**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