

Case Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

Child Protective Services Assessment Documentation for County of: \_\_\_\_\_

**I. CASE INFORMATION**

1. Initiation Worker:	_____
2. On-Going Case Worker:	_____
3. Supervisor:	_____
4. Date of Referral:	_____
5. Date Referral Assigned:	_____
6. Date Referral Initiated:	_____
7. Type of Report:	_____
8. Additional Allegation:	_____
9. Report Response Time Frame per <a href="#">N.C.G.S. § 7B-302</a> (circle one):	IMMEDIATE      24 HR.      72 HR.
10. Accepted As (circle one):	FAMILY ASSESSMENT      INVESTIGATIVE ASSESSMENT
11. New Report on This Open Assessment (circle one):	YES    NO    N/A    Explain: _____
12. Date Response Method Switched:	_____      Rationale: _____
Supervisor Signature:	_____
13. Previous CPS Record Reviewed (circle one):	YES    NO    INFORMATION ATTACHED    N/A
14. Substantiation or Services Needed in past year (circle one)?	YES    NO    INFORMATION ATTACHED    N/A
15. Briefly explain #14:	_____ _____ _____

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a. Child Full Name / Nickname	b. SIS # (11 digits)	c. Child's Date of Birth	d. Child's Race / Ethnicity Code	e. American Indian Heritage	f. School / Grade:	g. Child's Primary Language	h. Child Status (circle one)
1.				YES NO UNABLE			ABS RES VIS OTH
2.				YES NO UNABLE			ABS RES VIS OTH
3.				YES NO UNABLE			ABS RES VIS OTH
4.				YES NO UNABLE			ABS RES VIS OTH
5.				YES NO UNABLE			ABS RES VIS OTH
6.				YES NO UNABLE			ABS RES VIS OTH
i. Adult Full Name / Nickname	j. Relationship to Child(ren)	k. Adult's Date of Birth	l. Adult's Race / Ethnicity Code	m. American Indian Heritage	n. Adult's Employer Information	o. Adult's Primary Language	p. Adult's Status (circle one)
7.				YES NO UNABLE			ABS RES VIS OTH
8.				YES NO UNABLE			ABS RES VIS OTH
9.				YES NO UNABLE			ABS RES VIS OTH
10.				YES NO UNABLE			ABS RES VIS OTH
11.				YES NO UNABLE			ABS RES VIS OTH
12.				YES NO UNABLE			ABS RES VIS OTH
13. Household Physical Address: _____							
14. Household Mailing Address (if different than physical address): _____							
15. Contact Numbers: _____ 16. Other Information: _____							

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**III. CIVIL / CRIMINAL RECORDS**

List / Attach Relevant Information (or N/A if none found)

1. [N.C.G.S. §50B](#) Order Currently in Place as per Administrative Office of the Courts (AOC) Civil Case Processing System (VCAP) check: \_\_\_\_\_
2. Criminal History Check as per Administrative Office of the Courts (AOC) Automated Criminal Infraction System (ACIS) Reviewed: \_\_\_\_\_
3. 911 Response Log Reviewed: \_\_\_\_\_

**IV. DILIGENT EFFORTS TO INITIATE CASE** as per [10A NCAC 70A.0105 \(e\)](#)

List daily attempts from 8:00 a.m. to 5:00 p.m. and from 5:00 p.m. to 8:00 a.m. including weekends and holidays.

a. Date	b. Time	c. Type of Contact	d. Person Contacted / Relationship	e. Results of Attempt to Initiate
	AM		/	
	PM		/	
	AM		/	
	PM		/	
	AM		/	
	PM		/	
	AM		/	
	PM		/	
	AM		/	
	PM		/	
	AM		/	
	PM		/	

1. If not initiated within the specified timeframe, document rationale:

\_\_\_\_\_

2. If not completed within the specified timeframe, document rationale:

\_\_\_\_\_

3. Family notified of the delay in making a case decision (circle one)?      YES      NO      N/A

Document the discussion:

\_\_\_\_\_

\_\_\_\_\_

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**V. CPS CASE ACTIVITIES**

1. Parent / Caregiver contacted to schedule appointment prior to initiation (Family Assessment):  
\_\_\_\_\_
2. CPS / MRS / RIL Process fully explained to family and MRS brochure provided:  
\_\_\_\_\_
3. Possible case decision findings explained to family:  
\_\_\_\_\_
4. Personal written notice to Responsible Individual hand-delivered within 5 business days of case decision:  
\_\_\_\_\_
5. Parent / Caregiver / Safety Resource ([DSS-5231](#)) received a copy of the initiation Safety Assessment:  
\_\_\_\_\_
6. Family Strengths and Needs Assessment ([DSS-5229](#)) and Family Risk Assessment ([DSS-5230](#)) discussed with and/or completed with parent / caregiver:  
\_\_\_\_\_
7. Parent / Caregiver given an opportunity to provide collateral contacts:  
\_\_\_\_\_
  - a. Parent / Caregiver given an opportunity to participate during contact: \_\_\_\_\_
  - b. Parent / Caregiver participated with collaterals or received feedback about collaterals: \_\_\_\_\_
8. Work First Case (if "YES" Work First should be a collateral contact): \_\_\_\_\_
9. Local Law Enforcement / State Bureau of Investigation notified (as needed):  
\_\_\_\_\_
10. District Attorney notified (as needed):  
\_\_\_\_\_
11. Licensing Authority notified for CPS Assessments involving Out-Of Home Placements (as per [Family Services Manual Volume I, Chapter V](#)) (circle one) NC DCD          NC DHSR          NC DSSS          OTHER  
Explain: \_\_\_\_\_
12. CDSA referral made in cases in which the social worker has determined the need for a referral or in cases in which item S6 on the Family Strengths Needs Assessment ([DSS-5229](#)) is rated as a "Need":  
\_\_\_\_\_

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13. Functioning smoke detectors in home verified: \_\_\_\_\_

14. Fire safety plan discussed with family: \_\_\_\_\_

15. Firearms safely stored (as per [N.C.G.S. §14-315.4](#)): \_\_\_\_\_

16. Safe sleeping arrangements for infants discussed with family (for more information see [this article](#) from the Journal of the American Academy of Pediatrics):  
\_\_\_\_\_

17. Absent Parent / Caregiver located and contacted about the allegations in the report (include names and other contact information specifically related to fathers):  
\_\_\_\_\_  
\_\_\_\_\_

a. Absent Parent / Caregiver's level of involvement in the child(ren)'s life: \_\_\_\_\_

b. Level of Child Support Enforcement involvement: \_\_\_\_\_

18. Absent Parent / Caregiver's family located and contacted (include names and other contact information specifically related to paternal family members):  
\_\_\_\_\_

19. Other Social Service / Child Welfare agencies contacted for information on household members that have resided outside of North Carolina:  
\_\_\_\_\_

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**VI. CHILD AND FAMILY MEDICAL / WELL-BEING**

This Information is for the following family member(s):  
\_\_\_\_\_

1. Primary Medical Provider: _____ Contact Information: _____
2. Dentist Name: _____ Contact Information: _____
3. Therapist / Psychiatrist Name: _____ Contact Information: _____
4. Specialist Name: _____ Contact Information: _____
5. Place of Birth (City, State, Hospital): _____

6. Medication Name and Use	Dosing / Dispensing / Refill Information

7. Explain status of child(ren)'s immunizations: _____
8. Explain family's status as related to health insurance: _____
9. Explain any medical issues for family members: _____
10. Explain any mental health and/or substance abuse issues for family member: _____
11. Explain any educational issues / challenges facing family members: _____
12. Explain the need for any child in the family under the age of 3 to be evaluated by Early Intervention or provide details about any child who is currently receiving Early Intervention services from a CDSA: _____
13. As a result of the information above this worker took / needs to take the following action: _____





