CFS 687
Rev. 1/2007

State of Illinois
Department of Children and Family Services

SEXUAL ABUSE PROGRAM
SUMMARY OF REVIEW AND SCREENING

Filing Instructions: ***Upon completion, the CFS 687 Summary of Review and Screening is to be filed in Section VI Child Specific Section of the case record.***

I. UIR REVIEW

UIR # **DATE FILED:** **DATE RECEIVED:**

Name: ______________________ **ID#:** ______________

DOB: ____________ ☐ **Male** ☐ **Female**

Primary language: __________ **Legal status:** ______________________

Persons Contacted	Relationship to Child	Date		
			In person ☐	By phone ☐
			In person ☐	By phone ☐
			In person ☐	By phone ☐
			In person ☐	By phone ☐
			In person ☐	By phone ☐
			In person ☐	By phone ☐

Reporter: ______________________

Worker: ______________________ **R/S/F:** ______________

Supervisor: ______________________

CPSW investigation conducted? ☐ **Yes** ☐ **No**

If yes, outcome: ☐ **Indicated** **Date** __________
☐ **Unfounded** **Date** __________
☐ **Pending as of** __________ **(Date)**

Investigator: ______________________

Investigating Unit: ______________________

Investigation by law enforcement? ☐ **Yes** ☐ **No**

If yes, name of law enforcement / investigating unit: ______________________

____

Criminal charges filed for sexual offense? ☐ **Yes** ☐ **No**

Date charged: ______________

☐ **Pending as of** ______________ **(Date)**

What was the charge? ____

☐ **Adjudicated**

☐ **Charges pled down from** ______________ **to** ______________

☐ **Charges dropped**

☐ **Dependency**

Court of jurisdiction: ____

List all of the court's orders regarding this offense or violation: ______________________________

____

Was the ward placed on probation as a result of this offense? ☐ **Yes** ☐ **No**

If yes, list the conditions of probation: ______________________________

____

SASC NOTES: Summary of Contacts/Findings

(Include reason for disposition determination.)

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DISPOSITION

- ☐ NOT A SEXUAL BEHAVIOR PROBLEM.
- ☐ PROCEED WITH BEHAVIORAL REVIEW.

RECOMMENDATIONS

For caseworker / supervisor: ____________________

For caregiver: ____________________

Completed by: ____________________ **Date:** ____________________

II. BEHAVIORAL SCREENING

INFORMATION REVIEWED

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PARTICIPANTS

Participants Name	Relationship to Ward	Date		
____________	____________	________	In person ☐	By phone ☐
____________	____________	________	In person ☐	By phone ☐
____________	____________	________	In person ☐	By phone ☐
____________	____________	________	In person ☐	By phone ☐
____________	____________	________	In person ☐	By phone ☐
____________	____________	________	In person ☐	By phone ☐

BACKGROUND INFORMATION

Reason/Date(s) for DCFS involvement: _______________________________

____

Permanency plan: _______________________________

How often is family and/or sibling visitation occurring? _______________________________

If family / sibling visitation are not ongoing, reason why: _______________________________

____

Worker's knowledge of case: _______________________________

Worker's knowledge of alleged sexual incident: _______________________________

ALLEGED SEXUAL INCIDENT

Date of incident: ______________ **UIR #:** ____________________

Describe the behavior: ____________________

Describe the precursors/antecedents to the incident: ____________________

Describe the context in which the incident occurred: ____________________

The incident was witnessed by: ____________________

What time of day did the alleged incident occur? ____________________

Ward's age at time of alleged incident: ______________

How was the sexual incident discovered? Another child's report? Observed by the caregiver or a teacher? What documentation is there of the alleged incident, for example, case notes. school report, eyewitness?

____

How often does the behavior occur? ____

____

Where? ____

When? ____

Does the behavior place the child at risk? ☐ **Yes** ☐ **No**

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____

Does the behavior place other children at risk? ☐ **Yes** ☐ **No**

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____

Is the behavior physically self-abusive? ☐ **Yes** ☐ **No**

____

____

Is the behavior developmentally typical for this child? ☐ **Yes** ☐ **No**

____

____

OTHER REPORTED INCIDENTS OF SEXUAL MISBEHAVIOR

(Attach additional pages if necessary.)

