The Commonwealth of Massachusetts
Department of Social Services

CHILD PLACEMENT AGREEMENT

The Child Placement Agreement is a 3-part document that is used to provide specific information about a child placed with a foster or pre-adoptive parent.

Part 1 is used to provide information to the foster/pre-adoptive family with whom the child is placed and/or to assist a family resource worker in identifying a foster/pre-adoptive family for a specific child.

Part 2 is used as the agreement between the foster/pre-adoptive family and DSS to document roles and responsibilities around the placement of a specific child with the foster/pre-adoptive family.

Part 3 is used to document that the **Child Placement Agreement** has been reviewed and updated no less than once every six (6) months.

Part 1. Child Information/Family Resource Request (pages 1-3)

*(To be completed by child's social worker when a foster/pre-adoptive family needs to be identified **and/or** to provide information to the foster/pre-adoptive family with whom the child is placed.)*

Child's Full Name: Date Completed

Anticipated Date Placement Needed: Expected Length of Placement:

DOB: Religion: Ethnicity: Language:

Parents: Mother: Address:

Father: Address:

Other Significant Caretaker:

Address:

Child's Address Prior to Placement:

Child's Legal Status:

Legal Status:

Freed for Adoption:

Reason for Child's Placement *(Check all that apply)*:

- ☐ 51B Removal
- ☐ CHINS
- ☐ Court Ordered
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Placement Disruption
- ☐ Temporary Family Emergency
- ☐ Voluntary Placement Agreement
- ☐ Other (e.g., need for less restrictive setting, adoption surrender, etc.). Please describe briefly:

Child's Permanency Plan Goal:

Prior Placements: ☐ No ☐ Yes If yes, please note number and type:

Reason(s) for Leaving:

CHILD'S INDIVIDUAL NEEDS/EXPECTATIONS OF FAMILY RESOURCE *(Complete all sections. If information is unknown, indicate by writing a "U" in front of each item):*

A. Currently enrolled in child care or in school? ☐ No ☐ Yes

(Name) _____ (Address) _____

Grade Level: _____ Individual Educational Plan (I.E.P.)? ☐ No ☐ Yes

B. Preferences regarding placement related to child's individual/special needs (e.g., desired location, type of home or special conditions).

Please describe briefly:

C. Special Medical Needs (e.g., allergies, HIV, other acute or chronic conditions, etc.) ☐ No ☐ Yes

If yes, please describe briefly:

D. Is child receiving therapy/counseling, or is it anticipated? ☐ No ☐ Yes

Frequency: _____

If currently receiving: _____ (Therapist's Name) _____ (Address)

E. Anticipated Visitation Schedule:

With child's social worker:

With family members *[Please specify the name(s), relationship to child, frequency, location, whether visits will be supervised, and by whom]*:

F. Does this child have any special transportation needs? ☐ No ☐ Yes

If yes, please describe briefly:

G. Please describe the child's strengths, hobbies, interests and positive attributes:

BEHAVIOR/DEVELOPMENT / SPECIAL NEEDS CHECKLIST

Please check all information that applies. (If information does not apply, leave blank; if information is unknown, indicate by writing a "U" in front of each item):

___ Acting Out Aggressive
___ Enuresis
___ History of Physical Abuse
___ History of Neglect
___ Cerebral Palsy
___ Depression
___ Non-ambulatory
___ Past Psychiatric Hospitalization
___ Parenting Teen
___ Physical Disability
___ Pregnant Teen
___ Running Away
___ Seizure Disorder
___ Sexually Active
___ Severe Behavior Disorder
___ Vision Impairment
___ Tantrums
___ Suicidal
___ Stealing
___ Speech/Language Disorder
___ Smoking
___ Self Abuse
___ Fetal Alcohol Syndrome
___ Involvement in Delinquent Behavior
___ Involvement in Criminal Justice System
___ Other *(List)*

___ School Adjustment Disorder
___ Psychosis
___ Communicable Diseases
___ Chronic Medical Condition
___ Autism
___ Apnea
___ Alcohol Abuse
___ Motion Impairment
___ Development Delayed
___ Attachment Disorder
___ Hyperactivity
___ HIV Risk
___ History of Sexual Abuse
___ Hearing Impairment
___ General Emotional Disorder
___ Fire Setting
___ Encopresis
___ Feeding Disorders
___ Drug Addicted at Birth
___ Poor Social Skills
___ Failure to Thrive
___ Rocking or Head-banging
___ Sexually Acting Out/Perpetrator
___ Truancy
___ Racial, Ethnic, Linguistic or Cultural Issues

Please describe any other individual needs of this child, or any other information, that would be helpful for the foster/pre-adoptive family and that is not included elsewhere on this form:

Signatures

_____ _____
(Social Worker) (Date)

_____ _____
(Supervisor) (Date)

_____ _____
(Area Director/Designee) (Date)

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Part 2. Agreement (pages 4 & 5)

To be completed by the child's social worker in collaboration with the family resource worker and the foster/pre-adoptive family at the time of placement, or, in an emergency, within three (3) working days after the placement. It provides information about expectations and responsibilities of the foster/pre-adoptive family, the child's social worker, and DSS so that the foster/pre-adoptive family may provide optimal care for the child. This part of the Agreement is reviewed and updated as necessary but no less than once every six (6) months.

