2.1 *Intake Screening and Assignment*

I. SUBJECT

Intake screening of reports of child abuse and neglect and assignment of reports.

II. PHILOSOPHY

The Intake Unit of the Office of Child and Family Services is responsible for receiving reports of abuse and neglect from the community, evaluating those reports in a manner consistent with the law and responding in a way that respects family autonomy while prioritizing and maintaining child safety.

III. PURPOSE

This policy guides Child Welfare Intake Staff through the process of screening reports of child abuse and neglect to determine whether they qualify as reports under the law, how quickly the agency needs to respond, or if the report should be referred to other community intervention or prevention services. Intake screening and assignment requires focused gathering of facts from the reporter and the collection of other readily available information to determine the proper response.

IV. PRACTICE MODEL

- Child Safety, first and foremost.
    - Making children and families safe is a collaborative effort. We create a team for each family, consisting of family, staff, and community members to find safe solutions for children.
    - In our response to child safety concerns, we reach factually supported conclusions in a timely and thorough manner. Input from parents, children, extended family, and community stakeholders is a necessary component in assuring safety.
    - We value family perspectives, goals, and plans as critical to creating and maintaining child safety.
    - We separate dangerous caregivers from children in need of protection. When court action is necessary to make a child safe, we will use our authority with sensitivity and respect.

V. LEGAL BASE

22 M.R.S. §4004(2)(A) & (B)
20-A M.R.S. §5051-A(1)(C), 20-A M.R.S. §5001-A

VI. DEFINITIONS

Abandonment
Abuse or Neglect
Allegation
Alternative Response Program
Appropriate to Accept for Assessment Criteria
Appropriate Report
Child Protection Assessment
Caregiver
Community Intervention Program
Executive Management
Household
Intake Unit
Inappropriate Report
Non-Accidental or Suspicious Acts
Prevention Services
Report (Child Abuse and Neglect report)
Risk Factors
Structured Decision Making System Intake Screening and Response Priority Tool
Signs of Danger
Truant

See glossary for current definitions.

VII. PROCEDURE STATEMENTS

A. Related Documents

- Glossary of Child Welfare Terms for the Office of Child and Family Services
- Structured Decision Making Intake Screening and Response Priority Tool *(SDM SCRPT Tool)*

B. Responsibilities of Central Intake when Receiving, Documenting and Assigning a Report

1. The Child Protective Intake Unit is staffed with trained caseworkers and receives reports of suspected child abuse and neglect statewide via a toll-free number 24 hours a day, seven days a week.
   a. Telephone numbers and addresses of the Child Protective Intake Unit (intake) are made widely known through publicity.

2. It is the intake's role and responsibility to determine whether to accept a report as appropriate for assessment and to determine response time.
   a. Reports received at district offices by telephone, walk-in or other means are recorded by the district caseworker using the intake report template and sent to intake via a secure email for screening using the *SDM SCRPT Tool*.

   Guidance:

   IntakeReports.DHHS@maine.gov is the secure email address for intake.

3. Intake will review and make a decision about the disposition of all reports within 24 hours of receipt.

4. Intake caseworkers will use the appropriate intake template depending on the type of call received.

5. The *SDM SCRPT Tool* will also be used to determine if a report is appropriate for assessment and to determine the urgency of the response.

6. Intake staff are responsible for determining the following:
    - whether to screen in a report
    - which abuse type(s) are alleged: sexual abuse, physical abuse, neglect, emotional maltreatment or other
    - what the response priority should be
    - if not appropriate for assessment, whether risk factors indicate the need to refer to prevention services or community intervention programs.

C. Preliminary Screening Decision

1. The intake caseworker determines if a report involves these initial criteria:
    - A child under the age of 18
    - An allegation of abuse or neglect
    - A caregiver as the subject of the allegation
    - A child residing in Maine or the abuse having occurred in Maine.

    a. If initial criteria are **not met** the intake caseworker **screens out** the report and explores if additional risk factors are present (per Section E).

        i. Reasons for intake caseworker response (absent allegations) are found in the *SDM SCRPT Tool* and include the following: a prenatal report, a service request, safe haven baby, or concerns relating to an out of home facility.

    b. If initial criteria **are met** the intake caseworker **screens in** the report (per Section F or G).

D. Screening Out Reports

1. Upon the determination that the report does not meet criteria, the intake caseworker may explain to the caller why the report is not consistent with the law and/or policy and may refer the caller to other resources as appropriate.

2. A reporter may be informed of the decision to screen out a report, but not of its disposition if it is screened in for assessment. (See provisions for disclosure of information under Title 22, Chapter 1071, Subchapter 1, Sub-section 4008.)

Guidance:

Screened-out reports are documented in the intake caseworker's daily call log and MACWIS intake screens.

The intake supervisor who reviews the screened-out report generates a form letter, with no names, that states the report does not rise to the level for assessment at this time, but the reporter should call back if he or she has additional concerns.

E. Referrals to Community Intervention Program and Prevention Services

1. Even if a report is screened out, the intake caseworker explores if additional risk factors are present.
    a. If no risk factors exist, the intake caseworker documents his or her decision in the daily call log and MACWIS as appropriate.

    b. If risk factors do exist, the intake caseworker consults the *SDM SCRPT Tool* to determine if the family would benefit from Community Intervention Program or Prevention Services.

2. Referrals to a Community Intervention Program and prevention services are permitted if a family does not meet the criteria for a Child Welfare Assessment and one or more of the following are present:
    - Caregiver has a prior assessment in the past year;
    - Caregiver has a substance abuse, domestic violence and/or mental health issue(s);
    - Report of a substance-exposed newborn (also known as a drug-affected baby);
    - Child in the home has health concerns that the caregiver is struggling to address;
    - Caregiver is involved in criminal activity with little or no impact on the child;
    - Caregiver struggles with appropriate discipline and limit-setting; and
    - Someone in family has identified need that could be addressed with services.

a. Other situations considered more appropriate for Prevention Services are the family needs clothing, food, housing, counseling, education, financial assistance or other similar resources.

Guidance:

Intake staff will make referrals directly to Prevention Services or send reports to the District Office. At this time, district offices will continue to make referrals to the ARP (CIP) agencies. This process is under review and additional guidance will be provided by the executive management to ensure reports are being assigned appropriately.

F. Screening In Information on an Existing Report, Assessment or Case

1. If the intake caseworker searches MACWIS and finds that there is an open report, assessment or case with the individual or family then information is collected from the caller and added to the current open report, assessment or case in MACWIS.

Guidance:

Information-only calls do NOT include allegations of abuse and neglect. Some examples are as follows: (1) concerns about child running away from home, (2) missed visits, and (3) family address changes.

Upon completion of recording the information, the intake caseworker adds a new Narrative Log in MACWIS.

When new information is added to a Narrative Log in an open report, assessment, or case, the intake caseworker notifies the District Office (DO) caseworker and the DO caseworker's supervisor by tickler.

The intake caseworker updates their daily call log to reflect the changes.

G. Screening In New Allegations on an Existing Report, Assessment or Case

1. If the intake caseworker receives **new allegations** on a family currently involved with Child Protective Services the following applies:

Current status of family's involvement:	**Intake caseworker task:**
Existing open report	Adds allegations to the open report and consults the *SDM SCRPT Tool* to document new allegations and necessary response time
Existing open assessment	Adds allegations to the open assessment and consults the *SDM SCRPT Tool* to document new allegations and necessary response time
Existing open case	Creates a new report with new allegations on the family

Guidance:

The intake caseworker must consult the *SDM SCRPT Tool* to identify the new allegations and appropriate response time. When a 24 hour response is indicated, the intake caseworker calls the District Office to alert them.

Upon completion of recording the information, the intake caseworker adds a new Narrative Log in MACWIS.

When new information is added to a Narrative Log in an open report or assessment the intake caseworker will send a tickler to the intake supervisors for review and approval. The intake worker then notifies the District Office (DO) caseworker and the DO caseworker's supervisor by tickler.

The intake caseworker updates their daily call log to reflect the changes.

H. Screening In New Reports

1. Using the applicable intake template given the subject of the call, the intake caseworker listens to the reporter and asks questions as needed. The following information is documented in the MACWIS intake module for new reports:

Reporter Information

- Name, location, contact information
- Reporter's relationship to the child or family
- Reporter's last contact with the family, if applicable
- Reporter's source of information (first hand, second hand)
- Reporter's wishes regarding confidentiality and family's awareness of report

Family/Participant Information

- Identity and location of participants (parents/caregiver, children, other relatives)
- Information about primary caregiver of child(ren), visitation plan, other caregivers of the child(ren)
- Family's primary language
- Whether family has tribal affiliation and involves Indian Child Welfare Act

Nature of Suspected Abuse/Neglect

- Why family is being referred, precipitating incidents, concerning parental behaviors
- Any known impact of suspected abuse/neglect on the child (physical, emotional, other)
- Present condition of the child(ren) (*e.g.,* injured, alone, in potential danger) and other potential victims
- Other concerns such as serious substance abuse or mental health problems of the caregiver and household members,
- Any concerns that could lead to imminent danger to the child
- Cultural/ethnic factors

Resource Review

- Other people who may have direct knowledge and how to contact them
- Actions taken by the reporter thus far; whether situation has worsened, improved or remained the same

Additional Information to Gather

- Previous child welfare history regarding the family, child and/or alleged perpetrator
- Whether there is an open assessment, in-home or custody case on the child or family
- Additional information per the appropriate intake template depending on the type of report received.

2. If the reporter's information is not sufficient to determine if a report is appropriate the intake caseworker may, with supervisory approval, contact at least one professional person who may have direct knowledge of the child's current condition prior to creating a report in MACWIS.

Guidance:

The intake caseworker completes the profile screen, allegation screen, intake narrative, relationship screen, federal risk factor(s), and decision screen in MACWIS.

I. Determining Allegation Type

1. The intake caseworker reviews the information, additional sources as needed and determines whether the allegation(s) are either appropriate (meets the definition of abuse or neglect); inappropriate (does not meet the definition of abuse and neglect); involves a substance-exposed newborn or drug-affected baby with no allegations; or other (see second guidance box below).

