The CPS Assessment Structured Documentation Instrument is a tool designed to assist the assigned social worker in documenting their activities throughout the entire life of a CPS Assessment (210 services). Pre-Service Training teaches that documentation is a way to, “communicate to others in writing what you learned (through direct observation and in conversations with others), what you think about what you learned (your evaluation of that information) and what you plan to do.” Documentation is accomplished in a holistic manner using a worker’s knowledge of family-centered social work practice and in concert with the family. A holistic approach is one that examines every aspect of the family’s life. Also taught in Pre-Service Training, a mnemonic device for remembering all of the aspects of this holistic approach is referred to as S.E.E.M.A.P.S. This means documenting all of the aspects of family’s life including their: Social activities, Economic situation, Environmental issues, Mental health needs, Activities of daily living, Physical health needs, and a Summary of strengths. For a more detailed description of exploratory questions and statements related to S.E.E.M.A.P.S. refer to the Understanding S.E.E.M.A.P.S. section at the end of this document.

Documentation is completed constantly throughout the assessment as long as the case remains open and thorough documentation is used at critical intervals throughout the life of the case. It is used to inform decision-making about the nature and extent of services needed by the family, it can be used as evidence during legal actions brought about by the agency, and it is used to both obtain and maintain funding for CPS staff. For these reasons and many more it is critical that documentation be concise, organized, legible, and most critically…documentation must be current within seven days.

Which cases: All CPS Assessments (whether Family Assessments or Investigative Assessments) of child abuse, neglect and dependency require on-going and current documentation. This includes Conflict of Interest cases, Assessments of Out-of-Home placements, Requests for Assistance arising from Jurisdiction cases, etc.

Who completes: Any social worker(s) assigned to the CPS Assessment whether the primary worker or one acting in a supportive role (i.e., on-call social worker, assisting county social worker, etc.).

When completed: Documentation will be completed whenever there is any activity done on a case immediately following acceptance of a CPS referral by an agency for assessment of abuse, neglect, and/or dependency. This may include, but is not limited to: home visits, office visits, telephone calls, community or school visits, letters or e-mails sent and/or received, voice mail messages left and/or received, etc. Documentation will be current within seven calendar days of the occurrence the case activity.

Additional Information: This structured documentation instrument was designed using Microsoft® Word 2003 (SP3) and was designed to be used primarily as a form document. This means that if the Microsoft® Word version is being completed, this document can be protected and information can be entered into each of the fields as if one were completing a form. Locking the form will enable the drop-down menus so that the items available for selection can be accessed and selected. However, locking the instrument makes other portions of the form unavailable for edit (i.e., headers, etc.). For help on using forms in Microsoft® Word, click on F1 and conduct a search on the keyword “forms.” Using the interactive version of this instrument, the default view for drop-down menu items is

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1 The instructions outlined in this instrument are meant as a supplement and not a replacement to the policies and procedures found in the Family Services Manual Volume 1, Chapter VIII.

2 North Carolina Division of Social Services Pre-Service Training Module 6 – Documentation in Child Welfare Services
represented by two dashes (--). The non-interactive version of this form may also be printed out and completed by hand. Counties also have the discretion of converting this instrument into a case management system if the agency chooses. This instrument may be modified in any fashion to suit the agency’s needs, provided that the information found within this instrument is captured somewhere within the documentation as applicable to each case. The agency may also modify the instrument to capture additional information not reflected in this template based on the specific needs of their agency and/or community. (Note: if an agency elects to use a different word processing program or automation tool to document the case record, any page numbers referenced in the instructions may not correspond to the program or tool being used.)

**Case Identification Explanations:**

The case name and county case number should appear on each page. There is no specific format to these fields and is to be determined by each county. With the interactive version, this information is captured as a “header” and once completed on one page will be populated on all pages automatically. (Note: this information should be entered before the document is “protected” as a form as locking the document also prevents the header information from being changed.)

The county name should be entered at the beginning of the form in the space provided.

**I. CASE INFORMATION**

Detailed information related to the policies and procedures associated with items 4-14 within this section can be found in: Family Services Manual Volume I; Chapter VIII: Protective Services; Section 1407: Structured Intake or in Section 1408: Investigative and Family Assessments.

1. **Initiation Worker**
   
   This item captures the name of the social worker who has first face-to-face contact with the family (Note: this may be the same as the On-Going Case Worker in some agencies). The format for this field is: worker last name, first name middle initial (i.e., Goode, John B.).

2. **On-Going Case Worker**
   
   This item captures the name of the primary caseworker (Note: this field may need to be updated if case responsibility is assigned to a new worker during the course of the assessment). The format for this field is: worker last name, first name middle initial (i.e., Goode, John B.).

