**SWAN Post Permanency Assessment & Reevaluation Form**

**Referral Date:**

**Affiliate:**

**Contact Email:**

**Family Name:**       **SWAN ID#:**

**Child Name:** **SWAN ID#:**

**[ ]  Initial Assessment** **[ ]  6 months Review of Services**

Date Submitted:       Date Submitted:

**Units of Services Requested\*/Provided: Affiliate Requested by Family:**

[ ]  Case Management Advocacy

[ ]  Support Group

[ ]  Respite

[ ]  No SWAN Services Recommended

\* Either initial request or request for reauthorization.

**Risk Assessment:**  Date Completed:

Overall Risk:

**Child Safety Assessment:** Date Completed

Safety Assessment:

**FACES III Assessment:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Cohesion | Adaptability | /2 = Type | Date Completed |
| Parent One: |     |     |     |       |
| Parent Two: |     |     |     |       |
| Child: (Identified at risk if over age 12) |     |     |     |       |

**CAFAS™ Scoring Summary Youth Risk Behaviors**

**(For child identified at Risk)** [ ]  Has made a serious suicide attempt or is

School  considered to be actively or possibly suicidal.

Home [ ]  Has been or may be harmful to self or others due to:

Community [ ]  Aggression at School

Behavior toward others [ ]  Aggression in Community

Moods and Emotions [ ]  Aggression at Home

Self harmful behavior [ ]  Aggression in Behavior, in General

Substance abuse [ ]  Sexual Behavior

Thinking [ ]  Fire Setting

**Total**  [ ]  Runaway Behavior

 [ ]  Psychotic or Organic Symptoms (in the Context

of Severe Impairment)

**Initial Assessment (only)**

Parents rate the following on scale of 1 – 10 (least to most):

1. I (we) feel depressed

2. I (we) feel in control

3. I (we) understand our child’s problems

4. I (we) feel supported by other family members/friends

**Six Month Review (only)**

1. Has this service(s) offered you some feeling of relief?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

1. Has this service(s) helped you feel in more control of the situation?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

1. Has this service(s) educated you?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

4. Has this service(s) helped you feel more connected to someone, even in a small way?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

5. Do you feel more supported?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

6. Do you feel less isolated?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

7. Do you have more resources as a result of this service(s)?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

8. Do you feel that this service(s) has helped maintain the child in your home?

Parent One Parent Two

[ ]  Yes [ ]  No [ ]  Yes [ ]  No

1. I/we feel more confident about managing my child’s behaviors.

Parents rate the following on scale of 1 – 10 (Do Not Agree {1} to Strongly Agree {10}):

Parent One Parent Two

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**Administrative Approval: Date of Review**

Units Requested Requested Approved

Case Management/Advocacy [ ]  [ ]

Support Group [ ]  [ ]

Respite [ ]  [ ]