Date of incident: _______________

Describe: ____

____

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UIR submitted? ☐ **Yes** ☐ **No**

If yes, UIR #: ______________________

CPSW investigation conducted? ☐ **Yes** ☐ **No**

If yes, outcome: ☐ **Indicated** **Date** ______________

☐ **Unfounded** **Date** ______________

☐ **Pending as of** _______________ **(Date)**

Investigator: ____

Investigating Unit: ____

Investigation by law enforcement? ☐ **Yes** ☐ **No**

If yes, name of law enforcement / investigating unit: ______________________________

____

Criminal charges filed for sexual offense? ☐ **Yes** ☐ **No**

What was the charge? ______________________________

☐ **Adjudicated**

☐ **Charges pled down from** __________ **to** __________

☐ **Charges dropped**

☐ **Dependency**

Court of jurisdiction: ______________________________

List all of the court's orders regarding this offense or violation: ______________________________

____

Was the ward placed on probation as a result of this offense? ☐ **Yes** ☐ **No**

If yes, list the conditions of probation: ______________________________

____

OTHER UIRS

(Attach copies or summarize UIRs not described elsewhere.)

UIR #: __________ **Date:** __________ **Type:** __________

Summary of UIR: ______________________________

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UIR #: __________ **Date:** __________ **Type:** __________

Summary of UIR: ______________________________

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UIR #: __________ **Date:** __________ **Type:** __________

Summary of UIR: ______________________________

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COMPLETE LEGAL/CRIMINAL HISTORY

Have other charges been filed against this ward? ☐ Yes ☐ No

If yes:

Charge: ______________________________ **Date:** ____________

- ☐ **Adjudicated**
- ☐ **Charges pled down from** ____________ **to** ____________
- ☐ **Charges dropped**
- ☐ **Dependency**

Court of jurisdiction: ______________________________

List all of the court's orders regarding this offense or violation: ______________________________

____

Was the ward placed on probation as a result of this offense? ☐ Yes ☐ No

If yes, list the conditions of probation: ______________________________

____

Charge: ______________________________ **Date:** ____________

- ☐ **Adjudicated**
- ☐ **Charges pled down from** ____________ **to** ____________
- ☐ **Charges dropped**
- ☐ **Dependency**

Court of jurisdiction: ______________________________

List all of the court's orders regarding this offense or violation: ______________________________

____

Was the ward placed on probation as a result of this offense? ☐ Yes ☐ No

If yes, list the conditions of probation: ______________________________

____

PLACEMENTS

Attach NOMAD Report.

SCHOOL

Grade, Performance, Placement: ____

____

IQ	**IQ**	**IQ**
Verbal ______________	**Verbal** ______________	**Verbal** ______________
Performance ______________	**Performance** ______________	**Performance** ______________
Full Scale ______________	**Full Scale** ______________	**Full Scale** ______________
Date ______________	**Date** ______________	**Date** ______________

MEDICAL CONDITION

☐ **ASTHMA** ☐ **ENURESIS** ☐ **ENCOPRESIS**

☐ **GLASSES** ☐ **HEARING** ☐ **LEAD EXPOSURE**

☐ **OTHER**

Describe: ____

____

HOSPITALIZATIONS

Date: ______________ **Name of Hospital:** ______________________________

Reason: ____

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Date: ______________ **Name of Hospital:** ______________________________

Reason: ____

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Date: ______________ **Name of Hospital:** ______________________________

Reason: ____

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MENTAL HEALTH DIAGNOSES

Diagnosis: **Axis I** ______________________

Axis II ______________________

Axis III ______________________

Made by: ______________________

Agency/Facility/Hospital: ______________________

Date: ______________

Diagnosis: **Axis I** ______________________

Axis II ______________________

Axis III ______________________

Made by: ______________________

Agency/Facility/Hospital: ______________________

Date: ______________

Diagnosis: **Axis I** ______________________

Axis II ______________________

Axis III ______________________

Made by: ______________________

Agency/Facility/Hospital: ______________________

Date: ______________

Diagnosis: **Axis I** ______________________

Axis II ______________________

Axis III ______________________

Made by: ______________________

Agency/Facility/Hospital: ______________________

Date: ______________

BEHAVIORAL FUNCTIONING

- ☐ AOD
- ☐ DELINQUENCY
- ☐ EATING PROBLEMS
- ☐ RUNNING
- ☐ PHYSICAL AGGRESSION
- ☐ SEXUAL ORIENTATION/QUESTIONING
- ☐ SELF-ABUSE
- ☐ SLEEP DISTURBANCES
- ☐ GANG INVOLVEMEN
- ☐ OTHER

Describe: ____

____

Does this child have friends? ☐ **Yes** ☐ **No**

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What does s/he like to do?