3. **Supervisor**
   
   This item captures the name of the supervisor providing direct supervision to the primary caseworker (Note: this field may need to be updated if supervision is assigned to a different supervisor during the course of the assessment). The format for this field is: supervisor last name, first name middle initial (i.e., Public, John Q.).

4. **Date of Referral**
   
   This item captures the date the initial report requiring an assessment was received by the agency. The format for this item is MM/DD/YYYY.

5. **Date Assigned**
   
   This item captures the date the initial report requiring an assessment was assigned by the intake worker or by the supervisor to a caseworker. The format for this item is MM/DD/YYYY.

6. **Date Initiated**
   
   This item captures the date the caseworker had face-to-face contact with the family in response to the assigned report. The format for this item is MM/DD/YYYY.
7. Type of Report

This item allows the worker to enter one of seventeen primary maltreatment allegations made in the CPS referral that characterize why the referral was accepted for assessment. Workers should select the most severe form of alleged maltreatment for which the report was accepted. The referral allegations the worker may enter include:

- ABANDONMENT
- CONFLICT INVESTIGATION FOR COUNTY OF ___________
- CRUEL OR GROSSLY INAPPROPRIATE BEHAVIOR MODIFICATION
- DEPENDENCY
- DOMESTIC VIOLENCE
- EMOTIONAL ABUSE
- ILLEGAL PLACEMENT / ADOPTION
- IMPROPER CARE
- IMPROPER DISCIPLINE
- IMPROPER MEDICAL / REMEDIAL CARE
- IMPROPER SUPERVISION
- INJURIOUS ENVIRONMENT
- MORAL TURPITUDE (ABUSE)
- PHYSICAL ABUSE
- REQUEST FOR ASSISTANCE (RA) FOR COUNTY OF _____________
- SEXUAL ABUSE
- SUBSTANCE ABUSE

8. Additional Allegation

When applicable, this item allows the worker to enter an additional maltreatment allegation found in the CPS referral that characterize why the referral was accepted for assessment. Workers should enter the secondary form of alleged maltreatment for which the report was accepted if applicable. (Note: the most severe form of alleged maltreatment should be reflected in item 7 while this field should only be used to reflect an additional allegation for which the report was accepted at the county’s discretion. Therefore, this field is not required.) If there are no additional allegations for which the report was accepted the worker should enter “N/A.” The additional referral allegations the worker may enter include:

- N/A
- ABANDONMENT
- CONFLICT INVESTIGATION FOR COUNTY OF ________
- CRUEL OR GROSSLY INAPPROPRIATE BEHAVIOR MODIFICATION
- DEPENDENCY
- DOMESTIC VIOLENCE
- EMOTIONAL ABUSE
- ILLEGAL PLACEMENT / ADOPTION
- IMPROPER CARE
- IMPROPER DISCIPLINE
- IMPROPER MEDICAL / REMEDIAL CARE
- IMPROPER SUPERVISION
- INJURIOUS ENVIRONMENT
- MORAL TURPITUDE (ABUSE)
- PHYSICAL ABUSE
- REQUEST FOR ASSISTANCE (RA) FOR COUNTY OF _____________
- SEXUAL ABUSE
- SUBSTANCE ABUSE

County departments of social services face particularly challenging issues when having to assess licensed foster homes and pre-adoptive placements. Some examples of these issues may include, but are not limited to: consideration of whether a foster child may
need to be moved during the course of the assessment or whether the adoption process should be suspended until the outcome of the assessment of the pre-adoptive placement is determined. These challenging issues are compounded when there is involvement of multiple jurisdictions. When assessing (either agency or private) licensed foster homes and pre-adoptive placements, county departments are strongly encouraged to have thorough discussions with all involved parties to address these issues. These discussions should occur between the worker(s) and the supervisor(s) or within a child welfare team setting and should be thoroughly documented in the case record. When assessing privately licensed foster homes or private pre-adoptive homes, it is critical that the county department also engage these private agencies in the discussions as well.

9. Report Response Time Frame
This item contains a drop-down menu that allows the worker to select the response time frame required for initiation of the referral. The worker may circle either:
- IMMEDIATE
- 24 HR.
- 72 HR.

The North Carolina General Statute governing assessment response priorities is hyperlinked in this item for reference.

10. Accepted As
This item allows the worker to select one of the two response tracks for which the report was originally assigned. (Note: there will be an opportunity later to capture whether the report needed to be reassigned to the other assessment type during the course of the assessment). The worker may circle either:
- FAMILY ASSESSMENT
- INVESTIGATIVE ASSESSMENT

11. New Report on This Open Assessment
This item contains a drop-down menu that allows the worker to capture whether any new allegation and/or incident that meets the legal definitions of abuse, neglect and/or dependency is received from the public during the course of an open assessment. For further information on this policy requirement refer to Family Services Manual Volume I; Chapter VIII; Section 1408. An open narrative area to explain the selection is also provided. The worker may circle:
- YES
- NO
- N/A

12. Date Response Method Switched
This item reflects the date the worker and the supervisor made the decision to switch assessment tracks, if applicable. An open narrative area is also provided to document the rationale for the case re-assignment as well as a line for the supervisor’s signature on hard copy print-outs of the instrument. The format for this field is MM/DD/YYYY.