Guidance:

Additional sources of information include the following: (1) previous MACWIS reports or entries, and (2) information relevant to complete the report decision from related databases such as ACES, BMV (Bureau of Motor Vehicles), SBI (criminal history), and SOR (sex offender registry).

1. If appropriate, the intake caseworker determines the type(s) of allegation(s) as being one or more of the following:
   - **sexual abuse**: sexual act(s) or suspicious sexual act(s) performed by a caregiver or another individual
   - **physical abuse**: physical injury resulting from non-accidental or suspicious acts of a caregiver
   - **neglect**: failure or refusal of a caregiver to assume responsibility for a child's basic needs for reasons other than poverty including caregiver failure to protect the child
   - **emotional maltreatment**: caregiver action(s) have led or are likely to lead to child's sever anxiety, depression, withdrawal, or aggressive behavior toward self or others
   - **other (see below):**

Guidance:

Other scenarios considered appropriate for assessment:

a. studies requested under the Interstate Compact on Placement of Children (ICPC).

b. request from the Child Protective Services (CPS) agency in another state on behalf of a child not in that state's custody for a relative/kinship home review when the state is considering the use of a relative in Maine.

c. requests from another child welfare agency to interview family member(s) and view the home environment (not related to the ICPC).

d. referrals from the judiciary that may be absent substantive allegations; or response required by court order.

e. Safe Haven report (currently screened as CPS assessment without allegations, in the event circumstances change while assessing and parents want to be known).

f. referral from law enforcement for domestic violence homicide emergency assessment. The primary purpose is to find a safe, temporary placement for a child who has lost both parents to a homicide or one to a homicide with the other detained.

g. referral on a child in an out-of-home facility.

1. Issues that should be referred to Child Protective Services (CPS) Assessment and those that are better suited for Community Intervention Program or Prevention Services are identified below by type of allegation. For detailed information and a decision tree for each allegation type see the *SDM SCRPT Tool.*

a. Sexual Abuse

i. Allegations Appropriate for CPS Assessment

- Any sexual act on a child by an adult caregiver or other adult in the household, or unable to rule out household member as alleged perpetrator
- Physical, behavioral, or suspicious indicators consistent with sexual abuse
- Exposure to sexually explicit conduct or materials
- Sexual exploitation
- Known or highly suspected sexual abuse perpetrator lives with child

ii. Indicators that do not meet OCFS thresholds for a CPS response and could be better served by Community Intervention Program or Prevention Services

- A young child demonstrates sexual behaviors

b. Physical Abuse

i. Allegations Appropriate for CPS Assessment

- Non-accidental physical injury
- Unexplained and suspicious injury
- Caregiver action that caused or will likely cause injury without intervention, including shaking of an infant or child under three years old
- Suspicious child death due to abuse
- Substantiated prior serious injury/death of a child due to abuse AND there is a new child in the care of the perpetrator and there has been no subsequent OCFS involvement that shows the issues resulting in maltreatment have been resolved

ii. Indicators that do not meet OCFS thresholds for a CPS response and could be better served by a Community Intervention Program or Prevention Services

- A child displays or reports accidental injuries including regular and recurring minor physical injuries that could reasonably be expected to heal with no or minimal medical intervention. Examples are welts, cuts, bruises, sprains, strains, wound infections, minor burns and scalds (first degree), minor head injuries, insect and animal bites, minor eye injuries, injuries to the back, shoulder and chest

c. Neglect

i. Allegations Appropriate for CPS Assessment

- Caregiver does not meet basic needs and has refused assistance for the following: nutrition, clothing/hygiene, shelter, supervision, medical/mental health care and treatment
- Caregiver does not meet the basic needs for education (as defined in 20-A M.R.S. §5051-A(1)(C), a child who is required to attend school pursuant to 20-A M.R.S. §5001-A" see Glossary for additional information)
- Caregiver does not protect child from the following: neglect or physical, emotional, or sexual harm by others; labor trafficking; commercial sexual exploitation by a third party
- Caregiver absence/abandonment
- Involving child in criminal activity that creates danger of serious physical or emotional harm to the child
- Positive toxicology at birth AND inadequate caregiver response
- Non-organic failure to thrive
- Prior termination of parental rights and there is a new child in the home and there has been no subsequent OCFS involvement that shows the issues resulting in maltreatment have been resolved

- Substantiated prior serious injury/death or a child due to neglect and there is a new child in the care of the perpetrator and there has been no subsequent OCFS involvement that shows the issues resulting in maltreatment have been resolved
- Suspicious child death due to neglect

ii. Indicators that do not meet OCFS thresholds for a CPS response and could be better served by a Community Intervention Program or Prevention Services

- Prenatal substance use
- Lack of food, clothing appropriate for the weather, or shelter which is not injurious to the child
- Housing conditions or housing items within a child's reach in the home environment which causes or are likely to cause a level of deprivation which does not require medical attention
- Failure to provide necessary personal care (hygiene), or clothing, to protect the child where there is little demonstrated impact to the child
- Involvement of child in criminal activities where there has been little/no impact on the child
- Provide or permit child to use alcohol or other drugs, and there is little/no information on the impact to child
- Physical or mental impairment of a parent(s), including substance abuse, which may prevent the parent from meeting the basic needs of a child though there has been little/no impact on the child
- Failure by a person responsible for the child to ensure school attendance:
    - for a child younger than age seven or has completed grade six (when Title 20-A does not apply), OR
    - the child is within the parameters of Title 20-A and the truancy protocol has not yet been followed.

d. Emotional Abuse/ Maltreatment

i. Allegations Appropriate for CPS Assessment

- Caregiver actions have led or are likely to lead to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others
- Exposing the child to brutal or intimidating acts or statements, including but not limited to: harm or threatened harm to animals; threats or suicide or harm to family members; and/or consistently scapegoating the child
- Exposure to domestic violence

ii. Indicators that do not meet OCFS thresholds for a CPS response and could be better served by a Community Intervention Program or Prevention Services

- Concerning caregiver actions with limited adverse impact and/or limited expected impact
- Isolated domestic violence concerns where children were not present, are not aware of the incident, and where there is no pattern of violence or serious event which caused injury to a caregiver
- Caregiver describes or acts towards a child in negative terms or has unrealistic expectations, where there has been little/no impact on the child

J. Determining Response Priority and Completing a Report

1. Reports that are appropriate for referral are assigned a response time by Central Intake and reviewed by the Intake Supervisor. Intake Workers consult the *SDM SCRPT Tool* to determine response time, either 24 or 72 hours.

2. If it appears that a child is in immediate risk of serious immediate harm, or the *SDM SCRPT Tool* response priority indicates the need for a 24 hour response, the Intake Worker contacts the Intake Supervisor (or standby staff after hours) immediately. All other appropriate reports will be completed by the Intake Worker and submitted to the Intake Supervisor for approval by the end of the Intake Worker's shift.

3. Before making a recommendation to the Intake Supervisor, Intake Workers consider factors that could either result in an increased or decreased response time. Factors increasing a response time indicate a 24 hour response is needed. Factors decreasing response time requires that a response occurs within 72 hours. When multiple factors are present, factors that increase response time supersede factors decreasing response time. Factors to consider are as follows:

   a. Factors Increasing Response Time:

      - Law enforcement requests immediate response
      - Forensic considerations would be compromised by slower response
      - Reason to believe family may flee
      - Prior child death in household due to abuse or neglect.

   b. Factors Decreasing Response Time:

      - Child safety requires strategically slower response (e.g., value of coordinating multi-agency response outweighs need for immediate response)
      - Child is in alternative safe environment
      - Alleged incident occurred more than six months ago.

K. District Attorney Referrals

1. If a suspected criminal act of abuse to a child is alleged, intake staff make a referral to the District Attorney (DA) where the alleged crime occurred. This includes reports involving child death and/or serious injury, ingestion, and domestic violence homicide. In addition, reports with allegations involving physical abuse, sexual abuse, sex trafficking, and child endangerment require a referral to the DA.

Guidance:

The intake templates will include a question for law enforcement asking whether or not a referral has been made to the DA's office; if the answer is yes, intake staff are NOT required to make a referral to the DA's office; if the answer is no, intake staff should make a referral to the appropriate DA's office.
Intake staff documents the DA referral in MACWIS and the paper form is faxed to the DA's Office where the alleged crime occurred. DA Referrals do not include past history of CPS involvement, but should include the following information:

- Referent name and contact information
- Name and demographic information for the alleged perpetrator(s)
- Name and demographic information for the alleged victim(s) and victim caregiver(s)
- A summary of all known concerns at the time of report.

L. Intake Supervisor Review, Approval and Assignment of Reports

1. The intake supervisor reviews the report and determines if modifications are needed and whether or not the categorizations are correct.

    a. If changes or clarifications are needed, the intake supervisor may request that the intake caseworker make any necessary edits.

    b. This decision may be delayed by the need to contact collateral individuals and better understand the child's circumstances.

Guidance:

In some circumstances, intake staff consult District Office staff about whether or not a family or individual would benefit from a Community Intervention Program or Preventive Services.

2. Reports that require a response within 24 hours must be reviewed immediately by the intake supervisor (or standby supervisor after hours). If approved, the intake supervisor must assign it to the District Office as soon as possible. If a report contains a concern of child death and/or serious injury, ingestion, and domestic violence homicide, intake staff selects the appropriate box on the 'Intake Decision Screen' in MACWIS, and completes a notification to Executive Management.

3. Reports that require a 72-hour response must be reviewed by the intake supervisor by the end of his/her shift and within 24 hours of intake receiving the report.

4. Once approved by the intake supervisor, reports are either: sent to the appropriate district supervisor for assignment for CPS Assessment; or referred to a Community Intervention Program or Prevention Services.

5. Once a report is sent to the District Office the family must be seen within the response time specified by intake.

6. District Office staff may be aware of circumstances regarding a family or immediately learn new information about a report which could change the report decision or response time. Intake must be contacted within 24 hours of the report being transferred to the District Office to discuss the report decision.

Guidance:

When information regarding a report/family is learned through assessment activities which does not support the allegations of the Intake report, this should be noted in the decision window and the closing summary of the assessment rather than the Intake report being reopened to change the report decision.

Appendix I

STANDARD INTAKE TEMPLATE

Date/Time:

Report Summary:
Copy and paste decision summary or write brief 2-3 sentence summary.

