**Family Return Home Plan**

**Part 2A: Parenting and Safety**

1. Where are you currently living? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are currently homeless, what programs have you applied for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Who is living with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has everyone in your home completed background checks and submitted fingerprints? **YES NO**

List everyone that may need to complete the background process? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have social security cards and birth certificates for everyone for everyone that will be living with you? List the household member and the documents you need. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does lack of money prevent you from getting any of these documents? **YES NO**

1. A DCYF social worker completes a Children’s Health and Education Tracker (CHET) screening on every child. This tool is used as a tool to see if children are developmentally on track. Would you be interested in learning more or getting a copy of that screening? **YES NO**
2. List the names of your children are or were engaged in 0-3 or Early Intervention Services?

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Do you have copies of assessments, summaries or recommendations from these services? **YES NO**

*If “NO”, you can ask your social worker for a copy of any of these documents*

1. Do you need help accessing resources for visits such as diapers, snacks, transportation, etc?

**YES NO**

If yes, please list the items you need: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How do you currently transport yourself and your child(ren) to and from services and appointments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have a valid driver’s license? **YES NO**

Do you have car insurance? **YES NO**

Do you need help in getting your license or insurance?  **YES NO**

1. Who can you contact in an emergency to transport you or your children?

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How would you know that those people have a valid driver’s license and insurance?

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1. Share your plan to for childcare while you attend treatment/work/meetings and other necessary services. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. What is your plan to keep you children safe if feel like using or are in crisis?

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1. Give at least one example of what you do when your child is testing you.

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1. List 3 people you can talk to about parenting your child(ren). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What kind of support do each of these people provide? ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have any financial, criminal, housing or legal matters that may prevent you from accessing housing or other resources? **YES NO**

*If you answered “yes” above, please discuss these matters with your attorney.*

1. Does anyone in your family need help accessing medical or dental care? **YES NO**

Do you are someone else in your family need medical insurance? **YES NO**

Do you or someone else want help with birth control? **YES NO**

1. List the name of your primary care doctor and clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the name of your child’s pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the name of any specialized providers working with your child(ren). Examples include physical therapist, occupational therapist, hearing, vision provider, etc.

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List the name of your family dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If children are school-aged, what is your plan for childcare during holidays or school breaks?

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During summer breaks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Before and after school care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Would you want or need help getting a parenting plan (if unsure, ask your social worker)?

**YES NO**

Do you have any other outstanding legal matters that you need help with, such as protection orders, warrants, restraining orders, etc.? **YES NO**

*If you answered ‘YES’ to either of these questions, please talk with your attorney about your options.*

**Please complete this form and bring it to your next Wrap or team meeting.**