13. Previous CPS Record Reviewed
This item allows the worker to capture whether any previous agency records involving this same family have been reviewed by the assigned worker. The worker may circle:
- YES
- NO
- N/A
14. “Substantiation” or “Services Needed” in Past Year

This item allows the worker to capture whether there has been any determination that abuse, neglect, or dependency may have occurred within the family within the past twelve months. The worker may circle:

- YES
- NO
- INFORMATION ATTACHED (ABBREVIATED AS ATTACHED)
- N/A

15. Explain #14

This item, if applicable, is an open narrative area to explain the findings related to item 14 including, but not limited to: the level of the agency’s involvement with the family, the family’s responsiveness to agency intervention, outcomes of CFT meetings, level of case plan completion, significant case contacts, custody assumed or any significant information relevant to the case.

II. HOUSEHOLD MEMBERS

This landscape oriented page captures demographic information on up to six children and six adults within the household. If there are additional children or adults in the household an additional page should be copied and completed as needed.

a. This item captures the child’s full name in the full first, full middle and full last name format along with any nickname the child may be known by (Note: it is recommended that for organizational purposes the worker enter the youngest child first and progress to the oldest child).

b. This item captures the child’s eleven digit SIS identification number. For more information on assigning a child a SIS identification number refer to the Services Information System (SIS) User’s Manual.

c. This item captures the child’s date of birth in the MM/DD/YYYY format.

d. This item captures the child’s race or ethnicity code as reported by the family. The worker will enter the same race or ethnicity code found in Appendix A of the Services Information System (SIS) User’s Manual as will be reported on the DSS-5104. Workers shall not make assumptions or guesses regarding a child’s race, ethnicity, or heritage based on appearances. Rather, it is critical that worker engage the family in a discussion around the child’s race and ethnicity that the family most identifies for the child.

e. This item captures the child’s American Indian heritage status in a drop-down menu. During each CPS Assessment the agency will ask the family about the status of any American Indian heritage of each child within the family. Should the family discuss any American Indian heritage the child may have, the agency shall maintain the responsibility of completing the CPS Assessment and to provide any follow up services as needed. Should placement of a child identified as an Indian child become necessary during the CPS Assessment the worker should refer to the Family Services Manual; Chapter IV; Section 1201 for direction on how to proceed. Further guidance on the Indian Child Welfare Act (ICWA) can be found at: http://www.nicwa.org. While ICWA addresses provisions for federally recognized tribes, North Carolina General Statute §143B-139.5A directs that the North Carolina Division of Social Services and the North Carolina Association of County Directors of Social Services (representing the county departments of social services) work in
collaboration with the Commission of Indian Affairs (representing state recognized tribes) and the Department of Administration in a manner consistent with federal law (ICWA). The worker may circle:

- YES
- NO
- UNABLE TO DETERMINE (abbreviated as UNABLE)

f. This item captures the child’s current school and grade assignment. The name of the child’s primary teacher may also be entered here. Should the child be on summer break between school years the worker should enter the information related to the upcoming grade the child will be entering.

g. This item captures the primary language that the child speaks or will learn to speak based on the primary language spoken in the home.

h. This item captures the child’s status as it relates to his or her physical presence in the home during the CPS Assessment. A child that is absent may be so because s/he is at summer camp or a detention facility, etc. This should prompt workers to make a Request for Assistance (RA) from another county to interview the child if that child is not easily accessible by the assessing worker. A child that is a resident lives primarily in the home that is identified as the residence being assessed. A child that is visiting may be a step-child or a half sibling only in the home for brief periods of time but has his or her primary residence elsewhere. For further guidance related to jurisdiction issues in child welfare, refer to Family Services Manual Volume I; Chapter V – Jurisdiction in Child Welfare. The worker may circle:

- ABSENT (abbreviated as ABS)
- RESIDENT (abbreviated as RES)
- VISITING (abbreviated as VIS)
- OTHER (abbreviated as OTH) (specify in item 16)

i. This item captures the adult’s full name in the full first, full middle and full last name format along with any nickname the adult may be known by.

j. This item captures the relationship that the identified adult may have with the child(ren) listed in the section above. This information should be documented in global terms. For example, if the first adult listed is the biological father to child number 1 and the step-father to 2 and 3, the relationship information entered in this section may read as “bio dad child 1; step dad child 2-3.”