Referent Information:
Include referent's name, job title, organization, address and telephone number. Include mailing address if different.

Referent's role and/or how they obtained information:
Referent's last contact with family member(s):

Confidentiality Requested: Yes ☐No ☐

Household participants:

Family information in the format of:

The family is John and Susan Smith of 123 Anywhere Road, Somewhere, phone number 555-5555. John and Susan are the parents of 1yo Adam Smith and 2yo Eve Smith. Susan is the mother of 3yo Steve Jones. Also in the home is John's mother, Mary Smith

ACES

Out of Household Caregivers:
Out of home parent information in the format of:

Steven's father is David Jones of 456 Back Road, Somewhere, phone 555-9999. Steven visits with David every Wednesday from 4-6pm and every other weekend

ACES

Summary of Concerns:

Domestic Violence Concerns: ☐Yes (explain below) ☐None Known ☐Already Explored Above

Mental Health Concerns: ☐Yes (explain below) ☐None Known ☐Already Explored Above

Substance Abuse Concerns: ☐Yes (explain below) ☐None Known ☐Already Explored Above

Native American Heritage (ICWA): Choose an item.

Prior CPS History:
Indicate if the family has history. If so, complete history according to current standards (see CPS hx format and examples in the shared drive).

School/Childcare Information:

Language: Select Language

Collateral Contacts: ☐

☐DA Referral by Intake ☐DA Referral by Law Enforcement

Call to District Office/Standby: ☐Intake spoke with:

Worker Safety Concerns:
Any safety concerns a CW should be aware of (guns, dog, violent persons)

Screening Decision & Response Time:

Appendix II

HOUSEHOLD EXAMPLES

Scenario #	Circumstance	Which Household to Assess	Number of Intake Reports created
#1	Abuse by mother and mother's boyfriend in their household. *Child lives primarily with father though visits mother on weekends*.	**Mother's household, where abuse occurred.** *Mother is considered primary caregiver in this report; boyfriend is secondary caregiver of their household. Out of home father is "other" caregiver.*	**ONE, report is sent to district where mother resides.**
#2	Abuse by father who is also primary custodian of child. Mother lives out of home and visits with the child on weekends.	**Father's household, where abuse occurred.** *Father is considered primary caregiver in this report. Other caregiver in his household can be secondary (if applicable), and mother is out of home caregiver.*	**ONE, report is sent to district where father resides.**
#3	Abuse by both IN and OUT of home caregivers (who do not reside together).	**Both households: mother's household for sexual abuse allegations; father's household for**	**TWO, one report for each mother and father's households.**

	Example: *sexual abuse by mother in her household; father is aware of abuse by mother and not taking action to protect children.*	**neglect/failure to protect allegations.**	***Any time two reports are created on caregivers for the same children that do not live together, these will be marked as "companion" reports so district staff are aware.*
#4	Abuse by two caregivers in one household who each have children, though none of the children are shared. **Example**: *neglect by Dad & his live in girlfriend due to significant substance abuse by both dad and girlfriend which is causing lack of supervision. Dad has 3 & 5 yo, girlfriend has 8 yo in home.*	**Household of concern [Dad & Girlfriend's].** ***How to determine primary CG in this household as both caregivers have their own children:*** *Who provides most childcare? Or if 50/50, *Who contributed most to abuse/neglect (if both abusers) *Dad or GF could be primary/secondary	**ONE, no need for companion report though caregivers in household do not share mutual children,** *unless there are concerns of failure to protect by out of home parent(s).*
#5	Abuse by caregivers of multiple (more than one) unrelated family living in a household. *This does not include caregivers who are partners in a relationship raising children together.* **Example**: *Three adult siblings living together in a home with their significant*	**Household where all adults / children are residing. Though all adults live in the same physical structure, they are considered separate family "units" in this example.**	**THREE Reports, to capture each respective family unit living under the same roof.** (If a case were to open or court action filed, all of these adults and children living together could not be blended). However, if only one of the three families living together had clear abuse

	others and children. Abuse concerns are neglect by all adults to children due to all parents leaving small children alone for days at a time.		concerns at the time of report, we would only need ONE report and the other two families would be considered household members. Similarly, if two of the three families living together had clear abuse concerns at the time of report, we would need TWO reports and the other family would be considered household members.
#6	Abuse by step-parent who no longer resides in the household, though resides with other children who may be at risk. **Example:** *12 yo disclosed sexual abuse by step-father who moved out of family's home 4 months ago. Step-father now resides with woman and her two young children. Unclear if mom plans to resume contact w/ step-dad.*	**Household where abuse occurred (mom's home) by step-father when he was in caregiving role to child 4 months ago and sexually abused her.** **Household where alleged perpetrator/step-father currently lives with young children who may be at risk.**	**TWO Reports:** **One report** to capture abuse concerns by step-father to step-daughter in that household; and **One report** to capture concerns that step-father poses a risk of harm to children he currently has access to in new household.

#7	**Example A:** Sexual abuse by parent who resides in another state. Child lives in Maine with parent who is protective. Abuse occurred during visit with parent in other state. **Example B:** Sexual abuse by parent who resides in Maine. Child lives primarily in other state with parent who is protective. Abuse occurred during visit with parent in Maine.	**Example A:** Report is made under household of parent where abuse occurred out of state, and should be forwarded to state where alleged abuse occurred by parent in that state. **Example B:** Report is made under household of parent in Maine who is abuser, even if no other children currently in that home.	**Example A: ONE report** under name of out of state caregiver, with caregiver in ME and associated children screened in. (Other state may request courtesy interviews of child / parent in Maine). ***TWO reports only if parent in Maine is not protecting child.* **Example B:** ONE report in Maine under caregiver's name who is alleged abuser. Information should also be shared with other state where child resides primarily with other parent, so that joint investigation & interviews can occur.

Appendix III

FREQUENTLY ASKED QUESTIONS

Updated Intake Policy, SDM tool, & Threshold

1) **There are areas where the Intake Policy & SDM tool language does not match, why**?
We've reviewed the tool and policy to ensure definitions are clear and have made updates as needed. The tool and policy do not have to have the same examples, and will not account for all scenarios that we will encounter.

2) **Why do definitions for allegation types correspond more with high severity/substantiations rather than low/moderate/indications?**
Part of the work to prepare for the roll-out of SDM and to update our Intake policy has included a review of law, policy and practice, including an Organizational Assessment completed by Hornby Zeller Associates. This review showed that our threshold for assigning reports was too low and not consistent with the legal mandate outlined in Title 22 which outlines when we legally have the responsibility to intervene to protect children from allegations of child abuse and neglect. We have incorporated this shift into the updated Intake policy and SDM tool. Therefore, the most concerning reports will be handled by child welfare, and less concerning reports will be assigned to CIP (ARP) to most effectively use our resources.

3) **Do allegations in the Intake Policy and SDM tool match the findings policy?**
While working on both the policy and tool, we were careful to ensure there was a thread between what we are assessing and what we are able to make findings on. However, it is important to note that the screening threshold at Intake does not equate to the ability to make findings. Findings can only be made after a thorough assessment. If a finding is made after assessment it is possible that the finding type may be different than the initial allegation type as a result of the information gathered during the process.

4) **Where are substance abuse and mental health concerns screened in under the new policy and tool?**
These items are not listed as a separate item to check off on the tool, and OCFS must explore parental behaviors that have caused or are likely to cause impact on the child. This is an area some staff expressed concerns about during the SDM training, and we will continue to monitor and make adjustments as needed.

5) **Why do we need to reassess parents who have new children when they've had a prior TPR, child death, serious injury or sexual offense BUT have been subsequently assessed and found to be safe to parent children?**

These items were discussed at length throughout this process and adjustments have been made to the policy and tool so that we do NOT need to reassess families in these circumstances each time a new child is in their care when they have previously been assessed to be safe (unless there are specific circumstances that would cause us current concern).

6) **Will Intake no longer be making DA referrals when law enforcement reports that they already made one?** *Intake staff will ask law enforcement referents whether they have or will refer suspected crimes against children to the DA's office. If they have, Intake will not make an additional referral. A checkbox has been added to the Intake narrative report to prompt staff to ask this question. We will continue to monitor this to ensure that appropriate referrals are being made.*

MACWIS

7) **How will allegations be chosen in MACWIS by Intake since they don't mirror the SDM tool options?**
At this time, Intake will select high severity allegations for reports warranting 24 hour response, and low/mod severity allegations for reports warranting 72 hour response. For abuse types that require OCFS response where the report is not "ARP eligible," Intake will make a note of this in supervisory comments. This is an area we will work to streamline with potential MACWIS changes.

8) **How will new allegations added to open assessments be tracked?**
Intake will use the SDM tool on all reports of suspected abuse, even those currently added as narrative logs. Any new allegations will be added to an open assessment by Intake and the new SDM screening decision summary which includes the new response time will be added to the narrative log. Assessment staff will be expected to respond to the new allegations within the timeframe determined through the use of the tool. Work is being done with MACWIS to determine how best to capture this information in order to reflect the new timeframe and to track these new reports without needing to create a new report and assessment. In addition, Intake will use the SDM tool when adding information to open CIP (ARP) involvements to capture new concerns reported. When the SDM tool indicates the additional reported information is "ARP eligible" the new information will be followed up on by ARP. If the new information reported screens as requiring an OCFS response and not "ARP eligible" a new report will be created.

9) ***What are the Intake caseworker's responsibilities when adding narrative logs to a recently (within 30 days) screened out report?***
When the information is the same as in the initial report, Intake will use the preliminary screening portion of the SDM tool to verify that the new information would be a "screen out" and document that information in the narrative log.

10) **As Intake staff will be adding SDM decision information to open assessments and open CIP (ARP) involvements through a narrative log entry, should Intake supervisors be reviewing those narrative logs and decisions (currently Intake staff sends ticklers to the district caseworker and supervisor for review on open involvements)?**
Intake workers will send a tickler to the Intake supervisors for review and approval as well as the district caseworker and supervisor to notify them of the new information. Intake Supervisors will then review the new information and SDM decision for accuracy.

