

Guardian ad Litem/Child's Attorney Questionnaire

Name of Child(ren): _____ Board #: _____ Please return by: ___/___/___

Court Information	
What do you understand to be the child(ren)'s permanency plan?	<input type="checkbox"/> Reunification <input type="checkbox"/> Guardianship <input type="checkbox"/> Adoption <input type="checkbox"/> Independent living <input type="checkbox"/> Long-term Foster Care <input type="checkbox"/> Self-sufficiency <input type="checkbox"/> Plan in transition <input type="checkbox"/> Unclear <input type="checkbox"/> No plan
What problems, if any, keep this plan from succeeding?	<input type="checkbox"/> Lack of parental compliance <input type="checkbox"/> Funding problem for services <input type="checkbox"/> On waiting list for services <input type="checkbox"/> Parental mental limitations/deficiency <input type="checkbox"/> Services needed, not available in this area <input type="checkbox"/> Legal delays in filing for permanency <input type="checkbox"/> Legal delays due to criminal charges <input type="checkbox"/> Child's behavior/needs <input type="checkbox"/> Permanency goal inappropriate Other: _____
Date of the most recent Court hearing: ___/___/___	
Date of the next scheduled Court review: ___/___/___	

Services	
What additional services could or should be provided to the <u>family</u> ? <input type="checkbox"/> Domestic violence worker <input type="checkbox"/> Family support <input type="checkbox"/> More visitation <input type="checkbox"/> In-home services <input type="checkbox"/> Parenting classes <input type="checkbox"/> Homemaker services <input type="checkbox"/> Incest treatment <input type="checkbox"/> Family Counseling <input type="checkbox"/> Co-dependency treatment <input type="checkbox"/> Psychological evaluations <input type="checkbox"/> Alcohol/drug treatment <input type="checkbox"/> Other: _____	What additional services could or should be provided to the <u>child(ren)</u> ? <input type="checkbox"/> Counseling <input type="checkbox"/> Incest treatment <input type="checkbox"/> Dental care <input type="checkbox"/> Medical treatment <input type="checkbox"/> Special education <input type="checkbox"/> Independent living <input type="checkbox"/> Tutoring <input type="checkbox"/> Educational testing <input type="checkbox"/> In patient treatment <input type="checkbox"/> Psychological evaluation <input type="checkbox"/> Alcohol/drug treatment <input type="checkbox"/> Other: _____

Visitation	
Is visitation with the parents occurring?	<input type="checkbox"/> Both parents <input type="checkbox"/> Mom only <input type="checkbox"/> Dad only <input type="checkbox"/> Neither parent
How are visits supervised?	<input type="checkbox"/> Supervised <input type="checkbox"/> Monitored <input type="checkbox"/> No supervision
Is visitation with siblings occurring?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some <input type="checkbox"/> N/a *Please indicate here if child is visiting any other relatives: _____ _____
Do you believe that the current visitation arrangement is in the child(ren)'s best interest?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain) _____ _____

Placement	
Do you believe that the child(ren)'s current placement is appropriate	___ Yes ___ No (If no, please explain) _____ _____
Have you been informed of the child(ren) being placed in any restraints at his/her placement?	___ Yes ___ No (If yes, by whom and when were you informed) _____
Have you ever visited the child(ren)'s placement?	___ Yes Date ___/___/___ ___ No
When was the last time you visited personally with the child(ren)? ___/___/___	

Do you believe that the child(ren) could safely be returned home at this time?	___ Yes ___ No (If no, please explain why here) _____ _____
Have any new issues developed since the initial intervention?	___ new live-in companion ___ parental law violations ___ new child born/due ___ incarceration of parent ___ frequent parental moves ___ lost housing ___ parental whereabouts unkn ___ sexual abuse allegations have been made ___ child unwilling to return home ___ criminal charges filed on abuse/neglect ___ Other _____

Do you believe that communication is adequate between the parties is adequate?			
	Yes	No	N/a
Case manager			
CASA			
County Attorney			
Foster parents			
Services providers			

Please describe any communication barriers here:

Please include here any other information that you would like the Board to know; feel free to add extra pages if you need more room.

Form completed by: _____ Date completed: ___/___/___

THANK YOU, PLEASE RETURN THIS FORM TO:

To respond by taped questionnaire, call 1-800-577-3272