k. This item captures the adult’s date of birth in the MM/DD/YYYY format.

l. This item captures the adult’s race or ethnicity code as reported by the adult. The worker will enter the same race or ethnicity code found in Appendix A of the Services Information System (SIS) User’s Manual as will be reported on the DSS-5104. Workers shall not make assumptions or guesses regarding an adult’s race, ethnicity, or heritage based on the adult’s appearances. Rather, it is critical that workers engage the adult in a discussion around the race and ethnicity they most identify themselves with.

m. This item captures the adult’s American Indian heritage status. During each CPS assessment the agency will ask all adult family members about any American Indian heritage they may have. The adult’s disclosure as to the status of their American
Indian heritage will be captured in the section provided in this column. The worker may circle:
- YES
- NO
- UNABLE TO DETERMINE (abbreviated as UNABLE)

n. The adult’s current or most recent employer contact information is captured in this column. If the adult is unemployed other information may be captured here such as educational status, any Work First participation, disability information, etc.

o. This item captures the primary language the adult speaks.

p. This item captures the adult’s status as it relates to his or her physical presence in the home. The worker may circle:
- ABSENT (abbreviated as ABS)
- RESIDENT (abbreviated as RES)
- VISITING (abbreviated as VIS)
- OTHER (abbreviated as OTH) (specify in item 16)

An adult that is absent may be so because s/he is away attending school, deployed while serving in the military, incarcerated, etc. This should prompt workers to make a Request for Assistance (RA) from another county to interview the adult if that adult is not easily accessible by the assessing worker. An adult that is a resident lives full-time in the home that is identified as the residence being assessed. An adult that is visiting may be an out-of-town relative or a visiting friend who is only in the home for brief periods of time but has his or her primary residence elsewhere. For further guidance related to jurisdiction issues in child welfare, refer to Family Services Manual Volume I; Chapter V – Jurisdiction in Child Welfare.

13. This item captures the physical address that the residence is found.

14. This item captures a mailing address for the family if that address is different than the physical location of the residence.

15. This item captures any telephone numbers for the family including, but not limited to home telephone number, work telephone number, mobile telephone number, pager number, etc.

16. This item captures any other information that will assist the family in staying in contact with the family or may capture any information relating to the status of any children or adults in the home as listed previously.

III. CIVIL / CRIMINAL RECORDS

These items capture historical or on-going safety issues involving law enforcement or the court system. While agencies have the discretion to document any information found, agencies should pay particular attention to charges related to family violence, offenses committed against children, or offenses indicating chronic substance abuse issues. It is highly recommended that in reports involving allegations of family violence, the agency conduct these checks prior to initiation and the agency take appropriate measures to ensure the safety of the worker as well as the family. For further guidance on addressing issues of family violence, refer to: Family Services Manual Volume I; Chapter VIII; Section 1409: Domestic Violence. In lieu of manually entering information found during these checks, the agency has the option of
attaching the information to hard copy print-outs of the documentation instrument. Detailed information related to the policies and procedures associated with the items within this section can be found in: Family Services Manual Volume I; Chapter VIII; Section 1408: Investigative and Family Assessments.

1. This item captures information that may indicate whether there is currently a Domestic Violence Protective Order (DVPO) in place for any of the adults in the home. A hyperlink to the North Carolina General Statute related to the issuance of a DVPO is provided.

2. This item captures whether the worker has verified any criminal activities of any member within the family. The method for verifying this information may be through the Administrative Office of the Courts (AOC) Automated Criminal Infraction System (ACIS).

3. This item captures any information found during the assessment relevant to any calls that law enforcement may have made to family’s residence regardless of whether those calls resulted in an arrest or criminal conviction or not.

IV. DILIGENT EFFORTS TO INITIATE CASE

1. These items capture the workers efforts to initiate the case in a timely manner as outlined in the North Carolina Administrative Code (hyperlinked for reference). Each unsuccessful attempt made by the worker to initiate should be reflected in the grid in chronological order. Diligent efforts are described in: Family Services Manual Volume I; Chapter VIII; Section 1408: Investigative and Family Assessments.

   a. This item captures the date the worker attempted to initiate and is entered in the first block using the MM/DD/YYYY format.

   b. The time of the attempted initiation is captured in this item using either the 12-hour or 24-hour format. Should the worker elect to enter the time using the 12-hour format the worker should circle either AM or PM.

   c. This item captures the type of contact attempted. The type of contact the worker may enter includes:

      • AGENCY RECORDS SEARCHED (OLV, SIS, EPICS, ETC.)
      • COLLATERALS CONTACTED (LANDLORD, NEIGHBOR, ETC.)
      • COMMUNITY VISIT
      • E-MAIL (ATTACH CORRESPONDENCE)
      • FAX (ATTACH CORRESPONDENCE)
      • HOME VISIT
      • MEMO LEFT
      • OFFICE VISIT
      • PUBLIC UTILITIES (CABLE, ELECTRIC, TELEPHONE, ETC.)
      • REPORTER CONTACTED FOR ADDITIONAL INFORMATION
      • SCHOOL / DAYCARE CONTACTED
      • TELEPHONE CONTACT
      • VOICE MAIL MESSAGE LEFT
      • VOICE MAIL MESSAGE RECEIVED
      • PUBLIC RECORDS SEARCHED (D.O.C., INTERNET, ETC.)
      • OTHER (SPECIFY IN THE RESULTS SECTION)
d. This item captures information the name of the person that was the target of the attempted initiation contact and their relationship to the family.

e. This item documents the outcomes of the attempt to initiate or contacts made during the course of making diligent efforts. Information that should be captured in this field may include, but is not limited to: nature of messages left, contact memo left at home, arranged face-to-face visit, etc. If the attempt to initiate results in an interview the worker should cross-reference the case contact date the interview occurred.

2. If applicable, this item captures documentation as to why the case was not initiated within the specified timeframe.

3. If applicable, this item captures documentation as to why the assessment was held open longer than the specified timeframe as outlined in policy (30 days from the date of initiation for Investigative Assessments and 45 days from the date of initiation for Family Assessments). Rationales of delay in making a case decision within the specified timeframe may include but are not limited to: additional reports received, CME or C/FE needed and the final report is pending, petition filed and custody was assumed, etc.

4. This item captures whether the family was notified (consistent with the Family Centered principles of partnership) of the agency’s need to make a case decision outside of the prescribed timeframes. The worker will circle either:
   - YES
   - NO
   - N/A
   and document the family’s response to this discussion.

V. CPS CASE ACTIVITIES

Each of these nineteen case activities items captures narrative relevant to that specific activity (Note: not all nineteen activities may be applicable to every case). Detailed information related to the policies and procedures associated with these eighteen items within this section can be found in Section 1408: Investigative and Family Assessments.

VI. CHILD AND FAMILY MEDICAL / WELL-BEING

Frequently, in order to address issues related to child safety an agency may find itself also addressing issues related to family health and well-being needs. The information contained on this page is used to document relevant medical and well-being information on members of the family. The family member for whom the information is being documented is entered on the line provided.

1-4. These items capture the family’s medical, dental, mental health, and specialist provider information in an effort to identify the family’s “medical home” (a regular practitioner that provides care to the family on a routine basis). If the family has no medical home the agency shall explore with the family whether a referral to a provider should be made (Note: not all family members will have a provider in each of these disciplines. If a specific discipline is not captured on this instrument the agency is encouraged to document the provider information and specify which discipline the provider practices).
5. This item captures the place of birth for family members, especially children within the family. This information may be critical if the case continues beyond CPS Assessment (210) services as a means for locating necessary medical information.

6. This item, if applicable, captures information related to any family’s members current or recent medication needs. The medication name along with its use and any dosing, special dispensing instructions, or refill information should be documented in the appropriate blocks.

7. This item captures information relevant to the status of the child(ren)’s immunization record. Documentation that may need to be captured may include, but is not limited to: explanation for any missing immunizations, noted reactions to immunizations, the family’s objections to immunize, etc. A copy of the child(ren)’s immunization record may also be attached to a hard-copy print out of this instrument.

8. This item captures whether members of the family are currently insured (either by a private insurance provider or by Medicaid or Health Choice). Information that may need to be captured in this item may include, but is not limited to: the name of the private insurance provider, any lapse in coverage, co-pay amounts, deductibles, policy providers and policy numbers, eligibility workers, etc.

9. This item captures any medical issue that family members may have for which the agency should be aware. Examples of what may be documented may include, but is not limited to: surgeries, known allergies, significant impairments as a result of medical concerns, corrective lenses, hearing aids, etc.

10. This item captures any mental health or substance abuse issues that family members may have for which the agency should be aware. Examples of what may be documented may include, but is not limited to: current or previous diagnosis admitted or known addictions, current or previous treatments, hospitalizations related to substance abuse or mental health issues, counselor information, etc.

11. This item captures any education needs that family members may have for which the agency should be aware. Examples of what may be documented may include, but is not limited to: written education goals, current or lapsed Individual Educational Plans (IEP), adult level of education or Adult Learning Plan, learning or cognitive delays, whether the child is performing at current grade level, etc.

12. This item captures documentation related to whether any child in the family under the age of 3 has been or needs to be evaluated by Early Intervention services provided through a local Children’s Services Developmental Agency (CDSA). Information that may need to be captured in this item can include: reason for need to make a referral, plan of service from CDSA evaluation, services being provided (such as OT, PT, etc.), response of family to CDSA services offered, etc.

