



**INDIANA DEPARTMENT OF CHILD SERVICES
CHILD WELFARE POLICY**

Tool: Placement Needs Summary

Effective Date: June 1, 2008

Reference: 8.A ([8.1 Selecting a Placement Option](#))

Version: 1

This tool may be used to assist the Family Case Manager (FCM) in identifying the needs of a particular child. This is not a formal assessment of the child's needs. Rather, it is a place to gather information about the child. There is no scoring system associated with this summary. The FCM and the Child and Family team should use the information collected on the summary to begin discussion of the child's needs and determination of the most appropriate placement and level of care. Together the Child and Family team should make a recommendation on the best possible, least restrictive and most family-like placement option.

Instructions: Check all boxes that apply, then complete the summary section. The summary should be based on the average abilities, behaviors and health of children in the same age group, i.e. a baby would not be expect to feed himself/herself; however, one would expect that a 6-year old could feed himself/herself.

CHILD'S NAME: _____

CHILD'S AGE: _____

Area of Concern	Special Needs – Mild	Special Needs – Moderate	Special Needs – Severe	Therapeutic/ Treatment Needs
<input type="checkbox"/> Attention Deficit (ADD) <input type="checkbox"/> Attention Deficit – Hyperactivity (ADHD)	<input type="checkbox"/> ADD, mild <input type="checkbox"/> ADHD, mild	<input type="checkbox"/> ADD, moderate <input type="checkbox"/> ADHD, moderate	<input type="checkbox"/> ADD, severe <input type="checkbox"/> ADHD, severe	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Basic Care		<input type="checkbox"/> Excessive Crying – Baby/Toddler <input type="checkbox"/> Excessive Crying- older child	<input type="checkbox"/> Constant Crying – Baby/Toddler	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Blood Disorders		<input type="checkbox"/> Sickle Cell, infrequent episodes	<input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell, frequent episodes <input type="checkbox"/> HIV Positive <input type="checkbox"/> May require transfusion	<input type="checkbox"/> Additional precautions must be taken <input type="checkbox"/> Other _____
<input type="checkbox"/> Communication	<input type="checkbox"/> Stutters <input type="checkbox"/> Lisps	<input type="checkbox"/> Speech is hard to understand <input type="checkbox"/> Child does not speak English <input type="checkbox"/> Uses Sign Language	<input type="checkbox"/> Will always have trouble speaking and/or being understood <input type="checkbox"/> Mute <input type="checkbox"/> Communication Disorder	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Developmental Disabilities	<input type="checkbox"/> Mild delay, less than 6 months behind	<input type="checkbox"/> Moderate delay, 6-12 months behind <input type="checkbox"/> Autism, mild	<input type="checkbox"/> Severe delay, more than 12 months behind <input type="checkbox"/> Autism, severe <input type="checkbox"/> Autism, no communication <input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Requires specialized treatment

<input type="checkbox"/> Eating	<input type="checkbox"/> Hoarding food <input type="checkbox"/> Over-eating	<input type="checkbox"/> Binging/Purging	<input type="checkbox"/> Currently being treated for an eating disorder	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Education	<input type="checkbox"/> Has IEP, but participates in regular classes <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> Dyslexic <input type="checkbox"/> Gifted Student <input type="checkbox"/> Alternative school <input type="checkbox"/> Behavior plan	<input type="checkbox"/> Special education program <input type="checkbox"/> Expulsion or refusal to go to school	<input type="checkbox"/> Will always need supervision and/or sheltered educational environment	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Failure to thrive			<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Feeding		<input type="checkbox"/> Feeding Problems	<input type="checkbox"/> Feeding Tube <input type="checkbox"/> Unable to feed self - older child <input type="checkbox"/> Will never be able to feed self	<input type="checkbox"/> Requires a feeding tube <input type="checkbox"/> Requires other specialized treatment
<input type="checkbox"/> Fetal Alcohol/Drug Exposure		<input type="checkbox"/> Drug Exposed Child <input type="checkbox"/> Fetal Alcohol Syndrome	<input type="checkbox"/> Fetal Drug Addiction	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Hearing		<input type="checkbox"/> Hearing problem, hearing aid will correct <input type="checkbox"/> Hearing problem, hearing aid will not correct	<input type="checkbox"/> Deaf, but able to speak <input type="checkbox"/> Deaf, unable to speak <input type="checkbox"/> May require inner ear surgery	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Wetting during day, occasionally <input type="checkbox"/> Bed wetting, occasionally	<input type="checkbox"/> Bed Wetting, nightly <input type="checkbox"/> Wetting during the day, more than twice per month	<input type="checkbox"/> Bowel Problems <input type="checkbox"/> Will always wear diapers.	<input type="checkbox"/> Requires a Colostomy Bag
<input type="checkbox"/> Medical - General		<input type="checkbox"/> Requires weekly (or less frequent) monitoring <input type="checkbox"/> Multiple medications	<input type="checkbox"/> Requires daily/hourly monitoring <input type="checkbox"/> Chronic condition	<input type="checkbox"/> Requires specialized treatment <input type="checkbox"/> Requires use of specialized medical equipment
<input type="checkbox"/> Medical - Chronic	<input type="checkbox"/> Allergies to food, plants, medication, etc.	<input type="checkbox"/> Special Diet due to medical conditions	<input type="checkbox"/> Severe Allergies <input type="checkbox"/> Severe Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiac Problems <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Other (list) _____	<input type="checkbox"/> Requires specialized treatment

