

NORTH CAROLINA PERMANENCY PLANNING REVIEW

County:

Case Number:

Case Name:	
Agency Worker Name: Phone number & Email:	
Agency Supervisor Name: Phone number & Email:	

I. Family Demographics	Name:	DOB:	Age:	Date of Custody/ 1 st out-of-home placement:
Child/Youth:				
Child/Youth:				
Child/Youth:				
Child/Youth:				
Child/Youth:				
Child/Youth:				

Mother of:		Age:	
Address		Phone:	Email:
Attorney for Mother		Phone:	Email:
Mother of:		Age:	
Address		Phone:	Email:
Attorney for Mother		Phone:	Email:
Father of:		Age:	
Address		Phone:	Email:
Attorney for Father		Phone:	Email:
Father of:		Age:	
Address		Phone:	Email:
Attorney for Father		Phone:	Email:
Father of:		Age:	
Address		Phone:	Email:
Attorney for Father		Phone:	Email:
Other Caregiver		Age:	
Address		Phone:	Email:
Other Caregiver		Age:	
Address		Phone:	Email:
Guardian ad litem		Phone:	Email:

II. Child Specific Review (Complete this section for each child/youth. Make extra copies as needed.)

(a) Summary of Recommendations from Last Meeting: NA for 1st Permanency Planning Review

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(b) Child/Youth Status (The second and third columns should be completed by the worker prior to the meeting. Review of the information for accuracy, progress and follow up should occur during the meeting with notes taken in the last column.

At the 12-month (since date of custody) permanency planning review and every 12 months thereafter, complete DSS-5245 Educational Status form and include identified Progress/Follow up/Next Steps on this form.			
Educational / Developmental	School/Daycare: Grade: Has the child ever been retained/advanced in a grade? <input type="checkbox"/> Yes: Explain _____ <input type="checkbox"/> No Services in place, IEP, A/G:	Are child/youth's educational/developmental needs being met? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	Progress / Follow Up / Next Steps, if needed:
At the 12-month (since date of custody) permanency planning review and every 12 months thereafter, complete DSS-5207 Health History Form and document identified Progress/Follow up/Next Steps relating to Physical/Medical/Dental/Mental Health & Behavioral.			
Physical / Medical	Physician: Immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last medical checkup?	Any health issues, allergies, asthma, medication?	Progress / Follow Up / Next Steps, if needed:
Dental	Dentist: Date last dental appointment?	Issues:	Progress / Follow Up / Next Steps, if needed:
Mental Health / Behavioral Health / Juvenile Justice needs	Diagnosis/Behavior Concern: Provider: Issues and/or concerns?	Treatment Plan? Medication? Services Plan?	Progress / Follow Up / Next Steps, if needed:
Social / Other	Opportunities for age and/or developmentally appropriate activities, including employment: Community Resources:	Issues/Needs:	Progress / Follow Up / Next Steps, if needed:
Family Relationships	Visits & Contact with Parents (frequency, appropriateness): Is visitation in compliance with court order? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:	Visits with Siblings (frequency, location, etc.): Visits with Extended Family Members / Kin (frequency, location, etc.):	Progress / Follow Up / Next Steps, if needed:
Child/Youth's Participation in Case Planning	Opportunities provided:	Child/Youth's Input:	Progress / Follow Up / Next Steps, if needed:

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For youth over age of 12 <input type="checkbox"/> NA	<input type="checkbox"/> The youth been provided a copy of the DSS-1516 Understanding Foster Care – A Handbook for Youth <input type="checkbox"/> The youth has read or had read to them the Foster Care Rights Acknowledgement on page 9 of the handbook. <input type="checkbox"/> The youth has signed the Foster Care Rights Acknowledgement; and a signed copy of the acknowledgement is in the case file.
For youth 14 years of age or older <input type="checkbox"/> NA	Is youth receiving services from the LINKS program? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: Describe or attach the Transitional Living Plan (DSS-5096a) including: <ul style="list-style-type: none"> • The estimated date of discharge from out-of-home care • The youth’s anticipated living arrangement after discharge • What specific steps are being taken to help the youth prepare for discharge, including life skills training, work experience, a savings plan, education and job training, medical and mental health care, development of a personal support network • Supportive adults who are working with the youth as he/she progresses toward discharge • Credit checks completed: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: Has the Kinship Guardianship Assistance Program (KinGAP) been considered for the youth? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:

Other:

Does the child/youth have any Native American or International Heritage? Yes No

If yes, describe Agency’s efforts to notify the tribe/consulate if applicable.

(c) Child/Youth Placement

Date of current placement:

Number of placements for this child/youth:

Element	Yes / No	Explanation (if not, why?)
Least restrictive, most family-like setting which serves the child/youth’s individual needs.	<input type="checkbox"/> <input type="checkbox"/>	
Within the child/youth’s home community	<input type="checkbox"/> <input type="checkbox"/>	
Within the child/youth’s former school district	<input type="checkbox"/> <input type="checkbox"/>	
Placement is with a relative	<input type="checkbox"/> <input type="checkbox"/>	
If placement is with a relative, has the relative been given information about how to become licensed as a foster home?	<input type="checkbox"/> <input type="checkbox"/>	
Placement is with siblings	<input type="checkbox"/> <input type="checkbox"/>	If not, why not, and what are the efforts to place with siblings?