11) **When will Intake be creating a new report versus adding a narrative log with new information?**
During the first phase of roll out, the current process for adding narrative logs and creating new reports will not change, though we will be using the SDM tool for all calls with suspected abuse concerns to process the decision and pasting the decision at the bottom of the Intake template. If a family has a current open case, Intake will create a new report to capture new abuse concerns reported and the screening decision.

12) **Since SDM sorts households differently than the current OCFS process, does this mean that family members may be counted more than once as critical case members due to two open assessments with a family when concerns exist in more than one household?**
Yes, if abuse concerns exist in more than one household, children who are a part of both households would be captured as a victim or critical case member in both households. (see also information on households below).

Report Receipt & Decisions

13) **Will District staff have access to the automated SDM tool and Data Collection System (DCS)?**
At this time, Intake staff and Bobbi/Gina will have access to the DCS. SDM decision summaries will be copied into reports.

14) **What happens when District staff receive new reports from walk-ins or by phone in the district?**
District staff will document the new report using the standard Intake Report template. They will not turn callers or walk-ins away, or make them repeat their concerns by calling Intake directly. District staff will not complete the report in MACWIS. Once the report template has been filled out with report information, it will be emailed to Intake for completion in MACWIS and with the SDM tool at: IntakeReports.DHHS@maine.gov

15) **Will there be an increased need for stand-by staff to respond afterhours based on SDM decisions for 24 hour response?**

We do not anticipate that the amount of reports requiring response will increase dramatically, and we will continue to monitor the workload upon implementation.

16) **Will district staff be receiving more calls (during regular business hours, or stand-by staff on the weekends) because of SDM decisions?**
No, we do not anticipate that staff will receive more calls from Intake. Intake will call district staff during business hours and covering stand-by staff after hours regarding any report which results in a 24 hour response time so that response can be coordinated within the timeframe.

17) **Is OCFS becoming a 24/7 agency with implementation of SDM and clarified response times to include 24/72 hours?**
OCFS currently operates as a 24/7 agency, with the use of 24 hour emergency operations at Intake as well as stand-by staff who are on-call in each district during non-business hours. We do not anticipate any changes to regular staff "business" hours at this time.

18) **If the district supervisor (during business hours or on the weekend) does not agree with the report decision or response time, can they override Intake's decision?**
No, overrides can only happen at Intake. District supervisors may contact Intake supervisory staff within 24 hours to discuss concerns about report decisions. There is one Intake supervisor covering each weekend day and holiday for an 8 hour shift, primarily during business hours.

19) **What happens if the district supervisor does not agree with a 24 hour response time, and there is no Intake supervisor available to speak with?**
Given the current level of Intake supervisory staffing, a supervisor would be available to review and respond within 24 hours.

20) **How will overrides be measured and concerns monitored?**
Overrides should only be utilized in 5-10 percent of reports to ensure fidelity to the SDM tool. 5-10 percent accounts for times when district staff may know additional information within 24 hours, and for considerations that occur which may not be a part of the Intake Policy or SDM tool.

21) **Can district staff request that Intake staff complete collaterals to help weed out reports that may not require child welfare intervention?**
The updated policy states: "If the reporter's information is not sufficient to determine if a report is appropriate the intake caseworker may, with supervisory approval, contact at least one professional person who may have direct knowledge of the child's current condition prior to creating a report in MACWIS."

Intake is working hard to streamline their role in narrowing information to what is needed in order to make a decision about response. Any additional collateral contacts would be considered part of the assessment response and completed by district staff.

22) **If district staff start an assessment, and realize that the reported information is not true – can they request the report decision be screened out by Intake?**
No, this should be accounted for through documentation about assessment activities that produced additional information about safety. (See also Intake policy guidance (pg. 17) for more on this).

23) What is the supervisory approval process for reports that are now screened through the SDM tool?
Intake supervisors will review all reports and the screening decisions to ensure they are consistent with policy and practice expectations. Priority is given to reports that require a response within 24 hours. These are designated as "high severity" in MACWIS, and will be reviewed as soon as possible by intake supervisors. Any questions about a screening decision should be directed to the Intake supervisors within 24 hours.

CIP and Prevention Referrals

24) **Will referrals to CIP (ARP) and prevention be coming from both Intake and District staff?**
During phase 1 of SDM roll-out, District staff will continue to make referrals to the ARP agencies for 72 hour/CIP-Eligible or assign them to child welfare staff for response. Initially, referrals will not be made to CIP through prevention (reports formerly screened as low/moderates that now screen as inappropriate). This will be assessed weekly. Intake staff will make direct prevention referrals, such as to Cradle-Me (for Public Health Nursing and Maine Families Home Visiting Services). Inappropriate reports that meet the criteria for a CPPC response will continue to be sent to district supervisors for assignment to the Prevention Workers. Note: Bridging referrals are now made through Cradle-Me.

25) **If referrals to CIP and/or prevention are coming from both Intake and District staff, how will units be tracked, and who will manage the units?**
Initially, referrals to CIP-eligible (ARP) will only be sent by district office staff.

26) **What distinguishes referrals to CPPC versus other prevention or CIP-Inapp referrals? Are there definitions for what services each provides?**
The same criteria that has been used previously for referrals to CPPC (inappropriate in the identified CPPC neighborhoods) and Cradle-Me will continue to be utilized. Initially, we will not be referring to CIP-Prevention. We will outline the criteria for each service to ensure consistency and clarity.

27) **How will we make consistent referrals statewide with CPPC resources and varying CIP units per district?**
We continue to build the prevention tier of services, including expanding CPPC to all 8 district offices. The units allocated to CIP are based on the volume of referrals in the previous contract period. We anticipate that this will continue to vary for each district.

Impact of SDM Household definitions on Report, Assessment and Case

28) **When a child lives primarily with one parent, though abuse is occurring in the home of the non-custodial parent, which household is the report written under?**
Always assess the household of caregiver where abuse concerns exist, even if the child does not live primarily with that parent and only visits the home. As part of the assessment process, staff will still talk to the other parent/caregiver regarding the abuse allegations as is current practice.

29) **If a mother and her significant other are living together and both have their own children in the household, do we need more than one report to capture each of their children?**
No, since SDM focuses on concerns within a household, you would assess all concerns within the household through one report.

30) **Are there confidentiality concerns with having mom and her significant other's non-mutual children all blended in one report as in the above example? For example, if a case were to open?**
Information would need to be redacted respective to unrelated individuals in the same way that it does with any current case that may involve out of home parents and their significant others, and other sensitive information relating to the individuals as part of the case.

31) **If the household of concern is a parent who is the perpetrator of domestic violence, does this mean that we can't first reach out to the non-abusing parent/adult victim to coordinate assessment activities?**
No, we can and should still coordinate first with the parent who is an adult victim of violence to safely plan assessment activities when necessary.

32) **Since SDM assessments focus on the household of concern, does this mean that staff no longer need to make contact with out of home parents?**
No, contact will still be made with out of home parents during the assessment process as in current practice. Out of home parents will still be listed in the Intake report and screened into the report.

33) **What happens when one household/parent is being assessed, and new allegations regarding other parent(s) in another household are discovered?**

A new report needs to be created on other parents' household so that the new allegations in the other household can be additionally assessed. Any new allegations discovered during the process of completing an assessment will be documented on the standard Intake Report template and e-mailed to Intake at: IntakeReports.DHHS@maine.gov *for report completion using the SDM tool.*

34) **What happens when abuse concerns exist in two households (for example, parents share custody and visit equally and are both alleged to abuse the child)?**
Two reports are needed, one for each household. SDM assessments are conducted on households where abuse concerns exist.

35) **How should district staff mutually assess companion reports regarding two parents in different households when parents are in different districts?**
Collaboration is necessary; we don't want children or families to have multiple interviews regarding the same allegations. Intake will continue to identify these reports as companion reports so staff will be aware of the other report.

36) **Is it possible for one parent to be open to ARP/CIP while another parent is open with the Department? For example, when two different districts receive a referral on a parent in their respective area that involves the same children – is it allowable for ARP/CIP and OCFS to be mutually involved?**
This is possible…if both are household screen as 72 hour/CIP-eligible; we would want both families in the separate households to have the same response decision of being referred to CPS or CIP (ARP). If they need different levels of response, one may get referred to CPS or CIP-eligible, while the other may get referred to prevention services.

37) **Is it possible for one district to assume responsibility for two assessments (one within district, and one outside of district) that both involve the same family?**
In general, each district will assume responsibility for their own assessments with collaboration occurring between the two districts, however, if there are extenuating circumstances please consult with the PA.

38) **What happens when two districts are each assessing a parent/household in their district, and do not agree on the findings or decision to file court action?**
Each district would be responsible for findings related to the parent in the household they are assessing. The current expectation when considering filing court action is to convene a team decision making meeting that involves the worker, supervisor and PA. This should include staff from both districts. At any time, it may be helpful to convene a meeting to coordinate assessment activities.

39) **When court action is to be filed and two reports are open with parents in two households (in same district or different districts), which report should court action be filed under?**

Court action will be filed through the household assessment where the child(ren) primarily reside or current court orders exist.

40) **If a case is opened regarding a family that has two parents being assessed in different households, are both cases opened?**
Cases will be opened depending on the outcome of the assessment for each household. If there is court involvement, the court process involves both parents and a case will remain open for each to capture the work occurring within that household. Court/legal information will be documented in MACWIS through the case for the household which the court action was filed, though most information will be relevant to both cases. We continue to work with the MACWIS team to streamline this documentation.

41) **When two cases are opened regarding the same family, will this cause potential technical issues within MACWIS, or with funding such as IV-E?**
We are not aware of any issues that will occur with two cases being opened on the same family, though we will continue to monitor with the MACWIS team and make adjustments as needed.