13. This item captures documentation related to any action the worker took or needs to take in response to any of the information captured within this section.

VII. INITIAL FAMILY CONTACT

Documentation on this page pertains solely to the information gathered from the family during the initial contact made with the family. It is important to note that initial contact with the family may not constitute initiation. Provisions within the Child Abuse Prevention and Treatment Act (CAPTA) state the agency must notify the alleged
perpetrator of the complaints or allegations made against them regardless of how that contact is made. This first contact may differ from what constitutes initiation as defined by North Carolina Administrative Code 10A NCAC 70A .0105. For further guidance on initial contact versus initiation please refer to: Family Services Manual Volume I; Chapter VIII; Section 1408: Investigative and Family Assessments. Information related to both initiation and that which is gathered later during on-going case contacts will be documented in subsequent sections.

1. This item captures the date the worker had initial contact with the family in the MM/DD/YYYY format.

2. This item captures the names (using the format: first name last name) of the persons present during the initial family contact and their relationship to the family (i.e., John B. Smith – biological father or John E. Law – local law enforcement officer, etc).

3. This item captures the worker’s method of initial contact made with the family. The types of contacts include:
   - COMMUNITY VISIT
   - E-MAIL (ATTACH CORRESPONDENCE)
   - FAX (ATTACH CORRESPONDENCE)
   - HOME VISIT
   - MEMO LEFT
   - OFFICE VISIT
   - SCHOOL / DAYCARE CONTACTED
   - TELEPHONE CONTACT
   - VOICE MAIL MESSAGE LEFT
   - VOICE MAIL MESSAGE RECEIVED
   - OTHER (SPECIFY IN THE NARRATIVE SECTION)

4. This item captures the location that the initial contact with the family took place.

5. This item captures whether an interpreter was needed to make initial contact with the family.

6. This item captures the documentation on the information that was discussed with the family during initial contact including the allegations or complaints made against the family. The S.E.E.M.A.P.S. format should be used as a general guide to direct the discussion with the family. Each family is unique and each situation to be assessed is unique. Thus, every element of S.E.E.M.A.P.S. may not be applicable to be used with every family. Rather, it is meant as a guide to help prompt workers on items they should explore with families. For example, the worker may have adequate information related to the dimension of “Environment or Home” based on the allegations in the referral and from the worker’s direct observation and therefore the worker may not need to explore every single question under that dimension. However, workers are strongly encouraged to seek information related to a summary of the family’s strengths based on how the family views themselves.

VIII. CASE INITIATION

1-4. These items are meant to capture specific information relative to the worker’s initiation of the case. These items capture information in an open narrative format in order to allow the worker to document any information relevant that specific activity (Note: not all four activities may be applicable to every case).
5. An open narrative area is provided to further document the case initiation in greater detail using the S.E.E.M.A.P.S. format.

IX. ON-GOING CASE CONTACTS

Similar to the format used in Section VII INITIAL FAMILY CONTACT this page is used to capture on-going case related contacts. Each contact will be captured on a separate On-Going Case Contact form. For additional On-Going Case Contact sheets use form DSS-5010a. Workers will complete as many DSS-5010a forms as necessary to document the narrative for the entire case. At the bottom of DSS-5010a there is a blank to record the page number on hard-copy printouts of the instrument. It is strongly recommended that workers organize these contacts in a logical manner (i.e., in chronological order or in reverse chronological order). These pages will comprise the bulk of most case records as they capture the “running narrative” associated with child welfare records. There is only one narrative box per page and a separate On-Going Case Contact form will be used for each individual contact made on a case. Contacts documented in this section may include, but are not limited to: family contacts following case initiation, collateral contacts (both professional and non-professional), service providers, additional family members not residing in the home, other county departments of social services, law enforcement officials, the court, etc.

1. This item captures the date the worker had initial contact with the family in the MM/DD/YYYY format.

2. This item captures the names (using the format: first name last name) of the persons present during the initial family contact and their relationship to the family (i.e., John B. Smith – biological father or John E. Law – local law enforcement officer, etc).

3. This item captures the worker’s method of contact made with the family. The types of contacts include:
   - AGENCY RECORDS SEARCHED (OLV, SIS, EPICS, ETC.)
   - CHILD AND FAMILY TEAM MEETINGS (PRE-CASE DECISION)
   - COLLATERALS CONTACTED (LANDLORD, NEIGHBOR, ETC.)
   - COMMUNITY VISIT
   - E-MAIL (ATTACH CORRESPONDENCE)
   - FAX (ATTACH CORRESPONDENCE)
   - HOME VISIT
   - MEMO LEFT
   - OFFICE VISIT
   - REPORTER CONTACTED FOR ADDITIONAL INFORMATION
   - SCHOOL / DAYCARE CONTACTED
   - TELEPHONE CONTACT
   - VOICE MAIL MESSAGE LEFT
   - VOICE MAIL MESSAGE RECEIVED
   - PUBLIC RECORDS SEARCHED (D.O.C., INTERNET, ETC.)
   - OTHER (SPECIFY IN THE NARRATIVE SECTION)

