|  |
| --- |
| **SCHEDULE 4 /INITIAL VIABILITY ASSESSMENT**  **Placement of Child with a Connected Person** |
| Care Planning, Placement and Case Review Regulations 2014 Reg. 24 & Schedule 4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE OF IVA:** | |  | | | |
| **CHILD/REN’S NAME(S)** | | **DOB** | **AGE** | **RELATIONSHIP TO APPLICANTS** | **CAREFIRST ID** |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| **LEGAL STATUS** |  | **PLACEMENT DATE** | |  | |

**APPLICANTS DETAILS**

|  |  |  |
| --- | --- | --- |
|  | **APPLICANT 1** | **APPLICANT 2** |
| **CAREFIRST ID:** |  |  |
| **NAME:** |  |  |
| **DATE OF BIRTH:** |  |  |
| **TELEPHONE NUMBER:** |  |  |
| **ADDRESS:** |  | |
| **EMAIL ADDRESS:** |  |  |
| **ETHNICITY:** |  |  |
| **RELIGION:** |  |  |
| **DISCLOSURE OF ANY CRIMINAL CONVICTIONS, CAUTIONS OR DRIVING OFFENCES:** |  |  |

|  |  |  |
| --- | --- | --- |
| **CCSW NAME & TEAM:**  (include telephone number and email) |  |  |
| **NAME OF THOSE PRESENT AT INTERVIEW:** (if 2 prospective applicants, both should be present) |  |  |
| Has the applicant/s been provided with the Connected Persons IVA information leaflet in respect of this assessment? | **YES** | **NO** |

**CHILD/YOUNG PERSON’S FAMILY DETAILS**

*Include all siblings and those significant to the child/young person*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Relationship to child/ren** | **DOB** | **Ethnicity** | **Relationship to applicant/s** | **Please confirm PR/ Legal Status** |
|  | Mother |  |  |  |  |
|  | Father |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**ESSENTIAL AGENCY SAFEGUARDING CHECKS**

|  |  |
| --- | --- |
| **ESSENTIAL AGENCY**  **SAFEGUARDING CHECKS**  (CCSW to complete) | **DETAILS –** include:   * Date PNC initiated/completed and results **for all adults** in household. * Approximate dates of residence in other LA’s and the name of the LA/s. * Date NCC DBS check was initiated/completed and reference numbers for each applicant (for all household residents over 18 years of age.) |
| **PNC CHECK AND OUTCOME** |  |
| **DBS CHECK INITIATED OR COMPLETED WITH REFERENCE NUMBER** |  |
| **LOCAL AUTHORITY 1** |  |
| **LOCAL AUTHORITY 2** |  |
| **ANY CURRENT OR HISTORIC FAMILY LAW PROCEEDINGS**  **(Private or Public Law)** |  |

**REASONS FOR PROPOSED PLACEMENT / BACKGROUND INFORMATION**

|  |
| --- |
|  |

**INDIVIDUAL NEEDS OF CHILD/YOUNG PERSON**

|  |
| --- |
| **HEALTH:** |
| **EDUCATION:** |
| **EMOTIONAL/BEHAVIOURAL NEEDS:** |
| **LANGUAGE/CULTURAL AND IDENTITY NEEDS:** |
| **CHILD/YOUNG PERSON’S VIEWS IN RESPECT OF PROPOSED PLACEMENT:** |
| **CONTACT ARRANGEMENTS AND DETAILS:** |

**APPLICANTS HOUSEHOLD INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME** | **DOB** | **AGE** | **ETHNICITY** | **RELATIONSHIP TO APPLICANTS** | **TELEPHONE NUMBER & EMAIL ADDRESS**  (required for adults only) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**HOME / ACCOMMODATION INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **LENGTH OF TIME AT CURRENT ADDRESS:** |  | | |
| **PREVIOUS ADDRESS:**  (Only required if time at current address for less than 3 years) |  | | |
| **TYPE OF PROPERTY:** |  | | |
| **NUMBER OF BEDROOMS:** |  | **IS THERE SUFFICIENT BEDROOM SPACE TO ACCOMMODATE THE CHILD/YOUNG PERSON?** | YES / NO |
| **IS THE PROPERTY OWNED, MORTGAGED OR RENTED?** |  | **ARE RENT/MORTGAGE PAYMENTS UP TO DATE?** | YES / NO |

**HEALTH & SAFETY IN THE HOME**

|  |
| --- |
| **BEDROOM / SLEEPING ARRANGEMENTS**  *The Fostering National Minimum Standards (10.6) states “In the foster home, each child over the age of three should have their own bedroom. If this is not possible, the sharing of a bedroom is agreed by each child’s responsible authority and each child has their own area within the bedroom.” This requires a bedroom risk assessment to be completed. Children under the age of five are unable to sleep in bunk-beds.*   1. Sleeping arrangements? (Consider both short-term and long-term arrangements) 2. Is housing space a concern? 3. What support is available to mitigate this concern? 4. Is this realistic and achievable?   **HEALTH & SAFETY CHECKS**   1. Have all rooms in the home been viewed? 2. Have you been refused access to any areas of the home? 3. Is the inside of the property observed to be safe and suitable for children to reside in? 4. Does the back garden appear to be safe and secure for a child?   **PETS**  *If there are dogs or hazardous pets in the home a pet risk assessment will need to be completed*   1. Are there any pet/s in the home? 2. Are the pet/s registered with a veterinary practice to access health care and routine boosters?   **SMOKING / VAPING**  *NCC policy as of 1st September 2006, states that no household in which there are smokers/vapers*  *will be approved for fostering children under the age of four years old.*   1. Does anyone in the household smoke or vape? If so are they willing to undertake a smoking cessation programme which they can access via their GP? 2. If yes, how will any impact on the child/young person be minimised? |