Appendix IV

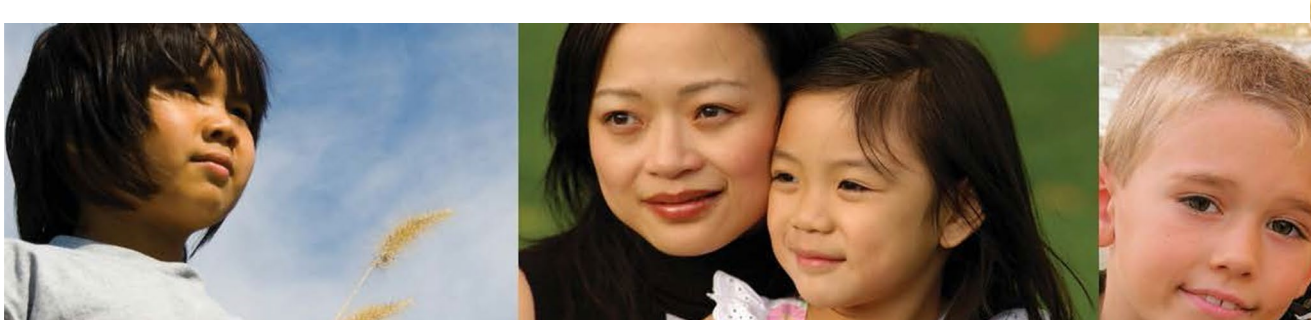
INTAKE SCREENING AND RESPONSE PRIORITY TOOL

SDM

The Structured Decision Making® System for Child Protective Services

Intake Screening and Response Priority Tool

May 2017



Maine Office of Child and Family Services

NCCD Children's Research Center

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The Children's Research Center is a nonprofit social research organization and a center of the National Council on Crime and Delinquency (NCCD).

Structured Decision Making® and SDM® are registered in the US Patent and Trademark Office.

MAINE OFFICE OF CHILD AND FAMILY SERVICES
SDM® ASSESSMENT DEFINITIONS

1. **Caregiver:** An adult, parent, or guardian in the household who provides care and supervision for the child.

Circumstance	Primary Caregiver	Secondary Caregiver
Two legal parents living together	The parent who provides the most child care. May be 51% of care. TIE BREAKER: If precisely 50/50, select alleged perpetrator. If both are alleged perpetrators, select the caregiver contributing the most to abuse/neglect. If there is no alleged perpetrator or both contributed equally, pick either.	The other legal parent
Single parent, no other adult in household	The only parent	None
Single parent and any other adult living in household	The only legal parent	Another adult in the household who contributes the most to care of the child. If none of the other adults contribute to child care, there is no secondary caregiver.

2. **Household:** All persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. This may include persons who have an intimate relationship with a parent in the household (boyfriend or girlfriend) but may not physically live in the home or a relative where the legal parent allows the relative authority in parenting and child caregiving decisions.

   WHICH HOUSEHOLD IS ASSESSED? Structured Decision Making® (SDM) assessments are completed on households. When a child's parents do not live together, the child may be a member of two households.

   Always assess the household of the alleged perpetrator. This may be the child's primary residence, if it is also the residence of the alleged perpetrator, or the household of a non-custodial parent if it is the residence of the alleged perpetrator.

   If the alleged perpetrator is a non-custodial parent, also assess the custodial parent *if there is an allegation of failure to protect.*

MAINE OFFICE OF CHILD AND FAMILY SERVICES
SDM® INTAKE SCREENING AND RESPONSE PRIORITY TOOL

r: 05/17

Referral Name: _____ **Referral #:** _____ **Date:** _____ **District:** _____

STEP I. PRELIMINARY SCREENING

☐ Automatic screen out
- ☐ No child under age 18
- ☐ Duplicate referral that contains no new information
- ☐ Referred to another state or tribal jurisdiction

☐ Response may be required but not through review of this screening criteria
- ☐ Service request
- ☐ Safe Haven baby
- ☐ Report documents concerns in out-of-home facility or foster home

If any of the above are selected, no further use of this SDM tool is required.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria

Physical Abuse

☐ Non-accidental physical injury
☐ Unexplained and suspicious injury
☐ Caregiver action that will likely cause injury without intervention
☐ Suspicious child death due to abuse
- ☐ No other child in the home
- ☐ Other child(ren) in the home

☐ Substantiated prior serious injury/death of a child due to abuse, no subsequent OCFS involvement, and there is a new child in the care of the perpetrator

Emotional Maltreatment

☐ Caregiver action(s) have led or are likely to lead to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others
☐ Exposure to domestic violence

Neglect

☐ Caregiver does not meet basic needs for:
- ☐ Nutrition
- ☐ Clothing/hygiene
- ☐ Shelter
- ☐ Supervision
- ☐ Education
- ☐ Medical/mental health care and treatment

☐ Caregiver does not protect child from:
- ☐ Neglect or physical, emotional, or sexual harm by others
- ☐ Labor trafficking
- ☐ Commercial sexual exploitation by a third party

☐ Caregiver absence/abandonment
☐ Involving child in criminal activity that creates danger of serious physical or emotional harm to the child
☐ Positive toxicology at birth AND inadequate caregiver response
☐ Non-organic failure to thrive
☐ Prior termination of parental rights, no subsequent OCFS involvement, and there is a new child in the home
☐ Substantiated prior serious injury/death of a child due to neglect, no subsequent OCFS involvement, and there is a new child in the care of the perpetrator

Neglect (Continued)
☐ Suspicious child death due to neglect
  ☐ No other child in the home
  ☐ Other child(ren) in the home

Sexual Abuse
☐ Any sexual act on a child by an adult caregiver or other adult in the household
☐ Physical, behavioral, or suspicious indicators consistent with sexual abuse
☐ Exposure to sexually explicit conduct or material
☐ Sexual exploitation
☐ Known or highly suspected sexual abuse perpetrator is a member of the same household as the child

B. Screening Decision

○ Screen out: No criteria are selected
If no override, proceed to Step IV, Community Intervention Program or Prevention Service Referral Guide

○ In-person response required: One or more criteria are selected
If no override, proceed to Step III, Response Priority and Community Intervention Program or Prevention Service Eligibility

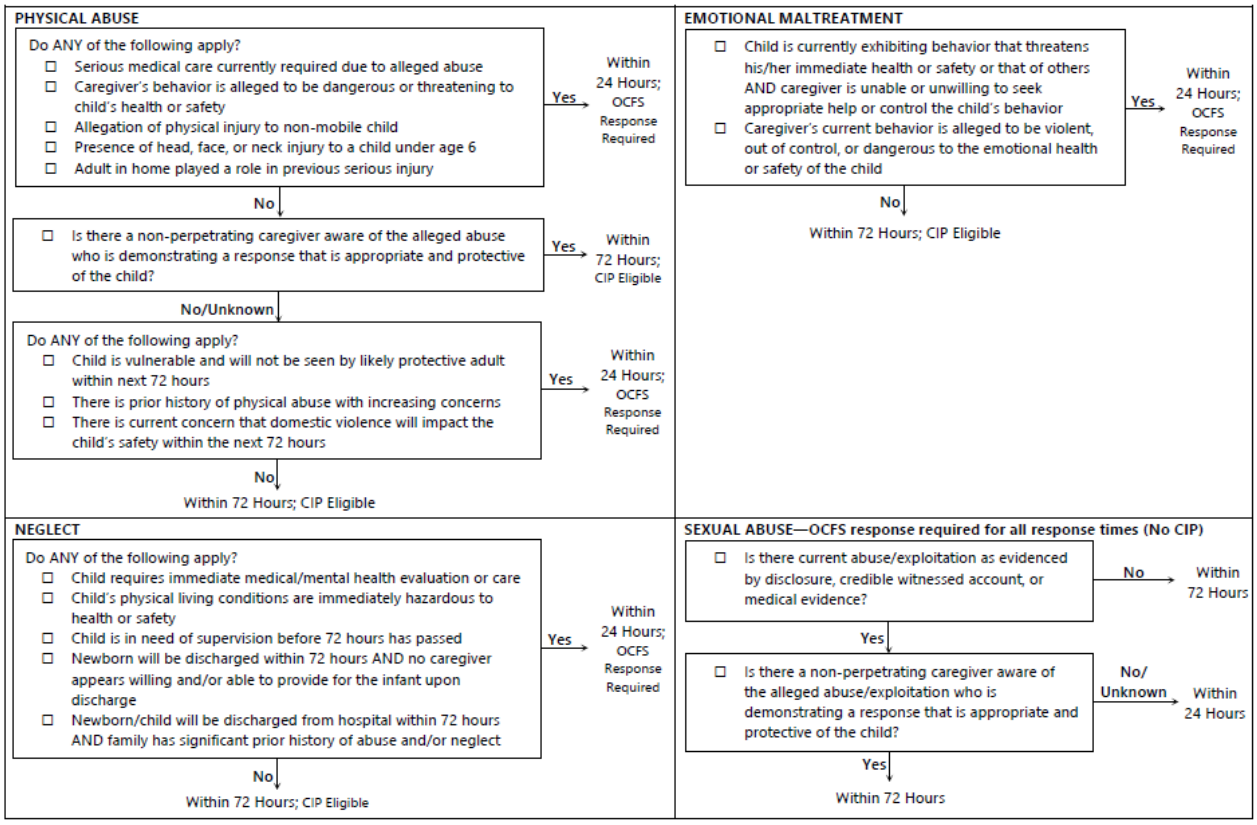
C. Overrides (intake supervisor approval needed)

○ In-person response required. No criteria are selected, but the report will be opened. Select all that apply and proceed to Step III.
  ☐ Response required by court order
  ☐ Other (specify): _____

○ Screen out. One or more criteria are selected, but the report will be screened out. No further SDM assessments required. Select all that apply.
  ☐ Insufficient information to identify or locate child/family
  ☐ Another agency such as law enforcement, probation, or court has jurisdiction
  ☐ Historical information only
  ☐ Other (specify): _____

STEP III. RESPONSE PRIORITY AND COMMUNITY INTERVENTION PROGRAM OR PREVENTION SERVICE ELIGIBILITY

A. Decision Trees



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B. Overrides

Policy
Increase to 24 hours whenever:
☐ Law enforcement requests an immediate response
☐ Forensic considerations would be compromised by slower response
☐ There is reason to believe that the family may flee
☐ Vulnerable child with caregivers who have significant history of abuse and/or neglect
☐ Prior child death in the household due to abuse or neglect or under suspicious circumstances

Decrease to 72 hours whenever:
☐ Child safety requires a strategically slower response
☐ The child is in an alternative safe environment
☐ The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period

Discretionary
☐ Response time increased to 24 hours (requires intake supervisory approval)
☐ Response time decreased to 72 hours (requires intake supervisory approval)
Reason: _____

Final Response Priority: ○ 24 hours ○ 72 hours

STEP IV. COMMUNITY INTERVENTION PROGRAM OR PREVENTION SERVICE REFERRAL GUIDE

For all referrals screened out, use the following guide to consider making a referral to a Community Intervention Program (CIP) or prevention service. Select "yes" or "no" for each as applicable based on information reported and/or available at the time of referral. If unknown at the time of report, answer "no." Referrals with more than one "yes" answer are likely to benefit from a CIP and/or a prevention service.

