



FORTY-FIVE (45) DAY REPORT OF ASSESSMENT

State Form 54854 (R / 6-19)
DEPARTMENT OF CHILD SERVICES

This form is confidential per IC 31-33-7-8.

INSTRUCTIONS: This form is to be completed and sent no later than forty-five (45) days after the Department of Child Services (DCS) receives a Preliminary Report of Alleged Child Abuse or Neglect (310). If the assessment is not complete within 45 days after receipt of the 310 this report must be sent, as required. An additional report must be sent every 30 days until the assessment is complete and upon completion of the assessment. This form may only be sent to the following entities and is confidential per IC 31-33-7-8: Administrator of Hospital, Community Mental Health Center, Managed Care Provider, Referring Physician, Dentist, Principal of School, Licensed Psychologist, Licensed Child Caring Institution, Licensed Group Home, Private Secure Facility, Licensed Child Placing Agency, or an appointed designee of the listed entities. See policy 4.21 Forty-five (45) Day Report of Assessment for additional information.

REPORTING ENTITY

| | |
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| Name of reporter | Reporting agency |
| Address of reporting entity (number and street, city, state, and ZIP code) | |

LOCAL OFFICE PROVIDING FORTY-FIVE (45) DAY ASSESSMENT REPORT

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|--|-----------------------------|---|
| Name of Family Case Manager | Telephone number () | Date report prepared (month, day, year) |
| DCS local office completing Forty-five (45) Day Report | | |
| Address of DCS local office (number and street, city, state, and ZIP code) | | |

STATUS OF ASSESSMENT

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| <input type="checkbox"/> Forty-five (45) Day Report – Assessment Completed; no further report to be sent. | <input type="checkbox"/> Forty-five (45) Day Report – Assessment Not Completed; further report to be sent within thirty (30) days. |
| Unable to complete Assessment because: | |

REPORT DETAIL

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| The name(s) of the alleged victim(s) of child abuse or neglect: | |
| The name of the alleged perpetrator and the relationship to the alleged victim(s): | |
| Alleged Perpetrator | Relationship to the Alleged Victim(s) |
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| Agency(ies) to which the alleged victim has been referred: | |
| Has the assessment been closed? <input type="checkbox"/> Yes <input type="checkbox"/> No | Has DCS completed an assessment of the case and taken no further action? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other information prescribed by DCS: | |

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| Printed name of Family Case Manager | Date (month, day, year) |
| Printed name of FCM Supervisor / Local Office Director | Date (month, day, year) |