DOB: _____ Team Member? Yes or No Is child AT-RISK? **Yes or No**
Relationship to PCG: _____ Name of School/Grade: _____ IEP? Yes or No
Private Insurance or Medical Assistance Numbers: _____

3. _____
Last Name First Name Middle Name Gender Race
SSN: _____ DOB: _____ Team Member? Yes or No Is child AT-RISK? **Yes or No**
Relationship to PCG: _____ Name of School/Grade: _____ IEP? Yes or No
Private Insurance or Medical Assistance Numbers: _____

4. _____
Last Name First Name Middle Name Gender Race
SSN: _____ DOB: _____ Team Member? Yes or No Is child AT-RISK? **Yes or No**
Relationship to PCG: _____ Name of School/Grade: _____ IEP? Yes or No
Private Insurance or Medical Assistance Numbers: _____

5. _____
 Last Name _____ First Name _____ Middle Name _____ Gender _____ Race _____
 SSN: _____ DOB: _____ Team Member? Yes or No _____ Is child AT-RISK? **Yes or No** _____
 Relationship to PCG: _____ Name of School/Grade: _____ IEP? Yes or No _____
 Private Insurance or Medical Assistance Numbers: _____

6. _____
 Last Name _____ First Name _____ Middle Name _____ Gender _____ Race _____
 SSN: _____ DOB: _____ Team Member? Yes or No _____ Is child AT-RISK? **Yes or No** _____
 Relationship to PCG: _____ Name of School/Grade: _____ IEP? Yes or No _____
 Private Insurance or Medical Assistance Numbers: _____

7. _____
 Last Name _____ First Name _____ Middle Name _____ Gender _____ Race _____
 SSN: _____ DOB: _____ Team Member? Yes or No _____ Is child AT-RISK? **Yes or No** _____
 Relationship to PCG: _____ Name of School/Grade: _____ IEP? Yes or No _____
 Private Insurance or Medical Assistance Numbers: _____

V. Reasons for Considering Placement in Out-of-Home Care: (check all that apply and further explain in section VI)

Identified CONCERNS/RISK FACTORS bringing this Family to IFP Services:

- | | |
|---|--|
| <input type="checkbox"/> Inappropriate/harsh discipline | <input type="checkbox"/> Chronic illness/disability (parent and/or child) |
| <input type="checkbox"/> Parental immaturity/lack parenting skills | <input type="checkbox"/> Labeled child (demonized, different, bad) |
| <input type="checkbox"/> Substance abuse (alcohol or drugs) | <input type="checkbox"/> Unrealistic expectations of child(ren) |
| <input type="checkbox"/> Adolescent Parent | <input type="checkbox"/> Child(ren) in parental role |
| <input type="checkbox"/> Marital Conflict | <input type="checkbox"/> Financial issues |
| <input type="checkbox"/> Parental History of Abuse | <input type="checkbox"/> Mental health issues (parent and/or child) |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Psychiatric Hospitalization(s) |
| <input type="checkbox"/> Lack of Supervision | <input type="checkbox"/> Child has conduct/behavioral problems |
| <input type="checkbox"/> Prior Foster Care Placement | <input type="checkbox"/> Violation of probation |
| <input type="checkbox"/> Suicidal Ideation (parent or child) | <input type="checkbox"/> School attendance, failure, suspension, expulsion |
| <input type="checkbox"/> Parents lost Parental rights to other child(ren) | <input type="checkbox"/> Rejects outside assistance |
| <input type="checkbox"/> Deficits in support system | <input type="checkbox"/> Medical Issues (parent and/or child) |
| <input type="checkbox"/> Parental over-involvement with child(ren) | <input type="checkbox"/> Runaway |
| <input type="checkbox"/> Child Welfare history (CPS, FC, etc.) | <input type="checkbox"/> Delinquency |
| <input type="checkbox"/> Housing issues | <input type="checkbox"/> Community resource have been accessed |
| <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Other (specify): _____ |

Identified STRENGTHS:

- | | |
|---|---|
| <input type="checkbox"/> One adult in home will perform parental duties | <input type="checkbox"/> One parent is substance-free, if in recovery, at at least 6 months |
| <input type="checkbox"/> Adult(s) has cognitive capacity to learn | <input type="checkbox"/> Parent is employed |
| <input type="checkbox"/> Adult(s) has demonstrated some degree of compliance with an agency | <input type="checkbox"/> One adult can defer own needs for the needs of the child(ren) |
| <input type="checkbox"/> Adult(s) is motivated to change | <input type="checkbox"/> Family expressing few stressors, is relatively stable |
| <input type="checkbox"/> Adult(s) is receptive and utilizes community support and extended family | <input type="checkbox"/> Adult(s) has some impulse control |
| <input type="checkbox"/> Adult has appropriate understanding of expectations of child(ren) | <input type="checkbox"/> Child has capacity for self-protection |
| <input type="checkbox"/> Family has history of using help successfully | <input type="checkbox"/> Destructive behavior is not pervasive |
| <input type="checkbox"/> Adult(s) accepts responsibility for destructive behavior(s) | <input type="checkbox"/> Adult(s) sought intervention |
| <input type="checkbox"/> One adult can control behaviors and protect child | <input type="checkbox"/> Family has other children who have not been harmed |
| <input type="checkbox"/> One adult provides some of the child' basic needs | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Destructive behavior is of low frequency | |
| <input type="checkbox"/> Adult-child relationship has positive component | |

SERVICES NEEDED (CHECK ALL THAT APPLY):

- Child Support Enforcement
- Day Care
- Energy Assistance
- Financial/Budgeting
- Furniture/Appliances
- Mental Health Treatment – substance abuse counseling
- Mental Health Treatment – individual counseling
- Mental Health Treatment – family counseling
- Mental Health Treatment – group counseling
- Clothing
- Other (specify): _____
- Housekeeping
- Nutrition
- Other - specify
- Parenting
- Physical/Health Related
- Social/Interpersonal Skills
- Telephone/Utilities
- Transportation
- Housing (rent, repair, relocation)
- Work Assistance

VI. Additional Information

1. Explanation why you believe this child(ren) is/are at imminent risk of out-of-home placement (please be specific):

2. What CHANGES are needed to avoid out-of-home placement:

3. Other relevant information about this family's situation (history of services, deaths in family, prior home placements, etc.):

VII. List Current Support/Contacts Available to Family (agencies, therapists, family friends, religious, work, etc.)

Contact Person	Agency	Phone Number

List Previous Out-of-Home Placement/Hospitalizations:

List History of Involvement with Child Welfare, Court, Medical, Other Programs/Services):

Contact Person	Agency	Phone Number

VII. Signatures

Based on the foregoing information, I believe the above named child(ren) is/are at imminent risk of an out-of-home placement and is/are appropriate for Interagency Family Preservation Services (IFPS). Documentation to support risk factors and other information will be attached to this referral.

Referring Worker's Signature Date

I understand that my family is being referred for Interagency Family Preservation Services (IFPS) so my child(ren) can continue to live at home. I agree to be contacted by the IFPS team.

Signature of Primary Caregiver Date