CFS 440-11
9/2006

State of Illinois
Department of Children and Family Services

SUBSTANCE AFFECTED FAMILIES PROCEDURES CHECKLIST

Alcohol and Other Drug Abuse Services

DOCUMENTATION

Copies of all CFS 440 AODA forms and treatment reports should be filed together in the case file. Case notes must document required activities.

DIRECTIONS: DCP, Intact and CWS workers must check points that apply at each stage of the case to ensure compliance with procedure. Add a date when the task is completed for each client as applicable. Worker and supervisor signatures are required at each case hand-off on page 3.	**Mother/ Caregiver**	**Father**	**Youth**	**Family/ Paramour/ Other**
I SCREEN FOR SUBSTANCE ABUSE				
☐ **CFS 440-5 Adult Substance Abuse Screen is completed on relevant adults including parents, household members or extended family, and child caregivers.**				
☐ **The CFS 440-8 Adolescent AODA Indicator is completed on any youth suspected of substance abuse.**				
☐ **NO AODA ASSESSMENT OR TREATMENT IS RECOMMENDED. STOP HERE.**				
II REFERRAL FOR AODA ASSESSMENT				
☐ **The CFS 440-5 Adult Substance Abuse Screen or the CFS 440-8 Adolescent AODA Indicator documents the need for further AODA assessment.**				
☐ **The CFS 440-6 DCFS Referral for Adult AODA Treatment Services is completed and faxed.** ☐ **JCAP initiated in Cook County.**				
☐ **The CFS 440-7 Consent for Disclosure is completed and faxed to the AODA provider.** ☐ **JCAP initiated in Cook County.**				
☐ **A relevant adult with a LEADS background check that indicates criminal history of drug related charges is referred for an AODA assessment.**				
☐ **DCFS/POS conveyed any information from the LEADS check to the DASA provider.**				
☐ **The Recovery Matrix is introduced and completed with the client.** ☐ Intact ☐ Placement				
☐ **DCFS obtained the Referral Acceptance Form or notice of appointment from the AODA provider.**				
☐ **Transportation for the initial appointment is confirmed, provided or arranged by the caseworker.**				
☐ **Appropriate childcare plans were facilitated with assistance of the caseworker.**				
☐ **Communication barriers such as literacy, language, or lack of telephone have been addressed.**				
☐ **A transitional visit was completed with the family within 48 hours of the case hand-off or TC.**				
☐ **SEI CASE – ALLEGATION #65**				
☐ Obtain information and records from hospital social worker and nurse about the baby's condition.				
☐ Collaborate with the local public health nurse or other health care professional.				
☐ Develop a child-care plan with intact family cases.				
☐ Screen cases involving second or subsequent SEI births with the State's Attorney to request an Order of Protection from the court. ☐ Accepted ☐ Declined				

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III INTAKE FOR AODA SERVICES	Mother/ Caregiver	Father	Youth	Family/ Paramour/ Other
☐ **The results of the initial scheduled appointment are documented.**				
☐ **The initial appointment was missed.**				
☐ Follow up contact with the client was made within 48 hours after notification for an Intact Family.				
☐ Follow up contact with the client was made within one week for a Placement case.				
☐ **Re-initiate the Referral for Adult AODA Treatment Services if client is willing to proceed.**				
IV AODA TREATMENT				
☐ **A Home Safety Checklist is completed.**				
☐ **A copy of the client's Integrated Assessment and Service Plan was given to the AODA provider within one week of completion.**				
☐ **Copies of the Client Progress Reports have been obtained from the AODA provider every 30 days.**				
☐ **Copies of the Observation of Parent Behavior Reports have been obtained from the AODA provider every 30 days.**				
☐ **The client is missing appointments.**				
☐ A joint visit was made to the client by the DCFS/POS worker and AODA provider.				
☐ **A relapse prevention plan has been developed with the client and AODA provider.**				
☐ **A copy of the Discharge Plan has been obtained.**				
V COORDINATION OF TREATMENT WITH AODA PROVIDER				
☐ **Weekly contact between the caseworker and the client is documented during the first six weeks of treatment regarding progress and needs.**				
☐ **Weekly contact between the caseworker and AODA provider is documented during the first six weeks of treatment regarding progress and needs.**				
☐ **An interagency staffing with the caseworker and AODA provider was coordinated with IA and convened within two weeks of beginning treatment.**				
☐ **Ongoing interagency staffings with the caseworker, the AODA provider, & other relevant service providers:**				
☐ At the Family Meeting within 45 days of case opening				
☐ At least quarterly				
☐ Prior to changes in level of AODA care				
☐ Prior to planned discharges from treatment				
☐ Prior to Intact Family case closures				
☐ Prior to recommendation for unsupervised visits				
☐ Prior to Reunification or changes in child custody				
☐ Whenever events occur that might affect child safety, permanency, or treatment needs				
☐ **AODA education and referrals to support services such AA, NA, Al-Anon, and Ala-Teen were provided to the client and family.**				

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VI CASE CLOSING OR REUNIFICATION REQUIREMENTS FOR CASES WITH AODA ISSUES	Mother/ Caregiver	Father	Youth	Family/ Paramour/ Other
☐ **Case Closing or Reunification Guidelines: Check all that apply.**				
☐ Risk and safety assessments demonstrate that any threats of harm to the children are addressed.				
☐ Family has achieved service plan goals.				
☐ The parent has made substantial progress according to the Recovery Matrix.				
☐ The parent/caretaker has had negative urinalysis reports for past six months.				
☐ A LEADS check is free of current drug related or violent charges.				
☐ The parent demonstrates appropriate parenting skills according to the Reunification Checklist.				
☐ Children have access to extended family or a community support system to call for assistance.				
☐ Parent/caregiver has not successfully completed a substance abuse treatment program, but the worker has verified that the needs of the children are met and they are safe.				

Investigator Signature_____ Date _____DCP Supervisor _____Date _____

Worker Signature _____ Date _____Supervisor _____Date _____

Worker Signature _____ Date _____ Supervisor _____ Date _____

Worker Signature _____ Date _____ Supervisor _____ Date _____

Worker Signature _____ Date _____ Supervisor _____ Date _____