<input type="checkbox"/> Medical - Urgent		<input type="checkbox"/> Condition that may require surgery in the next 6 months.	<input type="checkbox"/> Injuries or Conditions are life threatening <input type="checkbox"/> Shaken baby syndrome	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Counseling or therapy, less than twice per week <input type="checkbox"/> Depression/ Anxiety Disorder, Somewhat inhibiting <input type="checkbox"/> Other (list)	<input type="checkbox"/> Counseling or therapy, two or more times per week <input type="checkbox"/> Depression/ Anxiety Disorder, Moderately inhibiting <input type="checkbox"/> Other (list)	<input type="checkbox"/> Child may need hospitalization for emotional problems <input type="checkbox"/> Depression/ Anxiety Disorder, Severely inhibiting <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Bi-Polar Disorder <input type="checkbox"/> Other (list)	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Personal Conduct	<input type="checkbox"/> Curfew violation	<input type="checkbox"/> Runaway behavior <input type="checkbox"/> Fire Starting <input type="checkbox"/> Stealing in the home or school <input type="checkbox"/> On probation <input type="checkbox"/> Inappropriate language <input type="checkbox"/> Lying, excessive <input type="checkbox"/> Defiant Behavior	<input type="checkbox"/> Runaway behavior, 2 or more times in last 6 months <input type="checkbox"/> Gang affiliation <input type="checkbox"/> Stealing from community	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Aggressive, low risk of injury	<input type="checkbox"/> Superficial injury to self and others <input type="checkbox"/> Several days a week <input type="checkbox"/> Cruelty to animals <input type="checkbox"/> Fire Setting <input type="checkbox"/> Destruction to items in the home	<input type="checkbox"/> High risk of serious injury <input type="checkbox"/> Serious injury caused <input type="checkbox"/> Several days a week	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Placement Disruptions		<input type="checkbox"/> One disrupted placement in last 6 months	<input type="checkbox"/> 2 or more disrupted placements in last 6 months	
<input type="checkbox"/> Placement Transition			<input type="checkbox"/> Transitioning from a residential facility	
<input type="checkbox"/> Physical disability	<input type="checkbox"/> Minor disability, does not affect mobility <input type="checkbox"/> Minor disability, does not affect self-care	<input type="checkbox"/> Moderate disability, affects mobility <input type="checkbox"/> Moderate disability, affects self-care	<input type="checkbox"/> Severe disability, affects mobility <input type="checkbox"/> Severe disability, affects self-care <input type="checkbox"/> Paraplegic <input type="checkbox"/> Quadriplegic	<input type="checkbox"/> Requires specialized treatment <input type="checkbox"/> Requires wheelchair accessible home
<input type="checkbox"/> Sexual disorders	<input type="checkbox"/> Sex abuse victim	<input type="checkbox"/> Sexually reactive	<input type="checkbox"/> Sexual Perpetrator <input type="checkbox"/> Prostitution	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Social conflict	<input type="checkbox"/> Every 1-2 weeks <input type="checkbox"/> Monthly	<input type="checkbox"/> Daily <input type="checkbox"/> Several days a week		<input type="checkbox"/> Requires specialized treatment

<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Smokes cigarettes	<input type="checkbox"/> Uses Alcohol <input type="checkbox"/> Uses Marijuana	<input type="checkbox"/> Uses Other drugs <input type="checkbox"/> Multiple Drug Use	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Suicidal Tendencies		<input type="checkbox"/>	<input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Suicide attempts, recent <input type="checkbox"/> Suicide attempt, over 1 year ago	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Truancy		<input type="checkbox"/> Missed 2-5 days in last month	<input type="checkbox"/> Missed more than 5 days in last month <input type="checkbox"/> Dropped out of school	
<input type="checkbox"/> Vision	<input type="checkbox"/> Impaired vision, corrective lens needed	<input type="checkbox"/> Partial Vision	<input type="checkbox"/> Blind <input type="checkbox"/> May require eye surgery	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Low Severity	<input type="checkbox"/> Moderate Severity	<input type="checkbox"/> Severe	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Low Severity	<input type="checkbox"/> Moderate Severity	<input type="checkbox"/> Severe	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Low Severity	<input type="checkbox"/> Moderate Severity	<input type="checkbox"/> Severe	<input type="checkbox"/> Requires specialized treatment
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Low Severity	<input type="checkbox"/> Moderate Severity	<input type="checkbox"/> Severe	<input type="checkbox"/> Requires specialized treatment

Summary

Carefully review the information above and then answer the following questions.

Does the child have one or more moderate special needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments/Explanation:		
Does the child have one or more severe special needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments/Explanation:		
Does the child have any therapeutic needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments/Explanation:		
Is it possible to meet the child's special and/or therapeutic needs in a traditional resource (foster/relative) home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments/Explanation:		
Does the child have extensive special and/or therapeutic needs that require 24-hour monitoring and/or care that indicates a need residential placement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments/Explanation:		
Based on the identified special and therapeutic needs of the child and the answers to the questions above, the recommended placement type is:		
<input type="checkbox"/> Traditional Resource (foster/relative) Home	<input type="checkbox"/> Special Needs Foster Home	
<input type="checkbox"/> Therapeutic Foster Home	<input type="checkbox"/> Residential Placement	