(Child's Name) _____ (Date of Placement) _____

Type of Family Resource: ☐ Kinship ☐ Child-Specific ☐ Unrestricted

Service Being Provided to Above-Named Child: ☐ Foster Care ☐ Adoption

[Foster/Pre-Adoptive Family Name(s)] _____ (Provider #) _____

(Foster/Pre-Adoptive Family Address) _____

(Other DSS Office/Contracted Agency _____ (Telephone) _____

If there is another social worker involved, other than the child's social worker, identify who and what her/his responsibilities are:

RESPONSIBILITIES

The above-identified foster/pre-adoptive family is hereby authorized to, and will, obtain routine and emergency medical and dental services for this child and will submit applicable documentation to the child's social worker.

The foster/pre-adoptive family is encouraged to participate in the child's Foster Care Review. The next Review will be

scheduled for _____.
(Month/Year)

If this child is in need of Special Education Services, she/he may need an Educational Surrogate Parent. The foster/pre-adoptive family is ☐ **willing** ☐ **not willing** to allow DSS to identify the foster/pre-adoptive family to the Department of Education to be considered as an Educational Surrogate Parent for this child.

The foster/pre-adoptive family will be invited to attend court hearings held on the child's behalf, pursuant to MGL c. 119, §§ 26, 29B and 39G and c. 210, § 3, as applicable.

A copy of the child's Service Plan and the Medical Passport are given to the foster/pre-adoptive family along with this Agreement.

They include information on the child's medical and dental health, the child's emotional health and educational needs, child's placement history, and the visitation plan with her/his biological family. The **Service Plan** also includes the child's social worker's plan for visiting with the child and with the foster/pre-adoptive family, tasks the foster/pre-adoptive family has agreed to complete, and arrangements for contacts between the child's social worker and the contracted agency or other DSS Area Office with whom the foster/pre-adoptive family is involved, if applicable.

REIMBURSEMENT

$ _____ (Daily Rate) $ _____ (Quarterly Rate) $ _____ (Emergency Clothing

When the **Service Plan** indicates the child's needs require specialized services or a **Receiptable Reimbursement Expense** by the foster/pre-adoptive family, the child's social worker, the family resource worker and the foster/pre-adoptive family meet to complete a **Supplemental Reimbursement Request/Agreement**.

☐ A Supplemental Reimbursement Request has been initiated.

☐ A meeting will be scheduled to discuss Supplemental Reimbursement.

☐ The need for Supplemental Reimbursement Services is not anticipated at this time.

Daily payments are routinely issued twice a month. As applicable, Supplemental Reimbursement is included on an ongoing basis or in a lump sum with the check.

The foster/pre-adoptive family is responsible for reimbursing the Department for any and all overpayments for foster care, clothing grants, birthday and holiday allowances and Supplemental Reimbursement payments.

Signatures

I have reviewed this Agreement and hereby acknowledge my participation.

_____ (Foster/Pre-Adoptive Family) (Date)	_____ (Foster/Pre-Adoptive Family) (Date)
_____ (Family Resource Worker) (Date)	_____ (Family Resource Supervisor) (Date)
_____ (Child's Social Worker) (Date)	_____ (Child's Supervisor) (Date)
_____ (Child's Social Worker Office Address)	_____ (Other DSS Area/Agency Address)
_____ (Child's Social Worker Telephone)	_____ (After Hours Telephone)

Copies to: Foster/Pre-Adoptive Family, Child's Case Record, Foster/Adoptive Family Record

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Part 3. Agreement Update (page 6)

(Child's Full Name) [Family Resource Name(s)]

(Date of Placement) (Expected Length of Placement)

Permanency Plan Goal:

To be completed by the family resource worker, in collaboration with the child's social worker and the foster/pre-adoptive family. It is used to document that the Child Placement Agreement has been reviewed and updated no less than once every six (6) months.

While the Service Plan and the Medical Passport are updated on an ongoing basis as needed, this review provides an opportunity to ensure that the Medical Passport is up-to-date and that the foster/pre-adoptive family has a copy of the current Service Plan. Any changes in services being provided to the child and her/his family, especially the schedule for visitation between the child and her/his family, the social worker and the child, and/or the social worker and the foster/pre-adoptive family should be highlighted. This also provides the opportunity for review of any Supplemental Reimbursement services. If there are any additions or revisions, a new Supplemental Reimbursement Request/Agreement is completed.

- ☐ The Service Plan and Medical Passport have been reviewed with the foster/pre-adoptive family and any changes/modifications have been discussed.
- ☐ Supplemental Reimbursement services will continue without changes.
- ☐ Supplemental Reimbursement services are being initiated or are being modified. A new Supplemental Reimbursement Request/Agreement has been initiated.

Signatures I have reviewed this Agreement and hereby acknowledge my participation.

(Foster/Pre-Adoptive Family) (Date) (Foster/Pre-Adoptive Family) (Date)

(Family Resource Worker) (Date) (Family Resource Supervisor) (Date)

(Child's Social Worker/) (Date) (Child's Supervisor) (Date)

(Other DSS Area/Agency Address)

Copies to: Foster/Pre-Adoptive Family, Child's Case Record, Foster/Adoptive Family Record