Yes	No	
○	○	At least one prior assessment in the last year
○	○	Current caregiver substance abuse, domestic violence, or mental health issues
○	○	Substance-exposed newborn (also known as drug-affected baby)
○	○	Child in home has health concerns that caregiver is struggling to address
○	○	Caregiver is involved in criminal activity where there has been little/no impact on the child
○	○	Caregiver struggles with appropriate discipline and limit setting
○	○	Someone in the family has an identified need that could be addressed with services ☐ Clothing ☐ Housing ☐ Counseling ☐ Medical ☐ Education ☐ Food ☐ Financial ☐ Other (specify): _____
○	○	Other (specify): _____

Referral Decision (select one): ○ No referral ○ CIP ○ CPPC ○ CradleMe—Bridging ○ CradleMe—Other ○ Other (specify): _____

MAINE OFFICE OF CHILD AND FAMILY SERVICES
SDM® INTAKE SCREENING AND RESPONSE PRIORITY TOOL
DEFINITIONS

STEP I. PRELIMINARY SCREENING

Automatic screen out

- No child under age 18. The current referral may allege abuse or neglect, but the alleged victim is 18 years of age or older (including non-minor dependents).
- Duplicate referral that contains no new information. The report duplicates an existing referral. This report does not contain new allegations from an existing referral.
- Referred to another state or tribal jurisdiction. A referral has been received for a child who lives in another jurisdiction. The caller was referred to that jurisdiction and provided with contact information, OR the jurisdiction was notified and the referral was recorded in that jurisdiction.

Response may be required but not through review of this screening criteria

- Service request. Report is a request for services. The Maine Office of Child and Family Services (OCFS) is required to respond.
- Safe Haven baby. The referral concerns a child 30 days of age or younger. The caregiver has voluntarily surrendered physical custody of the child to any Safe Haven provider as defined by Title 22, Ch. 1071, Subchapter II, §4018, Subsection 1B.
- Report documents concerns in out-of-home facility or foster home. The report refers to actions taken by staff at an out-of-home facility or in a foster home.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria

Elicit reporter's concern and select all that apply. Consider age, developmental status, other child vulnerabilities, and expected child and family life events when assessing referrals.

MAINE OFFICE OF CHILD AND FAMILY SERVICES
SDM® INTAKE SCREENING AND RESPONSE PRIORITY TOOL
DEFINITIONS

STEP I. PRELIMINARY SCREENING

Automatic screen out

- No child under age 18. The current referral may allege abuse or neglect, but the alleged victim is 18 years of age or older (including non-minor dependents).
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STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria

Elicit reporter's concern and select all that apply. Consider age, developmental status, other child vulnerabilities, and expected child and family life events when assessing referrals.

Physical Abuse

Non-accidental physical injury
Infliction of physical injury on a child by a caregiver. Injury or injuries may be current or may be in different stages of healing. Include physical injuries to a child that resulted from a domestic violence incident or excessive discipline. Examples include but are not limited to the following.

- Head injuries.
- Fractured bones.
- Internal injuries.
- Second- or third-degree burns.
- Extensive bruising and/or lacerations.
- Substantial bleeding.

Unexplained and suspicious injury
Injury to a child for which the caregiver and/or child can give no plausible explanation, and the perpetrator is unknown. Injury or injuries may be current or may be in different stages of healing. Examples include but are not limited to situations such as the following.

- Physician reports that the injury type is consistent with non-accidental injuries.
- Injury to a non-ambulatory child with no plausible alternative explanation.
- Explanation for injury does not match injury.
- Injury is in the shape of an object (e.g., loop marks).
- Credible disclosure by the child to the reporting party or other adult.

Note: Minor injuries that could reasonably be expected given the child's age, stage, activity level, and developmental status should NOT be selected.

Caregiver action that will likely cause injury without intervention
Dangerous caregiver behaviors that will likely cause injury without OCFS intervention. It is not necessary for a reporter to determine that an injury occurred. Examples include but are not limited to the following.

- Shaking or throwing an infant or child under 3 years old.
- Caregiver actions such as strangling, suffocation, tying or locking child up, etc.
- Hitting a child or striking a child with objects that could cause a significant injury.
- Forcing the child to ingest any drug or substance not prescribed to the child.

- Dangerous behavior toward the child or in immediate proximity of the child, including domestic violence incidents that occur while the child is present (does not include situations where the child is not in immediate proximity—consider emotional maltreatment).

- Caregiver has made credible threats to cause physical harm to the child that, if carried out, would constitute child abuse, and it is likely that, without intervention, the caregiver will carry out these threats.

  Note: If threats are clearly for the sole purpose of emotional maltreatment, indicate as emotional maltreatment. If the purpose cannot be discerned, select both this item and an "Emotional Maltreatment" item.

Suspicious child death due to abuse
There is reasonable cause to suspect that abuse was a cause of or factor contributing to the child's death. Indicate whether there are other children in the home or no other children in the home.

Substantiated prior serious injury/death of a child due to abuse, no subsequent OCFS involvement, and there is a new child in the care of the perpetrator
There was a substantiated prior serious injury/death of a child in the home due to physical abuse, there has been no subsequent OCFS involvement showing that the issues resulting in maltreatment have been resolved, and a new child is in the care of identified perpetrator.

Emotional Maltreatment

Caregiver action(s) have led or are likely to lead to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others
Caregiver has a pattern of negative behavior; repeated, destructive interpersonal interactions; or a single, significant destructive interaction toward the child that has or likely will have an impact on the child's emotional well-being. The child may exhibit harmful impact through symptoms of depression, significant anxiety or withdrawal, self-destructive or outwardly aggressive behavior, or delayed development.

Types of caregiver action(s) include but are not limited to the following.

- Excessive rejecting and/or degrading of the child.

- Intentionally causing the child to experience extreme fear.

- Isolating and/or victimizing the child by means of cruel, unusual, or excessive methods of discipline.

- Exposing the child to brutal or intimidating acts or statements, including but not limited to:
  - » Harm or threatened harm to animals;
  - » Threats of suicide or harm to family members (including the child or family pets); and/or
  - » Consistently scapegoating the child; consistently berating, belittling, blaming, targeting, or shaming the child.

Exposure to domestic violence

The child has witnessed, intervened in, or is otherwise aware of physical altercations, serious verbal threats, or intimidation between adults in the home. These incidents may occur on more than one occasion OR on a single occasion that involved weapons, resulted in any injury to an adult, or resulted in arrest/court involvement.

Domestic violence perpetrators, in the context of the child welfare system, are caregivers who engage in a pattern of coercive control against one or more intimate partners. This pattern of behavior may continue after the end of a relationship or when the partners no longer live together. The alleged perpetrator's actions often directly involve, target, and impact any children in the family.

If a child has been injured or threatened with injury, also select the appropriate "Physical Abuse" item.

Neglect

Caregiver does not meet basic needs for:

- Nutrition. Caregiver has not and/or does not provide sufficient food or hydration to meet minimal requirements for the child; child experiences significant lack of food or complains of unmitigated hunger due to lack of food.
- Clothing/hygiene. The caregiver has failed to meet the child's basic needs for clothing and/or hygiene to the extent that the child's daily activities are negatively impacted and/or the child develops or suffers a worsening medical condition. Examples include but are not limited to:
  - » Sores, infection, or severe diaper rash;
  - » Clothing that is inappropriate for the weather and results in health or safety concerns; and/or

- Experiencing shame or isolation from peers due to poor hygiene/extreme body odor, chronic untreated and/or unmanaged head lice with scabs, etc.

- Shelter. The residence is unsanitary and/or contains hazards that have led or could lead to injury or illness of the child if not resolved. Examples include but are not limited to:
  - Housing that is an acute fire hazard, has structural deficiencies, exposes the child to lead, or has been condemned;
  - No utilities (e.g., water, electricity, heat source if needed) AND these are necessary based on current conditions and the child's age/developmental status or special needs;
  - Pervasive and/or chronic presence of rotting food, human/animal waste, or infestations or mold;
  - Presence of poisons, guns, or drugs within reach of child; and/or
  - Lack of safe sleeping arrangements for infant/child.

- Supervision. Child has been left unsupervised with responsibilities beyond his/her capabilities, and/or caregiver is present but not attending to critical needs of the child. Injury has occurred or likely could occur due to lack of supervision or has been avoided due to third-party intervention. If lack of supervision appears long term and the caregiver is not present, consider selecting "Caregiver absence/abandonment." Examples include but are not limited to the following.
  - A child has gained access to or ingested substances due to a lack of supervision.
  - Caregiver fell asleep in the home and young child wandered off.
  - Caregiver knowingly leaves child with unsafe individuals.
  - Child regularly plays unsupervised with dangerous objects (e.g., sharp knife, gun, matches).
  - Caregiver is unable to care for child due to substance use, mental illness, or intellectual/developmental disability.

- Education. Child is age 7 or older, has not completed grade 6, has five consecutive school days of unexcused absences OR 7 total full days of unexcused absences (20-A §5051-A(1)(C)), AND the protocol as laid out in §5051-A(2)(C) and (2)(D) was followed (meaning the school has notified the family in writing that attendance is mandatory, developed a plan, and held a meeting).

- Medical/mental health care and treatment. Caregiver unreasonably delays; refuses; or does not seek, obtain, and/or maintain necessary medical, dental, or mental health care or treatment. As a result, important components of the child's medical or mental health needs are unmet.

  Note: Religious exceptions exist in Title 22, §4010; however, if the factual basis of any exception is not known to the reporter, an assessment may be needed to establish those facts. Includes withholding medically indicated treatment from disabled infants with life-threatening conditions.

Caregiver does not protect child from:

- Neglect or physical, emotional, or sexual harm by others. The child is being harmed or likely would be harmed by a person other than the caregiver (including siblings), AND the caregiver is aware of this or reasonably should have this knowledge, AND nothing indicates that the caregiver has acted to protect the child.

