LANCASTER COUNTY JUVENILE COURT

Initial Protective Custody Hearing
Pre-Hearing Facilitation Checklist

Case No. _____ **Judge:** _____

Case Name: _____ **Date:** _____

Case Manager: _____

Supervisor: _____

Service Coordinator: _____ **KVC** ☐ **Visinet** ☐ **Cedars** ☐

Other Family/Friends Present _____ **Relation to Case** _____

_____ **Relation to Case** _____

_____ **Relation to Case** _____

CHILD(REN) INVOLVED:

	Name	Age/DOB	Mother	Father
1.				
2.				
3.				
4.				
5.				
6.				
7.				

IDENTIFY PARENTS

Is the biological father known and has his information been given to the Case Manager? Yes ____ No ____

Were the parents married at the time of child/rens birth? Yes ____ No ____

If no, mother must complete Affidavit of Identification for Paternity

PRIOR ORDERS IN EFFECT

Are there prior dissolution/custody orders that affect the children? Yes ____ No ____

Are there domestic abuse or harassment protection orders or sentences? Yes ____ No ____

Are there any other orders that affect the children such as child support? Yes ____ No ____

ICWA

Does the Indian Child Welfare Act apply? Yes ____ No ____ Parent Enrolled? Yes ____ No ____

Does either parent believe that they are eligible for enrollment in a Native American Tribe? Yes ____ No ____

Is/are the child(ren) enrolled or eligible for enrollment in a Native American Tribe? Yes _____ No _____

If yes, which tribe? _____ Who will check? _____

PLACEMENT OF THE CHILD(REN)

Current placement: Agency ____ Foster ____ Family ____

Are children placed together with siblings if applicable? Yes ____ No ____

If ICWA applies is present placement considered in compliance with preferences? Yes ____ No ____

Is it possible for the child(ren) to go home today?

If YES, is there a safety plan needed? If so, please describe below or attach separate sheet:

_____

_____

_____

If NO, are there appropriate family members or responding adults with whom the children would be placed? Please list:

Name: _____ Relationship **P | M** _____

Address _____ Phone _____

Name: _____ Relationship **P | M** _____

Address _____ Phone _____

Name: _____ Relationship **P | M** _____

Address _____ Phone _____

Name: _____ Relationship **P | M** _____

Address _____ Phone _____

Name: _____ Relationship **P | M** _____

Address _____ Phone _____

P = Paternal M = Maternal

PARENTING TIME (Visitation)

Current arrangements:

Proposed arrangements:

Parenting Time:

	How Often	How Much Time	Where	Circumstances
Mother's Schedule				Unsupervised ____ Monitored ____ Supervised ____ Therapeutic ____
Father's Schedule				Unsupervised ____ Monitored ____ Supervised ____ Therapeutic ____
Grandparents' Schedule				Unsupervised ____ Monitored ____ Supervised ____ Therapeutic ____
Schedule for Others (Relatives/Friends)				Unsupervised ____ Monitored ____ Supervised ____ Therapeutic ____

Transportation: Who will provide? _____ Arranged by: _____

Do parents have a drivers license? Mother: Yes ____ No ____ Father: Yes ____ No ____

Are there other considerations (e.g., safety) ? _____

_____

CHILD(RENS) NEEDS:

Are the child(ren) attending the same school? Yes ____ No ____ Where: _____

Does the child(ren) attend:

Social Activities	Yes ____	No ____	When: _____
Religious Activities	Yes ____	No ____	When: _____
Scouts	Yes ____	No ____	When: _____
4-H	Yes ____	No ____	When: _____
Sports	Yes ____	No ____	When: _____
Other _____	Yes ____	No ____	When: _____

Is the child(ren) working with TeamMates or other mentoring? Yes ____ No ____

SERVICES - Child(ren): Children in need of immediate services? YES _____ NO _____
If yes, complete Services Form

SERVICE	PROVIDER	WHEN AND HOW	WHO RESPONSIBLE FOR PAYMENT
Medical Examination			
Medication Evaluation			
Dental Examination			
Educational Evaluation			
Mental Health Evaluation			
Education			
Individual Therapy			
Alcohol/Substance Evaluation			
Independent Living			
Early Intervention			

SERVICES - Parents: Parent(s) willing to participate in services immediately? YES ____ NO ____

SERVICE	POTENTIAL PROVIDER	WHEN	WHO RESPONSIBLE FOR PAYMENT
Parenting Classes			
Housing			
Transportation			
Domestic Violence Counseling/Support Group			
Medical Examination			
Medication Evaluation			
Mental Health Evaluation			
Alcohol/Substance Evaluation			
Urine Drug Tests			
Education/Academic Testing			
Individual Therapy			

SERVICES - Family:

SERVICE	POTENTIAL PROVIDER	WHEN	WHO RESPONSIBLE FOR PAYMENT
Intensive Family Preservation			
Family Therapy			
Family Support Services			
Comprehensive Family Asst			

NEXT STEPS / ACTION PLAN

1. _____

2. _____

3. _____

INFORMATION ABOUT THE CHILDREN

Appointments (e.g., Dr./Dental):

School needs or Events:

Medication:

Behaviors or Special Needs:

Child's favorite toy, blanket, etc.:

Other: