SAFETY STAFFING

State Form 56567 (R5 / 2-20)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS:
Ensure all contacts, interviews, and actions taken to ensure safety are documented correctly in the Management Gateway for Indiana's Kids (MaGIK). Review this form and update relevant sections prior to and during each daily safety staffing until all requirements are met (see policy 4.41 Safety Staffing). Obtain signatures on the completed form and upload into the MaGIK case file.

Assigned Family Case Manager (FCM)	Assessment name	Assessment MaGIK identification number

On-call / after hours? ☐ Yes ☐ No	Date of report *(mm/dd/yy)*	Time of local office notification ☐ AM ☐ PM

Initiation timeframe ☐ Two (2) hours ☐ Twenty-four (24) hours ☐ Forty-eight (48) hours ☐ Five (5) day	Assessment initiated timely? ☐ Yes ☐ No

INITIAL FACE-TO-FACE CONTACT / INTERVIEW WITH CHILD VICTIM(S)

Name	Face-to Face Contact Date *(mm/dd/yy)* and Time	Face-to Face Contact Location	Interview Date *(mm/dd/yy)* and Time	Interview Location
Face-to face contact with all child victims? ☐ Yes ☐ No				

CONTACT / INTERVIEW WITH PARENTS / CAREGIVERS

Name	Type of Contact	Contact Date *(mm/dd/yy)* and Time	Contact Location	Interview Date *(mm/dd/yy)* and Time	Interview Location
Notification to the parent, guardian, or custodian was made the same day as the interview with the victim? ☐ Yes ☐ No					

OTHER CONTACTS

Name	Type of Contact	Contact Date *(mm/dd/yy)* and Time	Contact Location

UNSUCCESSFUL ATTEMPTS / EFFORTS	
Date *(mm/dd/yy)* and Time	**Details**

Initial Safety Plan? ☐ Yes ☐ No	***Bring Safety Plan and/or Plan of Safe Care to safety staffing and ensure FCM supervisor reviews for approval.***
Pediatric Evaluation and Diagnostic Service (**PEDS**) mandatory? ☐ Yes ☐ No	PEDS completed? ☐ Yes ☐ No ☐ N/A

HOW WAS SAFETY ENSURED? WHAT STEPS WERE TAKEN AND WHO WAS INVOLVED?	
Date *(mm/dd/yy)* and Time	**Actions**

IF SAFETY WAS NOT ENSURED, WHAT ARE THE NEXT STEPS?	
Date *(mm/dd/yy)* and Time	**Actions**

Safety assessment completed within twenty-four (24) hours? ☐ Yes ☐ No	Date completed *(mm/dd/yy)*
I have discussed the details of the assessment and all actions taken with the FCM at each daily safety staffing. I agree that all requirements to ensure initial safety have been met and that daily safety staffing is no longer warranted.	
Signature of FCM Supervisor / Division Manager (DM) / Local Office Director (LOD)	Date *(mm/dd/yy)*