**CURRENT RELATIONSHIP & PAST SIGNIFICANT RELATIONSHIPS**

*Significant relationships are any marriages or relationships with whom the applicant has had a child or has lived with / set up home with*

|  |
| --- |
|  |

**APPLICANTS DISCLOSURE OF ANY HISTORICAL OR CURRENT INVOLVEMENT WITH CHILDRENS SERVICES**

*For either themselves or their children*

|  |
| --- |
|  |

**APPLICANTS HEALTH DISCLOSURE & PRESCRIBED MEDICATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the applicant/s or any household member have, or has previously had, any of the following health issues: | | | | | |
| **ALCOHOL/DRUG DEPENDENCY** |  | **ANXIETY** |  | **DEPRESSION** |  |
| **VISUAL IMPAIRMENT** |  | **DIABETES** |  | **HYPERTENSION**  **(High blood pressure)** |  |
| **SELF-HARM/SUICIDAL IDEATION** |  | **LEARNING NEEDS** |  | **MOBILITY ISSUES** |  |
| Please provide details: | | | | | |

|  |
| --- |
| 1. Is anyone in the household registered disabled? If so are they in receipt of any benefits? 2. Does the applicant/s have any diagnosed medical condition? 3. How these concerns or health needs may impact on the applicant/s capacity to care for the child/ren/young person? 4. What, if any, medication is currently being taken? |

**APPLICANTS CAPACITY TO MEET THE CHILD/YOUNG PERSONS INDIVIDUAL NEEDS**

|  |
| --- |
| **APPLICANT(S) RELATIONSHIP TO THE CHILD/YOUNG PERSON AND THEIR RELATIONSHIP WITH THE CHILD’S PARENTS** |
| **APPLICANTS MOTIVATION TO CARE FOR THE CHILD/YOUNG PERSON** |
| **APPLICANTS UNDERSTANDING OF THE LOCAL AUTHORITY’S CONCERNS** |
| **APPLICANTS HOUSEHOLD INCOME AND EMPLOYMENT –** are the applicants able to meet their own financial needs without having to rely on the fostering allowance? How will they manage their working patterns to care for the child? |

**SOCIAL WORKER ANALYSIS**

|  |
| --- |
| **SIGNS OF SAFETY ANALYSIS –**  **STRENGTHS – WHAT IS WORKING WELL?**  **COMPLICATING FACTORS AND AREAS THAT REQUIRE FURTHER EXPLORATION:**  **IDENTIFIED AREAS OF CONCERN:** |

|  |
| --- |
| **CCSW RECOMMENDATION** |
| **NAME:** |
| **SIGNED:** |
| **DATE:** |

**MANAGERS COMMENTS**

|  |  |
| --- | --- |
| **TEAM MANAGER COMMENTS (CHILDREN’S TEAM)**  *e.g. The Team Manager is satisfied that at this stage this is a thorough assessment and the proposed recommendation of the social worker will safeguard and promote the child’s welfare and meet all of their needs. If possible please confirm recommendation for Fostering, Child Arrangement or Special Guardianship Order* | |
|  | |
| **NAME:** |  |
| **SIGNED:** |  |
| **DATE:** |  |

|  |  |
| --- | --- |
| **SERVICE MANAGER COMMENTS (CHILDREN’S TEAM)**  *e.g. The Service Manager is satisfied that at this stage this is a thorough assessment and the proposed recommendation of the social worker will safeguard and promote the child’s welfare and meet all of their needs. If possible please confirm recommendation for Fostering, Child Arrangement or Special Guardianship Order* | |
|  | |
| **NAME:** |  |
| **SIGNED:** |  |
| **DATE:** |  |

|  |  |
| --- | --- |
| **TEAM MANAGER/PRACTICE MANAGER COMMENTS (CP TEAM)**  *e.g. The Team Manager is satisfied that at this stage this is a thorough assessment and the proposed recommendation of the social worker will safeguard and promote the child’s welfare and meet all of their needs. If possible please confirm recommendation for Fostering, Child Arrangement or Special Guardianship Order* | |
|  | |
| **NAME:** |  |
| **SIGNED:** |  |
| **DATE:** |  |

|  |  |  |
| --- | --- | --- |
| **STRATEGIC MANAGER COMMENTS** | | |
|  | | |
| **DATE PLACEMENT COMMENCED/DUE TO COMMENCE:** | | |
| **Do you agree with the 16 weeks temporary fostering approval?**  (Care Planning, Placement and Case Review Regulations 2010 Reg. 24 & Schedule 4) | | **YES / NO** |
| **Nature of exceptional agreement?** | | |
| **NAME OF STRATEGIC MANAGER:** |  | |
| **SIGNED:** |  | |
| **DATE:** |  | |