Special Guardianship Support Plan

*The forms detailing the assessed needs for Special Guardianship support services of the child and the Special guardian/s and of the birth relatives in relation to contact should be attached to this form.*

Child’s Name:

Date of Birth:

BAAF ADOPTION & FOSTERING 2003

Placing Local Authority:

Name of Family (Guardian): DOB:

Name of Family (Guardian): DOB:

Address:

Telephone number(S):

Email Address:

Relationship to child:

Approving Local Authority or Voluntary Adoption Agency:

Local Authority where the Family Lives:

If this is neither the placing nor the approving local authority, date of the required consultation and name and position of person with whom this took place:

The proposed sp guardianship support plan is based on the assessed support needs of the child and the Special guardianand of the birth relatives in relation to contact as detailed on the attached forms, and updated as necessary.

Date Proposed Plan was Completed:

Name of Author:

Date SGO awarded or court date:

**INDIVIDUAL WORKER RESPONSIBLE FOR CO-ORDINATING AND MONITORING THE DELIVERY OF THE SERVICES IN THE PLAN**

Name:

Agency:

Address:

Telephone:

E-mail:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| HEALTH (to include any special needs which a disabled child may have) | | | | | | | |
| Support Needs of Child and Special Guardians | Services to be Provided | | Person/Agency Responsible | | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review | |
|  |  | |  | |  |  | |
| **EDUCATION** | | | | | | | |
| Support Needs of Child and Special Guardians | Services to be Provided | | Person/Agency Responsible | | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review | |
| . |  | | **(Has the local Education Department agreed to provide the required services?)** | |  |  | |
| EMOTIONAL AND BEHAVIOURAL DEVELOPMENT | | | | | | | |
| Support Needs of Child and Special Guardians | Services to be Provided | Person/Agency Responsible | | Frequency, Duration and Starting Date | | | Planned Outcome and Plans for Review |
| (Please detail any need for therapy or counselling) |  | (Has an agreement been given locally to provide the required services?) | |  | | |  |
| IDENTITY | | | | | | | |
| Support Needs of Child and Special Guardians | Services to be Provided | Person/Agency Responsible | | Frequency, Duration and Starting Date | | | Planned Outcome and Plans for Review |
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| **FAMILY AND SOCIAL RELATIONSHIPS** | | | | |
| Support Needs of Child and Special Guardians | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
|  |  |  |  |  |
| **SOCIAL PRESENTATION** | | | | |
| Support Needs of Child and Special Guardians | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
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| **SELFCARE SKILLS** | | | | | | | | | | |
| Support Needs of Child and Special Guardians | | Services to be Provided | | Person/Agency Responsible | | Frequency, Duration and Starting Date | | Planned Outcome and Plans for Review | | |
|  | |  | |  | |  | |  | | |
| CONTACT  ARRANGEMENTS PLANNED AFTER PLACEMENT | | | | | | | | | |
| Person – Name and Relationship to Child | Type  (eg. letterbox, face to face) | | Frequency, Duration, Venue and Starting Date | | Will Contact Need to be Supervised | | Who Will do This? | | Purpose of this Contact |
|  |  | |  | |  | |  | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| SUPPORT ARRANGEMENTS | | | | | | | |
| Support Needs of Child and Special Guardians | | Services to be Provided | | Person / Agency Responsible | | Plans for Review | |
|  | |  | |  | |  | |
| FINANCIAL AND PRACTICAL | | | | | | | |
| Support Needs of Child and Special Guardians | Services to be Provided | | Person/Agency Responsible | | Frequency, Duration and Starting Date | | Planned Outcome and Plans for Review |
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| Actual funding being requested and item/ service | Duration of Payments | Details of person or agency that will receive the funding | Frequency of payment | Review date/ who will review |
| Eg.:  Provide details of costs ie £100 for a new cot | Ongoing is not a option. Ie one off – until 2017 etc. | Direct to carer / Swindon contact team, Swindon road, SW1 | One off | FFAST will ensure purchase has been made within 1 month |
| E.g  SGO allowance at £122.00 pw week | Until child is 18 | Direct to carer | Fortnightly | Annual review by FFAST and FAB team |
| **How does this request support the long term needs / permanency plan for the child** | | | |  |
|  | | | | |

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|  | **Breakdown of proposed**  **FINANCIAL BREAKDOWN** **–** this should not be included in court bundles and is for Guardians and GCC only |  |

**SPECIAL GUARDIANS FAMILY**

|  |  |  |
| --- | --- | --- |
| BASIC SUPPORT SERVICES | PROVIDED BY | |
|  | Own Agency | Other  (please specify) |
| Point of contact available long term for advice and information and onward referral as necessary | F&F Team  01452 427847 |  |
| Group meetings with other adopters/ SGO carers | Via F&F Team  01452 427847 |  |
| Regular workshops/training eg. on telling, managing difficult behaviour, etc. | As above |  |
| Opportunity to keep in touch through a newsletter or regular social event | As above |  |

SUPPORT SERVICES TO BE PROVIDED TO OTHER INDIVIDUALS IN THE FAMILY OF THE SPECIAL GUARDIANS

(eg. birth children, other family members in the household, grandparents, etc)

**Family Member**

Service to be provided

Timescale for providing service

Person/agency responsible

What is it hoped this will achieve?

How will this be measured and reviewed?

Please add further family members as necessary.

**SUPPORT SERVICES TO BE PROVIDED TO BIRTH RELATIVES IN RELATION TO CONTACT**

**Birth Relative**

Name and relationship to child

Service to be provided

Timescale for providing services

Person/Agency responsible

What is it hoped these services will achieve?

How will this be measured and reviewed?

Please add further birth relatives as necessary.

**Birth Relative**

Name and relationship to child

Service to be provided

Timescale for providing services

Person/Agency responsible

What is it hoped these services will achieve?

How will this be measured and reviewed?

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| **SIGNATURES** | | | |
|  | Signature | Print Name | Date |
| Child / Young Person (where appropriate) |  |  |  |
| Child’s Social Worker |  |  |  |
| Child’s Manager |  |  |  |
| Social Worker |  |  |  |
| Adoption Support Manager |  |  |  |
| Special Guardian |  |  |  |
| Special Guardian |  |  |  |
|  |  |  |  |
| Co-ordinating Worker (listed on front page if not one of above) |  |  |  |