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Details of carer/s	
Name/s	
Date of birth/s	
Address	
Contact details	Phone: Email:
Household members' details – including if Blue Card required	

Details of child or young person <i>currently</i> in placement (enter all current primary and respite placements)						
Name/s	Date of birth	Gender	First Nations	CALD	Type of Order (Interim/ST/LT)	Type of Placement (P/R/E)

Review details	
Date of review	Person completing file review/role
CSSC affiliation	CSO and STL details for all relevant CSSC placements

Carer Blue Card details

Carer renewal details
Expiry date

Mandatory training modules completed/ not completed (provide explanation)

1. Placement history information *(to be explored in detail in section 4)*

Child/ren name, duration of placement, current or previous placement, how placement ended (breakdown, planned transition)

2. Cultural considerations where relevant

Refer to Carer Assessment, Subsequent renewals, Suitability Assessments, CPP for any relevant placement.

3. Any information sources from current or previous child/ren in placement?

Information about carers actions/inactions/worries/challenges will often be in these types of documents, and these should be reviewed.

- | | |
|---|--|
| <input type="checkbox"/> Genogram | <input type="checkbox"/> Collaborative and Assessment Plan (CAP) |
| <input type="checkbox"/> Eco Map | <input type="checkbox"/> Placement Agreement |
| <input type="checkbox"/> Child Strengths and Needs (CSN) | <input type="checkbox"/> Safe Contact Tool |
| <input type="checkbox"/> Parental Strengths and Needs (PSN) | <input type="checkbox"/> Client Information Form (CIF) |
| <input type="checkbox"/> Case Plan | <input type="checkbox"/> Positive Behaviour Support Plan |
| <input type="checkbox"/> Cultural Support Plan | <input type="checkbox"/> Medical Reports/Assessments (e.g. speech, OT) |
| <input type="checkbox"/> Review Report | <input type="checkbox"/> Education Support Plan (ESP) |
| <input type="checkbox"/> Evolve Initial Assessment/Reports | <input type="checkbox"/> Court documents (including CP Hx Table) |
| <input type="checkbox"/> Criminal history document | <input type="checkbox"/> Record of FGM (or other documents completed as part of FGM process) |
| <input type="checkbox"/> Previous kinship assessments | <input type="checkbox"/> Other _____ |

4. Overview of Carer/Household history as carers

Refer to CMS, Assessments, relevant child documents on file, SOC's, IR's

- Provide a timeline for carers, from initial contact, assessment/s (support needs identified in assessments and actions to address), placements, issues identified throughout support period (IRs, SOC's, etc.) systematic challenges (i.e., communication with stakeholders, CSSCs) challenges working with biological family, other carers, external stakeholders (school, medical).
- Also highlight where carers have done things well.
- Include any previous affiliations with other agencies and review those assessments.

5. Summary of key *concerns* identified above in *any IRs/SOC's* and recommendations.

*What standards have not been met, any patterns of behaviour or supports needed, systematic challenges, carer/s willingness to engage and tangible actions indicating willingness to adapt. *This is not to repeat above, but to draw summary of the information.*

6. Individual Carer and Household strengths *(refer to information outlined in section 4)*

7. Individual Carer and Household vulnerabilities *(refer to information outlined in section 4 and 5)*

8. Carer/household current safety and support network outlined in Assessments

Refer to Eco Maps/ references/ emergency contacts/ identified supports

9. Key points, observations and recommendations for ongoing support needs for individual carers and/or household, any training needs identified, types of appropriate placements

Refer to sections above where details are recorded in full for reader reference – this section should contain a concise summary and assessment of findings and no new information