4. This item captures the location that the on-going contact took place.

5. This item captures whether an interpreter was needed to make on-going contacts within the case.
6. This item captures the documentation on the information that was discussed (or that was found) with the contact during the on-going contact. Again, the portions of the S.E.E.M.A.P.S. format with which the contact may be able to provide information on should be used as a guide to direct the discussion with that contact. Every element of S.E.E.M.A.P.S. is not meant to be used with every contact every time. Rather, it is meant as a guide to help prompt workers on items they should explore with those contacts. For example, a school teacher may have important insight into the child’s environmental issues and activities for daily living while a Work First (TANF) worker may be able to address the family’s economic situation. However, workers are strongly encouraged to seek information related to a summary of strengths from all contacts.
Understanding S.E.E.M.A.P.S.

The key to understanding the purpose of S.E.E.M.A.P.S. is found in understanding that a holistic assessment makes for a more accurate and overall stronger assessment while a partial assessment makes for a poor assessment. The one question that is not asked might be the key to an underlying need of the family or the strength that could be unlocked to help the family remain together. S.E.E.M.A.P.S. is an acronym used to assist the worker in structuring their documentation of the assessment process. The family’s life is divided into seven domains or dimensions. These dimensions (Social, Economic, Environmental, Mental health, Activities of daily living, Physical health and a Summary of strengths) help ensure that the worker assesses all areas of a family’s life. Use of the S.E.E.M.A.P.S. method:

- gives structure to the assessment process,
- ensures coverage of many of the possible areas in which the family may have issues, and
- sets the foundation for the identification of needs and strengths upon which interventions with the family will be planned

These seven S.E.E.M.A.P.S. dimensions are comprised primarily of exploratory questions that the worker should use not as a script, but rather as prompts to better understand the family and their strengths and needs. It may not be necessary to ask each of these questions every time the worker makes contact on a case. However, the more familiar a worker becomes with these questions, the better equipped the worker will be to assess the family.

**Social**

Who lives in the house? How are people connected to each other? What is the feeling when you enter the house (comfortable, tense, etc.)? How do people treat one another? How do they speak to and about one another to someone outside the family? How far away is this home from other homes? Would it be likely that people would be able to visit here easily? Who does visit the family? Ask questions to determine what individuals, organizations, and systems are connected to the family. Are those people/organizations/systems helpful or not? What do people in this family do for fun? What stories do they tell about themselves? What kind of social support systems the family can depend on? How does the family use resources in the community? How does the family interact with social agencies, schools, churches, neighborhood groups, extended family, or friends? Do the children attend school regularly? Are there behavior problems at school? Can children discern between truths and lies? Do the children have age appropriate knowledge of social interactions? Do the children have age appropriate knowledge of physical or sexual relationships? Are pre-teen or teenage children sexually active? Do not forget the importance of non-traditional connections a family may have.

**Economic**

Are people willing to discuss their finances after a period of getting acquainted? Do adults here know how to pay bills and handle money? Do people in this house know how to acquire resources well enough to get their basic needs met? Does the stated amount of income seem reasonable and possible to live on? If it does not, do members have any plan or idea what to do? Has the family made plans to use economic services? Are food stamps, child support, TANF, LIEAP available to them? If not, why not? If income seems adequate but the residence and family members seem needy, is there any comprehensible explanation about where the money goes? Do the adults in the family demonstrate an awareness of how to budget the money that is available to them? Do people in this family tend to make workable fiscal decisions? What is the strongest economic skill each person in this family displays? Do they have enough money to make it through the month? Do they have any plan for where the money goes? Where does the money come from? Does the parent subsystem agree about the destination of any monies available? Are they content with the job they have? Have they considered changing job fields or careers? If so, what has prevented it?
Environment / Home
How does the residence look from the outside (kept up; in disrepair; etc.)? What is the surrounding area like? Places for children to play? Are there obvious hazards around the house (old refrigerators, non-working cars, broken glass, etc.)? What is the feeling you get when you arrive at this residence? Is the neighborhood comfortable or dangerous? Are there people walking around? Do you get a sense that people in this neighborhood would intervene if a child were in danger? Inside the residence, is there light and air? Is there any place to sit and talk? Are there toys appropriate for the ages of the children who live there? Can you tell if someone creates a space for children to play? Is there a place for each person to sleep? Is it obvious that people eat here? Can you determine what kind of food is available for people who live here? Are there any pictures of family members or friends? Is there a working phone available to the family? Is there a sanitary water supply available to the family? Are there readily available means of maintaining personal hygiene (toileting, bathing, etc.)? Is there a heating and/or cooling system in the home? What are the best features of this environment? Is the family aware of weapons safety issues?

