BAAF ADOPTION & FOSTERING 2003

Post Adoption Support Plan

*The forms detailing the assessed needs for post adoption support services of the child and the Adopter/s and of the birth relatives in relation to contact should be attached to this form.*

Child’s Name:

Date of Birth:

Placing Local Authority:

Name of Family

Parent 1 DOB:

Parent 2 DOB:

Address:

Telephone number(S):

Other household members: Relationship to child:

Approving Local Authority or Voluntary Adoption Agency:

Local Authority where the Family Lives:

If this is neither the placing nor the approving local authority, date of the required consultation and name and position of person with whom this took place:

The proposed support plan is based on the assessed support needs of the child and the adopters and of the birth relatives in relation to contact as detailed on the attached forms, and updated as necessary.

Date Proposed Plan was completed:

Date adoption order made or court date:

**INDIVIDUAL WORKER RESPONSIBLE FOR CO-ORDINATING AND MONITORING THE DELIVERY OF THE SERVICES IN THE PLAN**

Name:

Agency:

Address:

Telephone:

E-mail:

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| HEALTH (to include any special needs which a disabled child may have) |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
|  |  |  |  |  |
| **EDUCATION** |
| Support Needs of Child and Adoptre(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
| .  |  | **(Has the local Education Department agreed to provide the required services?)** |  |   |
| EMOTIONAL AND BEHAVIOURAL DEVELOPMENT |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
| (Please detail any need for therapy or counselling) |  | (Has an agreement been given locally to provide the required services?) |  |  |
| IDENTITY |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
|  |  |   |  |  |

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| **FAMILY AND SOCIAL RELATIONSHIPS** |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
|  |  |  |  |  |
| **SOCIAL PRESENTATION** |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
|  |  |  |  |  |

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| **SELFCARE SKILLS** |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
|  |  |  |  |  |
| CONTACTARRANGEMENTS PLANNED AFTER PLACEMENT |
| Person – Name and Relationship to Child | Type(eg. letterbox, face to face) | Frequency, Duration, Venue and Starting Date | Will Contact Need to be Supervised | Who Will do This? | Purpose of this Contact |
|  |  |  |  |  |  |

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| SUPPORT ARRANGEMENTS |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person / Agency Responsible | Plans for Review |
|  |  |  |  |
| FINANCIAL AND PRACTICAL |
| Support Needs of Child and Adopter(s) | Services to be Provided | Person/Agency Responsible | Frequency, Duration and Starting Date | Planned Outcome and Plans for Review |
|  |  |  |  |  |

**ADOPTIVE FAMILY**

|  |  |
| --- | --- |
| BASIC SUPPORT SERVICES | PROVIDED BY |
|  | Own Agency | Other(please specify) |
| Point of contact available long term for advice and information and onward referral as necessary |  |  |
| Group meetings with other adopters/ SGO carers |  |  |
| Regular workshops/training e.g. on telling life story, managing difficult behaviour, etc. |  |  |
| Opportunity to keep in touch through a newsletter or regular social event |  |  |

SUPPORT SERVICES TO BE PROVIDED TO OTHER INDIVIDUALS IN THE FAMILY

(e.g. birth children, other family members in the household, grandparents, etc.)

**Family Member**

Service to be provided

Timescale for providing service

Person/agency responsible

What is it hoped this will achieve?

How will this be measured and reviewed?

Please add further family members as necessary.

**SUPPORT SERVICES TO BE PROVIDED TO BIRTH RELATIVES IN RELATION TO CONTACT**

**Birth Relative**

Name and relationship to child

Service to be provided

Timescale for providing services

Person/Agency responsible

What is it hoped these services will achieve?

How will this be measured and reviewed?

Please add further birth relatives as necessary.

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| **SIGNATURES** |
|  | Signature | Print Name | Date |
| Child / Young Person (where appropriate) |  |  |  |
| Parent 1 |  |  |  |
| Parent 2 |  |  |  |
| Family Placement Service Social Worker |  |  |  |
| Family Placement Manager |  |  |  |
| Co-ordinating Worker (listed on front page if not one of above) |  |  |  |
|  |  |  |  |