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.
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):

<table>
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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Role/Relationship to identified child(ren)</th>
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<td>DOB</td>
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<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>Work Phone</td>
<td>Cell Phone</td>
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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 | Team Member? Yes or No | Is child AT-RISK? Yes or No | IEP? Yes or No | Private Insurance or Medical Assistance Numbers: ______________________

2. Last Name | First Name | Middle Name | Gender | Race | Team Member? Yes or No | Is child AT-RISK? Yes or No | IEP? Yes or No | Private Insurance or Medical Assistance Numbers: ______________________

3. Last Name | First Name | Middle Name | Gender | Race | Team Member? Yes or No | Is child AT-RISK? Yes or No | IEP? Yes or No | Private Insurance or Medical Assistance Numbers: ______________________

4. Last Name | First Name | Middle Name | Gender | Race | Team Member? Yes or No | Is child AT-RISK? Yes or No | 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:

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

Identified STRENGTHS:

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

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<th>Contact Person</th>
<th>Agency</th>
<th>Phone Number</th>
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List Previous Out-of-Home Placement/Hospitalizations:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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

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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

Revised 8/8/08