



Arkansas Department of Human Services Division of Children & Family Services Quarterly Monitoring Checklist for Foster Home

Resource Worker: _____ County: _____

Date of Visit: _____ Foster Parents' Names: _____

Provider Number: _____ Training Hours Completed: _____

Training Hours Needed: _____

	Yes	No
1. Have you reviewed the Contact Screens in CHRIS in order to address any concerns or issues during the visit?	<input type="checkbox"/>	<input type="checkbox"/>
2. Foster family and their physical surroundings continue to meet all standards of approval, as outlined in PUB-22, including but not limited to the following? a. Sleeping arrangements? b. Smoke detectors? c. Fire extinguishers? d. Posted emergency exit plan? e. Firearms? f. Medication Logs? g. No more than 2 children under the age of 2? h. No more than 3 children under the age of 6? i. Lifebook? j. Auto insurance valid and up-to-date? k. Homeowner's or renter's insurance valid and up-to-date?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
3. Has either parent's work situation changed?	<input type="checkbox"/>	<input type="checkbox"/>
4. Will there be any planned changes in the next few months?	<input type="checkbox"/>	<input type="checkbox"/>
5. Foster family meets the needs of the children placed in their home (physical health, emotional, educational, recreational)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Did the foster family choose to update CFS-409: Foster/Adoptive Family Preference Checklist?	<input type="checkbox"/>	<input type="checkbox"/>
7. Did the foster family choose to update CFS-419: Foster Family Support System Information? a. If so, have you submitted the appropriate background checks for each FFSS member?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
8. Does the on-going narrative in CHRIS address issues the following issues: stress family may be experiencing related to foster parenting; financial difficulties; relationship conflicts with spouse, birth/legal children, in-laws, etc.; illness or death of family member, close friend, etc.?	<input type="checkbox"/>	<input type="checkbox"/>

Comments/Summary of Observations:

Were there any corrective action plans needed and agreed upon that are to be corrected by the next quarterly visit? Yes No

If yes, provide corrective action plan:

Foster Parent Signature: _____

Date: _____

Foster Parent Signature: _____

Date: _____

Resource Worker's Signature: _____

Supervisor/Designee Name: _____

Date: _____

Supervisor/Designee Signature: _____