Reset Form

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

THIRTY (30) DAY REPORT OF ASSESSMENT

State Form 54854 (11-11)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS: This form is to be completed and sent no later than thirty (30) days after DCS initiates an assessment of a Report of Alleged Child Abuse or Neglect. This form can only be sent to the following entities and is confidential per IC 31-33-7-8: Administrator of Hospital, Community Mental Health Center, Referring Physician, Principal of School, Dentist, Licensed Psychologist, Managed Care Provider, Licensed Child Caring Institution, Licensed Group Home, Private Secure Facility, Licensed Child Placing Agency, Appointed Designee of Listed Entities.

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

LOCAL OFFICE PROVIDING THIRTY (30) DAY ASSESSMENT REPORT		
Name of Family Case Manager	Telephone number ( )	Date report prepared *(month, day, year)*
DCS local office completing Thirty (30) Day Report		
Address of DCS local office *(number and street, city, state, and ZIP code)*		

STATUS OF ASSESSMENT	
☐ Thirty (30) Day Report – Assessment Completed; no further report to be sent.	☐ Thirty (30) Day Report – Assessment Not Completed; further report to be sent within thirty (30) days of initial referral to CPS.
Unable to complete Assessment because:	

REPORT DETAIL	
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)**
Agenc(y/ies) to which the alleged victim has been referred:	
Has information concerning the assessment been closed? ☐ Yes ☐ No	Has local child protection service made an assessment of the case and not taken any further action? ☐ Yes ☐ No
Other information prescribed by DCS:	

Printed name of Family Case Manager	Date *(month, day, year)*
Printed name of Supervisor / Director	Date *(month, day, year)*