Is the current placement appropriate to meet this child/youth’s needs? Yes No

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Explain "No" answers and specify efforts that are being made to secure an appropriate placement:

(d) Child/Youth Concurrent Permanency Plans

CHILD/YOUTH NAME:

DOB:

What is the identified Primary plan?	<input type="checkbox"/> Reunification with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian / Custodian	Guardianship with: Relative <input type="checkbox"/> or Court approved caretaker <input type="checkbox"/> Custody with: Relative <input type="checkbox"/> or Court approved caretaker <input type="checkbox"/> <input type="checkbox"/> Adoption <input type="checkbox"/> Another Planned Permanent Living Arrangement <input type="checkbox"/> Reinstatement of Parental Rights
Regarding the Primary Plan:	Anticipated completion date for the primary plan is: Is the primary plan appropriate for this child/youth? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
What could prevent achievement of this plan?	Identify and explain any barriers to the primary plan.	
What is the identified Secondary plan?	<input type="checkbox"/> Reunification with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian / Custodian	Guardianship with: Relative <input type="checkbox"/> or Court approved caretaker <input type="checkbox"/> Custody with: Relative <input type="checkbox"/> or Court approved caretaker <input type="checkbox"/> <input type="checkbox"/> Adoption <input type="checkbox"/> Another Planned Permanent Living Arrangement <input type="checkbox"/> Reinstatement of Parental Rights
Regarding the Secondary Plan:	Anticipated completion date for the secondary plan is: Is the secondary plan appropriate for this child/youth? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
What could prevent achievement of this plan?	Identify and explain any barriers to the secondary plan.	

(e) Timely permanence: (N.C.G.S. 7B-907-(d)):

This child/youth has been in agency custody _____ days of the past 22 months.

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If 12 or more months, has TPR been filed? Yes No Not Applicable because child/youth has been in care less than 12 of the previous 22 months.

If TPR has been not been filed on a child/youth who has been in agency custody 12 or more of the past 22 months, indicate why:

- The child/youth is being cared for by a relative.
- The agency has documented in the case plan compelling reason for determining that TPR if not in the best interest of the child/youth.

Date court ordered TPR is not in the best interest of the child/youth:

- The agency has not provided to the child/youth the services deemed necessary for a safe return of the child/youth to the child/youth's home if reasonable efforts continue to be required by the court.

(f) Court

Are the orders of the court relating to services for this child/youth incorporated above? Yes No

If not, explain:

Date of next Court Review:

Recommendations regarding this child/youth for the next court hearing:

Services:

Primary Permanent Plan:

Secondary Permanent Plan:

PLACEMENT PROVIDER:

III. Placement Provider(s) (complete this section for each placement provider. Make extra copies if needed.)

Children in this placement:

- (a)** What is going well in this placement? What are the strengths?
- (b)** What are the concerns/needs, if any, regarding this placement?
- (c)** How is the placement provider meeting the needs of the child(ren)? Describe child/youth specific actions or activities (including age and/or developmentally appropriate activities).

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(d) Describe services provided to placement provider designed to assure the child(ren)'s needs are being met. This should include meetings, referrals, and/or support provided by the county agency or a private licensing agency.

(e) Describe training provided to the placement provider to meet specific needs of the child(ren).

Has the placement provider received training on trauma-informed care?

Yes When?

No When will they receive training on trauma-informed care?

(f) Describe respite or other services provided to the placement provider to ensure self-care.

(g) Describe how the provider is engaged in shared parenting (if not appropriate, explain why).

(h) Other.

(i) Follow up, Next Steps:

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VI. Signatures In signing below, I understand that the information obtained during this meeting shall remain **confidential** and not be disclosed. Strict confidentiality rules are necessary for the protection of the child(ren). Information will be shared only for providing services to the child/youth and family, and in accordance with North Carolina General Statute and Part V, Privacy Act of 1974. Any information about child abuse or neglect that is not already known to the child welfare agency is subject to child abuse and neglect reporting laws. Any disclosure about intent to harm self or others must be reported to the appropriate authorities to ensure the safety of all involved. My signature indicates that I participated in this meeting.

Role	Signature & Comments	Date	Participated in:	Received copy
Parent			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Parent			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Child/Youth			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Child/Youth			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Child/Youth			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Child/Youth			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Agency Worker			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Agency Supervisor			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Guardian ad litem			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Placement provider			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Placement provider			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Tribal Representative			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Other Relationship/Phone/Email			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Other Relationship/Phone/Email			<input type="checkbox"/> PPR	<input type="checkbox"/> Yes
			<input type="checkbox"/> FSA <input type="checkbox"/> CFT	<input type="checkbox"/> No
Others Invited but Unable to Attend				