- Labor trafficking. Caregiver allowed child of any age to participate in labor via force, fraud, or coercion. Participation could include: being recruited, harbored, or transported; recruiting for; or being engaged in the above activities. A child working for a caregiver's business (e.g., restaurant, farm) should NOT be considered labor trafficking.

- Commercial sexual exploitation by a third party. A child has been sexually exploited by a third party, and the caregiver has failed in protecting or been unable to protect the child from being commercially sexually exploited and/or sex trafficked. This includes situations where the caregiver has been coerced or otherwise been unable to prevent exploitation.

  The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed.

Note: Children and youth ages 17 and younger are sexually exploited when they have engaged in, been solicited for, or been forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit (e.g., money, food, drugs, shelter, clothing, gifts, or other goods) or for financial or some other gain for a third party.

Caregiver absence/abandonment.
Caregiver is unable/unwilling to care for the child AND no provisions are made for another safe adult to care for the child. If the absence of a caregiver does not appear permanent, consider selecting "Caregiver does not meet basic needs for supervision." Permanent absence may be indicated by taking clothing or other belongings, quitting jobs, establishing another residence, or an absence that has significantly exceeded the planned length of time.

- Caregiver has deserted the child with no apparent plans for return.
- Child is being discharged from a facility and caregiver refuses to accept child back into his/her home AND has not helped the child find an alternative placement.
- Caregiver kicked the child out of the home/refuses child entry to the home and has not provided a safe alternative.

Note: If the caregiver is incarcerated, hospitalized, or absent and has made a plan of care for the child with a safe adult or is otherwise able to safely mitigate the impact of his/her absence on the child, this item should NOT be selected.

Involving child in criminal activity that creates danger of serious physical or emotional harm to the child
The caregiver causes the child to perform or participate in illegal acts that create danger of serious physical or emotional harm to the child. These can include but are not limited to:

- Exposing the child to being arrested; and/or
- Forcing the child to act against his/her wishes.

Positive toxicology at birth AND inadequate caregiver response
There is a positive toxicology finding for a newborn infant OR his/her mother OR other credible information that there was prenatal substance abuse by the mother (e.g., witnessed use, self-admission); AND there is indication that the caregivers will be unable to fulfill the basic needs of the infant upon discharge from the hospital. Indicators may include, but are not limited to:

- Statements or behavior that suggests that the caregivers intend to continue use of a substance that would render them unable to safely parent.
- Caregiver's refusal to engage with services.

- Caregiver's unwillingness and/or inability to seek assistance in caring for the infant.

Non-organic failure to thrive
The child has a current diagnosis by a qualified medical professional of non-organic failure to thrive, OR a qualified medical professional states that there are indicators of failure to thrive but a formal diagnosis has not yet been made.

Prior termination of parental rights, no subsequent OCFS involvement, and there is a new child in the home
There is confirmed information that a current caregiver had a termination of parental rights, there was no subsequent OCFS involvement, and there is a new child in the home.

Substantiated prior serious injury/death of a child due to neglect, no subsequent OCFS involvement, and there is a new child in the care of the perpetrator
There was a substantiated prior serious injury/death of a child in the home due to neglect, there has been no subsequent OCFS involvement showing that the issues resulting in maltreatment have been resolved, and a new child is in the care of identified perpetrator.

Suspicious child death due to neglect
There is reasonable cause to suspect that neglect was a cause of or a factor contributing to the child's death. Indicate whether there are other children in the home or no other children in the home.

Sexual Abuse

Any sexual act on a child by an adult caregiver or other adult in the household
Based on verbal or nonverbal disclosure, medical evidence, or credible witnessed act. This includes physical contact with the child's breasts, buttocks, genitals, or other parts of the child's body in a sexualized manner or for sexual gratification.

Note: Select this item if the perpetrator is a household member OR OCFS is unable to rule out household members. If reporter knows that the alleged perpetrator is not a household member but does not know his/her identity, DO NOT SELECT and consider whether 'Caregiver does not protect child from' item threshold may have been reached instead.

Physical, behavioral, or suspicious indicators consistent with sexual abuse
Basis exists for concern that a child has been sexually harmed; at this time, the perpetrator is unknown and the caregiver or a household member cannot be ruled out. Indicators include but are not limited to the following.

- A pre-adolescent child has a sexually transmitted infection, symptoms of a sexually transmitted infection, or otherwise unexplained injuries to his/her genital or anal area.
- A pre-adolescent child has initiated sexual acts or activities with caregivers, family members, or peers who are outside age-appropriate exploration or development.
- Child complains of pain in the genital or anal area AND there are other indications of sexual abuse.

Exposure to sexually explicit conduct or materials
Caregiver or other adult in the home allows child to see sexually explicit material, witness sexual acts, or hear sexual language that is inappropriate to their age/developmental status AND this has resulted in the child exhibiting age-inappropriate sexual behavior OR emotional distress.

This does not include incidents that are accidental or inadvertent unless the report indicates that the behavior is persistent or frequently occurring.

Sexual exploitation
Children and youth age 17 or younger are sexually exploited by a caregiver or household member. Sexual exploitation is defined as the child/youth being engaged in, solicited for, or forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit (e.g., money, food, drugs, shelter, clothing, gifts, or other goods) or for financial or some other gain for a third party. This includes but is not limited to the caregiver:

- Subjecting the child to prostitution; and/or
- Engaging the child in pornography.

The sexual conduct of exploitation may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed.

Known or highly suspected sexual abuse perpetrator is a member of the same household as the child
An individual with a known or suspected record for sexual crimes toward children is a member of the same household as the child.

B. Screening Decision

Screen out: No criteria are selected
Select if no criteria in Section A are indicated. The report does not meet statutory requirements for an in-person response.

In-person response required: One or more criteria are selected
Select if any criteria in Section A are indicated. At least one reported allegation meets statutory requirements for an assessment. Proceed to Step III, Response Priority and Community Intervention Program or Prevention Service Eligibility.

C. Overrides

In-person response required. No criteria are selected, but the report will be opened. Select all that apply and proceed to Step III.
Select if no criteria in Section A are indicated but a report will be opened due to other protocols. Indicate the reason for opening a report and proceed to Step III.

- Response required by court order. A court with jurisdiction requires a child welfare response.
- Other (specify).

Screen out. One or more criteria are selected, but the report will be screened out. No further SDM assessments required. Select all that apply.

- Insufficient information to identify or locate child/family. The caller was unable to provide enough information about the child's identity and/or location to enable an in-person response. Select ONLY after following protocol for attempting to discern identity/location from information provided by caller.
- Another agency such as law enforcement, probation, or court has jurisdiction. Protocol determines that an agency (e.g., law enforcement, probation, or court) will be the investigating entity for this issue AND a child welfare response is not required.
- Historical information only. Child is at least 10 years old AND the alleged maltreatment occurred more than one year ago, AND there were no reports of abuse or neglect since the alleged incident, AND the conditions that contributed to the alleged incident are no longer present. If reported incident is sexual abuse, all of the above criteria must apply AND the reported perpetrator must be either an unidentifiable non-household member or deceased.
- Other (specify).

STEP III. RESPONSE PRIORITY AND COMMUNITY INTERVENTION PROGRAM OR PREVENTION SERVICE ELIGIBILITY

A. Decision Trees

Physical Abuse

Serious medical care currently required due to alleged abuse
Serious medical care is immediately necessary. If not provided, the child's health and well-being will be permanently affected. This includes injury treatment and/or evaluation that is needed or currently in progress. It does not include medical examination completed solely for forensic purposes.

Caregiver's behavior is alleged to be dangerous or threatening to child's health or safety
Caregiver acted in brutal or dangerous ways, or caregiver has made threats (other than empty threats or threats made solely for intimidation) of brutal or dangerous acts toward the child AND absent intervention, it is likely that the child will experience an injury within the next 72 hours. Examples include but are not limited to:

- Hitting with closed fist;
- Hitting with substantial force;
- Strangling, kicking, or hitting with belt buckle or other dangerous object;
- Using restraints;
- Poisoning; or
- Other actions that could reasonably result in severe injury.

Allegation of physical injury to non-mobile child
There has been an allegation of abuse affecting a child who is not mobile either due to age or due to developmental, physical, or emotional disability.

Presence of head, face, or neck injury to a child under age 6
A child under 6 years of age is presenting with injuries to the head, neck, or face as a result of alleged physical abuse.

Adult in home played a role in previous serious injury
There is an adult in the household who is believed to have played a role in a serious physical injury to a child in the past. Select regardless of findings in any previous child welfare assessment.

Is there a non-perpetrating caregiver aware of the alleged abuse who is demonstrating a response that is appropriate and protective of the child?
A non-perpetrating caregiver is aware that physical abuse has been alleged AND demonstrates the ability to prevent the alleged perpetrator from having access to the child. The non-perpetrating caregiver will not pressure the child to change his/her statement and will obtain or has obtained medical treatment for the child as needed.

Child is vulnerable and will not be seen by likely protective adult within next 72 hours
Child is vulnerable (due to age, developmental status, or physical disability he/she is unable to protect him/herself) and/or will not be seen within the next 72 by other adults who would report concerns (e.g., school personnel).

There is prior history of physical abuse with increasing concerns
There is credible information that there are one or more prior investigations for physical abuse with escalating severity or frequency of concerns.

There is current concern that domestic violence will impact the child's safety within the next 72 hours
There are physical altercations between the caregiver and another adult living in the home. Include situations where one of the adults does not live in the home but has substantial contact in the home.

Emotional Maltreatment

Child is currently exhibiting behavior that threatens his/her immediate health or safety or that of others AND caregiver is unable or unwilling to seek appropriate help or control the child's behavior
Examples of child behavior that threatens the health or safety of the child or others include but are not limited to the following.

- Attempted or threatened suicide or other self-harmful behavior.
- Violent behavior and/or threat of violence toward others involving weapons.
- Fire-setting behavior.

Caregiver's current behavior is alleged to be violent, out of control, or dangerous to the emotional health or safety of the child
Examples include but are not limited to the following.

- The caregiver harms him/herself, others, or pets or threatens to do such in the child's presence.

- Domestic violence incidents that involve weapons or result in serious injury.

