Minnesota Department of Human Services
Out of Home Placement Plan

Name:	Length of time in foster care:
This plan starts on:	Current placement:
Age:	Permanency Plan:
Birthdate:	Permanency Hearing due by: ___/___/____
ICWA:	Concurrent Permanency Plan:

Family Information

Parent: DOB: Age:
Address: Phone:

Parent: DOB: Age:
Address: Phone:

Legal Guardian: DOB: Age:
Address: Phone:

Sibling: In Placement:

Placement

WHY WAS THIS CHILD PLACED IN FOSTER CARE?

LIST THE ☐ ACTIVE / ☐ REASONABLE (SELECT ONE) EFFORTS TO PREVENT THIS PLACEMENT.

Family strengths have been identified and used to develop this plan.

SELECT THE REASONS THIS FOSTER HOME OR FACILITY WAS CHOSEN, THIS FACILITY CAN MEET:

- ☐ Child's current functioning and behaviors. Describe:
- ☐ Child's medical, educational and developmental needs. Describe:
- ☐ Child's history and past experience. Describe:
- ☐ Child's religious and cultural needs. Describe:
- ☐ Child's connections with community, school and church. Describe:
- ☐ Child's interest and talents. Describe:
- ☐ Child's relationship to current caregiver, parents, siblings and relatives. Describe:
- ☐ Child's preference, when appropriate. Describe:
- ☐ Child's needs for least restrictive, most family-like setting. Describe:
- ☐ Child's need for close proximity to child's reunification home and school. Describe:

TASKS TO PROVIDE FOR THE CHILD'S SAFETY, PERMANENCY AND WELL-BEING:
TASKS FOR SAFETY:

1. Risk to child:
   Task:
2. Risk to child:
   Task:

TASKS FOR PERMANENCY:

1. Task:
2. Task:

TASK FOR THE WELL-BEING NEEDS OF THE CHILD:

1. Task:
2. Task:

Tasks for all parents when their child is in out-of-home placement:

1. Visit your children as ordered by the court or as described by the visitation plan. Being on time is important to your child. Let your social worker know if you cannot be at the visit.
2. Sign releases to allow the agency to share information about your case or family with persons or agency providing services to help you complete your plan.
3. Visit with your social worker to review your progress on this plan.
4. Participate and complete the agreed upon or court order tasks of this plan.
5. Attend court hearings and meetings to plan for your child's permanency.
6.
7.

WE COULD NOT AGREE ON THESE SERVICES?

WAS THE CHILD PLACED WITH SIBLINGS? ☐ Yes ☐ No
IF NOT, WHAT EFFORTS ARE BEING MADE TO PLACE THE CHILD WITH SIBLINGS?

Visitation/Contact Plan

Visitation plan for:	Frequency	Supervised? If yes, identify the supervisor	Location	Transportation arrangements
Parent				
Parent				
Siblings				
Grandparent				
Kin/other relative				

Other consideration about visitation:

Plan Development:

This plan will be reviewed on___/___/____.

(SocialWorkerName) met with(Enter parents) on ___/___/____ to jointly make this plan. In the development of this plan, (SocialWorkerName) consulted with:

This information is available in other forms to people with disabilities by contacting us at (651) 282-5329 (voice). TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Signature page follows this page.

SIGNATURE	DATE	This plan was explained to me.	I received a copy of this plan.

Child: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Parent: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Parent: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Step parent, if applicable: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Legal Guardian: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Foster Parent/Facility: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Foster Parent/Facility: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Guardian Ad Litem: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Tribal Representative: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Other: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Social Worker: Comments:		☐ Yes ☐ No	☐ Yes ☐ No
Supervisor: Comments:		☐ Yes ☐ No	☐ Yes ☐ No

Out-of-Home Placement Plan
Health and Education Plan/

Medical

Physician: Clinic:
Primary: Phone:
Address: .

Allergies / Medical Problems:
Medications:
PLAN TO ADDRESS HEALTH NEEDS:

Last date seen by a physician:
Last Child & Teen Check up:

AGENCY HAS A COPY OF THE CHILD'S IMMUNIZATION RECORD ☐ Yes ☐ No
WAS THE CHILD'S IMMUNIZATION RECORD PROVIDED TO THE FOSTER PARENT/FACILITY?
If yes, to: Date: ___/___/____
If no, reason:

Other health providers:

Name: Field:
Clinic:
Address: Phone:

Name: Field:
Clinic:
Address: Phone:

Dental Information:

Dentist: Clinic:
Address: Phone:

Special dental needs:

PLAN TO ADDRESS DENTAL NEEDS:

School

PREVIOUS SCHOOL ATTENDED:
Current School:
Current grade:
AGENCY HAS A COPY OF RELEVANT SCHOOL RECORDS: ☐ Yes ☐ No

SPECIAL EDUCATION NEEDS:

HOW ARE THE SPECIAL EDUCATION NEEDS ADDRESSED?

Independent Living Plan

Name:

Social worker:

EMPLOYMENT AND CAREER PLAN:

TRANSPORTATION AND DRIVER'S LICENSE PLAN:

MONEY MANAGEMENT PLAN:

SOCIAL AND RECREATION SKILLS PLAN:

HOUSING PLAN:

HEALTH CARE AND MEDICAL COVERAGE PLAN:

EDUCATIONAL AND VOCATIONAL PLAN:

ESTABLISHING & MAINTAINING CONNECTIONS WITH FAMILY AND COMMUNITY PLAN:

BUDGET: ITEMIZE EXPENDITURES ANTICIPATED IN COMPLETING THE INDEPENDENT LIVING PLAN:

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