Mental Health
Take a mental picture of the people in this family. What is their affect? Does their affect make sense, given the situation? Do members of this family have a history of emotional difficulties, mental illness, or impulse problems? Does anyone take medication for “nerves” or any other mental health condition? Are persons you interview able to attend to the conversation? Are there times when they seem emotionally absent/distant during conversation? Do people make sense when they speak? Are they clearly oriented to time and location? When people speak to each other, does their communication make sense to you as well as to other family members? Are people able to experience pleasure in some things? Are there indicators that persons in this family have substance abuse addictions? Is there some awareness of the developmental differences between adults and smaller children? How do people in this family express anger? Can people in this family talk about emotions, or do they only “express” them? What is the major belief system in this family? Do members of this family seem generally okay with themselves? Is anyone exhibiting signs of depression (remember that depression in children can show up as hyperactivity)? Has anyone ever received counseling or been under the care of a physician for a mental health problem? Is there any history of mental illness in the family? Do their thoughts flow in ways you can understand? If you cannot understand the person, does the rest of the family act like they understand (there may be some cultural language habits that you will have to learn)? Is anyone on medication? Are any of the medications for mental health related issues (i.e., medications for depression, sleeping pills, anti-anxiety medications, tranquilizers, etc.)? Are there funds to buy that medication? Is anyone abusing substances? What kind? Do they acknowledge a problem?

Activities of Daily Living
Do family members understand “Safe Sleeping” habits (for infants under the age of 18 months)? Is the children’s clothing adequate (appropriate as to: weather, size, cleanliness, etc.)? What activities does the family participate in? How does the family spend its free time? Do adults in this family know how to obtain, prepare, and feed meals to children in this family? Does this family speak English or the prevalent language of their community? Does the family engage in some activities of a spiritual nature? Are adults able to connect usefully with their children’s schools, doctors and friends? Do the adults in the house demonstrate developmentally appropriate and accurate expectations of the children in the home? Does the family own a car? If not, are there neighbors close by who will give them rides? Is public transportation convenient and available? Do people in this family have the ability and willingness to keep the home safe and reasonably clean? What skill does this family demonstrate the most? Do the parents know how to discipline their children or adolescents? Do they need some support in learning how to manage or organize their household, or how to stretch their limited budget? Are the family members employable?

Physical Health
Obtain demographic information for all household members. Discuss parents’ or safety resources’ willingness to protect the children. Discuss any additional concerns. Do the children appear healthy? Do the children appear on target with their height and/or weight? Are there any special medical concerns faced by family members? If so, who knows how to treat or administer to those concerns? How do people in this family
appear? Do they tend to their hygiene on a regular basis? Does anyone appear fatigued or overly energetic? Is anyone chronically ill, taking medication, or physically disabled? Is anyone in this family using illegal drugs or abusing prescription drugs? Do people in this family eat healthy food and/or get regular exercise? Does anyone in this family use tobacco products? Are there any members of the family who appear to be significantly obese? Are there any members of the family who appear to be significantly underweight? How long has it been since members of the family had a physical examination? Are there older children who continue to have bedwetting problems? Do people have marks or bruises on their bodies (remember that people may overdress or apply heavy makeup, perhaps to hide injuries)? Have steps been taken to ensure that the area where small children live is reasonably free from life-threatening hazards? Do small children ride in safety seats or use seatbelts? What is the healthiest thing this family does? What is the skin tone, hair quality, color of lips (especially with infants) with family members? Have the children had vaccinations? Are they up to date? Does anyone in the family have mobility issues? Are there any signs of palsy or other unusual movements? What is the family’s perception of their own physical health? Does family have medical and/or dental insurance coverage? If so, who is provider? If not, is family eligible to apply for Medicaid? If the family is not eligible to receive Medicaid are there other resources available? Does the family have a “Medical Home”? If so, who are the providers that make up that “Medical Home”?

Summary of Strengths
What are the major interpersonal strengths about this family? Assess if any adults in the family (especially regular caregivers) were abused or neglected as children. Was there substance abuse or domestic violence issues in their homes of the adult family members? How was adult family members disciplined? Strengths may be identified by observation from the worker or by disclosure from the family. Family strengths take many forms and appear as dreams, skills, abilities, talents, resources, and capacities. Strengths apply to any family members in the home (grandparents, aunts, uncles, etc.). Strengths can be an interest in art, the ability to throw a football, getting to work everyday, drawing a picture, making friends, and cooking a balanced meal, etc. These interests, talents, abilities, and resources can all be used to help a family meet its needs. Strengths can be found by asking family members and by asking other professionals.