NOTIFICATION OF CPS INVOLVEMENT

Division of Health Service Regulation (DHSR)	Division of Child Development (DCD)	Division of Social Services (DSS)
Complaint Intake Unit 2711 Mail Service Center Raleigh, North Carolina 27699 1.800.624.3004 (P) 919.715.7724 (F) http://www.ncdhhs.gov/dhsr/index.html Mental Health Facilities, Residential Treatment Facilities - Level II and up	2201 Mail Service Center Raleigh, North Carolina 27699 Courier # 56-20-17 1.800.859.0829 (P) 919.662.4547 (P) 919.661.4844 (F) http://ncchildcare.dhhs.state.nc.us/general/home.asp Child Care Programs	Regulatory and Licensing Services 952 Old US Highway 70 Black Mountain, North Carolina 28711 Courier # 12-84-05 828.669.3388 (P) 828.669.3365 (F) http://www.ncdhhs.gov/dss/licensing/listings.htm Family and Therapeutic Foster Homes, Level I Group Homes, Maternity Homes

Please indicate if this is: ☐ **Initial Notification** ☐ **Case Decision Notification**

This notice satisfies the requirement that DHSR/DCD/DSS receive notification of Child Protective Services (CPS) involvement **AND** completion of a CPS assessment.

Administrative Code 10A N.C.A.C. 70A.0106 authorizes the release of the confidential information contained in this notice.

However, N.C.G.S. 7B-302 requires that the confidential information contained in this report shall remain confidential and may only be re-disclosed if directly connected to the mandated responsibilities of the DHSR/DCD/DSS.

Name of Facility/Home: _____

Location of Facility/Home (physical address): _____

Licensing/Supervising Agency: _____

License ID#: _____

Perpetrator (Name and Date of Birth): _____

County Conducting the Investigative Assessment: _____
If the county responsible for the assessment is different from the county conducting the assessment, the county responsible for the assessment submits this form. County responsible (if different from county investigating): _____

Name of Investigating Social Worker: _____

Phone Number: _____

Social Work Supervisor: _____

Phone Number: _____

Initial Notification:

Date: _____ **Time:** _____

Name and age of child(ren): _____

Information Needed: Please provide sufficient information so that alleged victim child(ren) are not re-interviewed.

What happened (how, when, where, who was involved, were there any witnesses)? _____

_____

_____

_____

_____

_____

_____

Who was told about this and what did they do about it? _____

_____

Has this happened before? _____

Has the resident/patient/client experienced any negative outcome? ☐ Yes ☐ No

If so, How has the negative outcome affected the residents'/patients'/clients' functioning? ____

_____

_____

Was the incident reported to staff? _____

Is anything being done to prevent it from happening again? _____

_____

What is the residents'/patients'/clients' current location (room number)? _____

_____

If this is a Case Decision Notification:
The completed North Carolina Case Decision Summary (DSS-5228) shall be attached to this notice and will serve as notification of the case decision.

Assessments conducted on DSS and DHSR facilities require consultation with the assigned Children's Program Representative (CPR).

CPR Name: _____

Date case decision staffed with CPR: _____