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What does s/he do well?

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Overall, what are this child's strengths?

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MEDICATIONS

Name: ______________________ **Dosage:** ______________________

Instructions: ____

Name: ______________________ **Dosage:** ______________________

Instructions: ____

Name: ______________________ **Dosage:** ______________________

Instructions: ____

Name: ______________________ **Dosage:** ______________________

Instructions: ____

Name: ______________________ **Dosage:** ______________________

Instructions: ____

CURRENT TREATMENT SERVICES

Type: ______________________ **Dates:** __________

Provider/Clinician: ______________________

Agency/Facility/Hospital: ______________________

Type: ______________________ **Dates:** __________

Provider/Clinician: ______________________

Agency/Facility/Hospital: ______________________

Type: ______________________ **Dates:** __________

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Agency/Facility/Hospital: ______________________

Type: ______________________ **Dates:** __________

Provider/Clinician: ______________________

Agency/Facility/Hospital: ______________________

PREVIOUS TREATMENT SERVICES

Type: ______________________ **Dates:** __________

Provider/Clinician: ______________________

Agency/Facility/Hospital: ______________________

Type: ______________________ **Dates:** __________

Provider/Clinician: ______________________

Agency/Facility/Hospital: ______________________

Type: ______________________ **Dates:** __________

Provider/Clinician: ______________________

Agency/Facility/Hospital: ______________________

Type: ______________________ **Dates:** __________

Provider/Clinician: ______________________

Agency/Facility/Hospital: ______________________

SASC NOTES / SUMMARY OF FINDINGS

DISPOSITION

- ☐ **THIS WARD DOES NOT HAVE A SEXUAL BEHAVIOR PROBLEM.**
- ☐ **THIS WARD HAS A SEXUAL BEHAVIOR PROBLEM.**

III. RECOMMENDATIONS

TREATMENT RECOMMENDATIONS

Refer for: ______________________________

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Prognosis: ______________________________

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SUPERVISION RECOMMENDATIONS

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Ability of current caregiver to provide recommended level of Supervision:

Caregiver's age: ______________

Caregiver's physical condition: ______________________________

Number of children in home: ______________ **Age range:** ______________________________

Total number of people living in the home: ______________

Can the ward's needs be met in the current living arrangement? ☐ **Yes** ☐ **No**

If no, is a change in placement recommended? ☐ **Yes** ☐ **No**

If yes, explain why a change in placement is recommended: ______________________________

____

Type of placement setting recommended: ______________________________

____

Are PCD restrictions needed? ☐ **Yes** ☐ **No**

(If yes, complete the PCD Requirements section.)

PCD REQUIREMENTS
(Complete only if a hold is placed on the home.)

- ☐ **This ward should be the only child in the home, including biological children of the caregiver, sibs, or other DCFS wards.**

This ward may be placed with other children who are:

_____ or more years older

Females who are _____ or more years older.

Males who are _____ or more years older.

This ward may not be placed with other children:

- ☐ **No additional children should be placed in the home.**
- ☐ **Who are physically handicapped or mentally retarded**
- ☐ **Who have sexual behavior problems**
- ☐ **Who are victims of sexual abuse.**

Note: The above criteria must be followed for placement of this ward in respite care.

COMMENTS

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SASC PLACEMENT AND SUPERVISION RECOMMENDATIONS AND APPROVAL

Supervision

Use of alarms, motion detectors, or other electronic monitoring devices:

- ☐ **Not Approved**
- ☐ **Approved**

Describe the devices that will be used, where they will be located, and why they are necessary:

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Notification of School / Others

Notification of school personnel or other adults outside of the ward's living arrangement:

- ☐ **Not Approved**
- ☐ **Approved**

List the activities which require notification of other adults, using the addendum to the Supervision Plan, and the names of the adults who will supervise:

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PLACEMENT RECOMMENDATIONS

Change in placement:

- ☐ **Not Approved**
- ☐ **Approved**

If approved, recommended placement setting: ____________________________

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OTHER RECOMMENDATIONS

For caseworker / supervisor: ____

For caregiver: ____

Completed by: ______________________________ **Date:** ______________

Sexual Abuse Services Coordinator

Date of next staffing: ______________