Neglect

Child requires immediate medical/mental health evaluation or care
Medical or mental health care is necessary. If not provided within the next 72 hours, the child's health and well-being will be seriously affected. In addition to medical conditions, this includes extreme dental and mental health conditions.

Child's physical living conditions are immediately hazardous to health or safety
Based on the child's age, medical condition, and developmental status, the child's physical living conditions are hazardous and pose imminent danger to the child. Examples include but are not limited to the following.

- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger his/her health and/or safety.
- Illegal drug production in the home.

Child is in need of supervision before 72 hours has passed
Based on the child's age, medical condition, and developmental status, the child is not receiving appropriate supervision from his/her caregiver, and there is no appropriate alternative plan for supervision within the next 72 hours. Examples include but are not limited to the following.

- Child is currently alone (time period varies with age and developmental stage).
- Caregiver does not attend to the child to the extent that important needs are going unnoticed or unmet.
- Child has been left unattended and has no caregiver willing and/or able to provide care for a minimum of 72 hours.
- Caregiver uses substances that severely impair his/her ability to function while being the sole caregiver of the child.

Newborn will be discharged within 72 hours AND no caregiver appears willing and/or able to provide for the infant upon discharge
A newborn has been discharged or will be discharged within 72 hours, AND the sole caregiver or both caregivers appear unwilling and/or unable to provide for the child upon discharge OR there is reason to believe the caregiver will remove the child against medical advice. Indicators include the following.

- Caregiver has intellectual/developmental disabilities or unmanaged mental health issues that limit his/her ability to safely provide care for the child.

- Caregiver is unwilling or unable to learn how to manage the medical needs of the newborn.
- Caregiver appears indifferent to the newborn's needs or is continually absent.
- Caregiver has indicated to hospital staff that he/she has no intention of remaining at the hospital despite staff's advice.

Newborn/child will be discharged from hospital within 72 hours AND family has significant prior history of abuse and/or neglect
Examples include but are not limited to:

- Prior termination of parental rights; and/or
- Prior serious injury/death of a child due to neglect or abuse.

Sexual Abuse

Is there current abuse/exploitation as evidenced by disclosure, credible witnessed account, or medical evidence?
Disclosure may be verbal or nonverbal (e.g., extreme sexual acting-out behavior). Medical evidence includes medical findings related to sexual abuse and suspicious findings such as sexually transmitted diseases in young children.

Is there a non-perpetrating caregiver aware of the alleged abuse/exploitation who is demonstrating a response that is appropriate and protective of the child?
A non-perpetrating caregiver is aware that sexual abuse has been alleged, supports the child's disclosure, AND demonstrates the ability to prevent the alleged perpetrator from having access to the child. The non-perpetrating caregiver will not pressure the child to change his/her statement and will obtain or has obtained medical treatment for the child as needed.

B. Overrides

Policy

Increase to 24 hours whenever:

Law enforcement requests an immediate response
A law enforcement officer is requesting an immediate child protective services response.

Forensic considerations would be compromised by slower response
Physical evidence necessary for the investigation will be compromised if the investigation does not begin immediately, OR there is reason to believe statements will be altered if interviews do not begin immediately.

There is reason to believe that the family may flee
The caregiver has stated an intent to flee or is acting in ways that suggest an intent to flee, OR there is a history of the family fleeing to avoid investigation.

Vulnerable child with caregivers who have significant history of abuse and/or neglect
Child is vulnerable (i.e., due to age, developmental status, or physical disability, he/she is unable to protect him/herself) AND caregivers have history of multiple findings or serious incidents of abuse or neglect.

Prior child death in the household due to abuse or neglect or under suspicious circumstances
There has been a prior death of a child in this household due to clear abuse or neglect concerns OR there is reason to believe abuse or neglect may have played a role.

Decrease to 72 hours whenever:

Child safety requires a strategically slower response
The child's current location is such that initiating contact may create a threat to the child's safety OR the value of coordinating a multi-agency response outweighs the need for immediate response.

The child is in an alternative safe environment
The child is no longer in the same place or no longer with the caregiver who is the alleged perpetrator, and the child is not expected to return within the next 72 hours.

The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period
The incident being reported occurred at least six months prior to the report AND no other maltreatment is alleged to have occurred in the intervening time period.

Discretionary
Increase or decrease response time with supervisor approval only. Document rationale for change.

STEP IV. COMMUNITY INTERVENTION PROGRAM OR PREVENTION SERVICE REFERRAL GUIDE

At least one prior assessment in the last year
Credible information shows that there has been at least one prior assessment for maltreatment by a current caregiver of the child.

Current caregiver substance abuse, domestic violence, or mental health issues
Credible information shows at least one of the following.

- A caregiver has a substance abuse problem.
  - The caregiver is diagnosed with chemical dependency or abuse AND is currently using. Current use does not require that the caregiver be under the influence at the moment of the call but that the caregiver has used within the past two weeks and has not entered into a formal or informal program to achieve abstinence; OR
  - The caregiver is using illegal drugs; OR
  - The caregiver's substance use suggests a probability that dependency or abuse exists, such as blackouts, secrecy, negative effects on job or relationships, identified drinking patterns, etc.
- There are physical altercations between the caregiver and another adult living in the home within the past year, regardless of whether children were present. This includes situations where one adult does not live in the home but has substantial contact in the home, or has previously lived in the home and continues to behave in threatening ways.
- A caregiver has current mental health concerns based on a diagnosis of a major mental illness (e.g., schizophrenia, bipolar disorder, depression) or exhibits symptoms that suggest a probability that such a diagnosis exists, such as hearing voices, paranoid thoughts, severe mood changes, suicidal thoughts or behavior, or extremely depressed affect.

Substance-exposed newborn (also known as drug-affected baby)
An infant was born with positive toxicology. Strongly consider bridging referral to public health nursing (PHN) or Maine Families Home Visiting (MFHV) even if there are protective caregivers in the home and if caregivers are taking steps to keep child safe.

Child in home has health concerns that caregiver is struggling to address
Child has major health concerns that the caregiver is addressing moderately to poorly, and caregivers would benefit from some assistance.

Caregiver is involved in criminal activity where there has been little/no impact on the child
Caregiver may have had contact with criminal justice system, but child is showing little or no affect from this involvement.

Caregiver struggles with appropriate discipline and limit setting
Caregiver uses punishment that may not be appropriate for child's age and stage, and/or they and others report that discipline is not effective or helpful.

Someone in the family has an identified need that could be addressed with services
The reporter describes a service or resource need that does not rise to the level of the screening threshold but could be addressed through a community agency. Select all that apply.

Other (specify)
Specify any other information that was used in making a referral.

MAINE OFFICE OF CHILD AND FAMILY SERVICES
SDM® INTAKE SCREENING AND RESPONSE PRIORITY TOOL
POLICY AND PROCEDURES

The purpose of the screening and response priority tool is to assess the following.

- Whether a referral meets the statutory threshold for an in-person OCFS response.
- If so, how quickly to respond and the path of response.
- If not, whether a CIP or prevention service referral is appropriate.

	Preliminary Screening and Appropriateness of a Child Abuse/Neglect Report for Response	Response Priority and CIP Eligibility	Community Intervention Program or Prevention Service Referral Guide
Which Cases	All referrals created in the Maine Automated Child Welfare System (MACWIS).	All referrals that meet statutory threshold for an in-person response, per Step I, Preliminary Screening and Step II, Appropriateness of a Child Abuse/Neglect Report for Response.	All referrals that did not meet the statutory threshold for in-person response.
Who	Worker receiving the referral.	Worker receiving the referral.	Worker receiving the referral.
When	Within 24 hours of receipt of the call.	Within 24 hours of receipt of the call.	Within 24 hours of receipt of the call.
Decision	Does the referral meet statutory threshold for in-person OCFS response?	How quickly should the response time be and is the referral CIP eligible?	Is a CIP/prevention service referral appropriate?

Appropriate Completion

STEP I. PRELIMINARY SCREENING
If the referral does not involve a child under 18, is a duplicate referral, or is being referred to another jurisdiction, select the specific reason under "automatic screen out." If the referral is strictly a request for services; concerns a safely surrendered baby; or is limited to alleged harm in a foster/group home, residential treatment facility, or other institution, select the specific reason under "response may be required but not through review of this screening criteria." In these cases, the use of this SDM tool is complete.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria
Based on the caller's concerns, select all criteria that apply. Do not select items if the caller's information does not reach the threshold of the definition for an item.

B. Screening Decision
Indicate the screening decision. If one or more screening criteria are selected, the referral is assigned for an in-person response (if no override applies, proceed to Step III). If no criteria are selected, the referral will be screened out (if no override applies, proceed to Step IV, Community Intervention Program or Prevention Service Referral Guide).

C. Overrides
After completing all required screening criteria, determine whether any overrides apply.

STEP III. RESPONSE PRIORITY AND COMMUNITY INTERVENTION PROGRAM OR PREVENTION SERVICE ELIGIBILITY

A. Decision Trees
Select the response priority decision tree that corresponds with the allegation type (physical abuse, emotional abuse, neglect, or sexual abuse). If there is more than one allegation, begin with the most serious allegation. Start with the first question and gather information from the caller that will lead to an answer of yes or no. Be sure to consult the definitions. The tree will lead either to a decision regarding response time/CIP eligibility OR to another question (24-hour responses are not CIP eligible). Continue to complete the decision trees until a recommended response time/CIP eligibility are reached.

B. Overrides
After completing all required decision trees, determine whether information from the caller or any other source suggests that the child's safety, permanency, or well-being is best served by a different response time than the presumptive response. Select whether the response time will be increased or decreased and briefly describe the fact(s) that led to this conclusion. Discuss a discretionary override with a supervisor and obtain approval.

Final Response Priority
Indicate a final response priority. For screened-in reports, this tool is complete.

STEP IV. COMMUNITY INTERVENTION PROGRAM OR PREVENTION SERVICE REFERRAL GUIDE
For all referrals screened out, use the guide to consider making a referral to a CIP or a prevention service. Select "yes" or "no" for each as applicable based on information reported and/or available at the time of referral. If unknown at the time of report, answer "no." Referrals with more than one "yes" answer are likely to benefit from a CIP or prevention service referral.