

## In Home Family Services Agreement

<b>Family Name:</b>		<b>Social Worker Name</b>	
<b>Address and Telephone:</b>		<b>Telephone:</b>	

**Children/date of birth:**

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**Date of the next review of the Services Agreement:**

**Names of persons participating in the development of the Services Agreement:**

<b>Child/ren's Caregiver:</b>	
<b>Child/ren's Caregiver:</b>	
<b>Other Participants (including children)</b>	<b>Relationship to Family</b>
1.	
2.	
3.	
4.	
5.	
6.	
7.	

### I. Family Strengths and Resources

**II-a. Plan to Address Identified Needs:**

1. Need (from Strengths and Needs Assessment)
2. Describe behaviors that are of concern.

3. Objective

4. Activities/Responsibility/Target Dates

Activities	Who is Responsible	Target Date

**Review Status**

Review Status: Date ___/___/___	Status: Date ___/___/___	Status: Date ___/___/___
Achieved in full	Achieved in full	Achieved in full
No longer appropriate	No longer appropriate	No longer appropriate
Partially Achieved	Partially Achieved	Partially Achieved
Not achieved	Not achieved	Not achieved

**Comments regarding the review status and/or areas of concern:**

**II-b Voluntary Services Requested by the Family**  
**Family Objective:**

**Activities/Responsibility/Target Dates**

Activities	Who is Responsible	Target Date

**Progress toward meeting the identified objectives:**

**II-c. For each question below, be specific for each child. This information must be updated at least every six months for each child.**

**What are the effective services being provided to this child(ren) to keep the child(ren) from going into foster care?**

**What will happen if the child's safety can no longer be assured?**

**If the child must be removed from the home, what are the parent's preferences for placement?**

**Under what circumstances will the agency end services and close the case?**

**III. Child well-being needs identified with family and from Family Assessment of Strengths and Needs Instrument, Page 2, and how they will be addressed:**

**A. Educational:**

**B. Physical:**

**C. Mental Health:**

**D. Other**

**Progress toward meeting the child well-being identified needs:**

**Page 5 of 7**

**Notification for Parents/Guardians/Caretakers:** Unless otherwise indicated, the activities and services provided by DSS staff or other public providers are funded with TANF (Temporary Assistance to Needy Families) or other public funds.

**Signatures of persons who wrote this agreement and who will work toward meeting the identified objectives:**

SIGNATURE	DATE OF SIGNATURE	REVIEW DATE(S)	DATE(S) COPIES PROVIDED
Parent/Caregiver _____ _____ _____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____
Parent/Caregiver _____ _____ _____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____
Youth _____ _____ _____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____
Youth _____ _____ _____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____
Youth _____ _____ _____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____
Social Worker/Agency Rep. _____ _____ _____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____
Supervisor/Agency Rep. _____ _____ _____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____	____/____/____ ____/____/____ ____/____/____ ____/____/____

