

Parent's Attorney Questionnaire

Name of Child(ren): _____ Board #: ____ Return by: ____/____/____

What do you understand to be permanency objective for the child(ren)?	<input type="checkbox"/> Reunification <input type="checkbox"/> Long-term foster care <input type="checkbox"/> Guardianship <input type="checkbox"/> Adoption <input type="checkbox"/> Self-sufficiency <input type="checkbox"/> In transition <input type="checkbox"/> No plan <input type="checkbox"/> Independent living <input type="checkbox"/> Unclear
What problems if any, are keeping this plan from succeeding?	<input type="checkbox"/> lack of parental compliance <input type="checkbox"/> services not available in the area <input type="checkbox"/> lack of funding for services <input type="checkbox"/> legal delays in filing for permanency <input type="checkbox"/> child's behaviors/needs <input type="checkbox"/> parental mental limitations/deficiency <input type="checkbox"/> on waiting list for services <input type="checkbox"/> legal delays due to criminal charges <input type="checkbox"/> other, please describe: _____

What services has your client participated in or would your client like to participate in?

	Not needed	Needed, not provided	Provided	Completed	Refused	On Waiting list
Alcohol/Drug Treatment						
Co-dependency Treatment						
In-home Services						
Psychological Evaluation						
Housing						
Sex Offender Treatment						
Family Counseling						
Domestic Violence Program						
Family Support Worker						
Homemaker Services						
Parenting Classes						
Transportation Services						
Support Groups						
In-patient Treatment						
Individual Counseling						
Language Translator Services						
Other:						
Is your client on the waiting list for any of these services, please describe.						

Visitation

In your opinion, are the current visitation arrangements for your client appropriate, please describe:

Are visits supervised, monitored, or unsupervised? (Please circle which applies)

Is your client attending all scheduled visitation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Have any conditions that caused the child(ren) to come into foster care changed? Please explain.	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Do you feel the child(ren) could return safely home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, but with services (Please describe) <hr/> <hr/> <hr/>
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Have any new issues developed since the initial intervention?	<input type="checkbox"/> New live-in companion <input type="checkbox"/> parental law violations <input type="checkbox"/> new child born/due <input type="checkbox"/> incarceration of parent <input type="checkbox"/> frequent parental moves <input type="checkbox"/> lost housing <input type="checkbox"/> parental whereabouts unkn <input type="checkbox"/> sexual abuse allegations have been made <input type="checkbox"/> child unwilling to return home <input type="checkbox"/> criminal charges filed on abuse/neglect <input type="checkbox"/> Other
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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.	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Form completed by: _____ Date completed: ___/___/___

THANK YOU, PLEASE RETURN THIS FORM TO:

Foster Care Review Board Executive Building, 521 S. 14 th St. Suite 401 Lincoln, NE 68508-2707 Fax # 1-402-471-4437
