OVERVIEW

The Michigan Department of Health and Human Services (MDHHS) ongoing program seeks to prevent further maltreatment and keep children safe in their own home. The ongoing program builds on family strengths and partners with families to address the needs and safety of children and families following a confirmed investigation. The goal of the department is to ensure child safety by partnering with families and providing resources that are available, accessible, and culturally appropriate.

This policy outlines requirements for engagement and contact with the family, development of a services agreement, referral to services based on family needs as identified by the family and the case manager, and completion of structured support tools.

DEFINITIONS

Family Team Meeting (FTM)

A deliberate and structured approach to involving youth, families and caregivers in case planning through a facilitated meeting of family and their identified supports; see FOM 722-06B, Family Team Meeting.

Family Assessment of Needs and Strengths (FANS)

A Structured Decision Making (SDM) tool used to evaluate the presenting needs and strengths of a family; see PSM 713-11, Assessments and FOM 722-09A, Family Assessment of Needs and Strengths.

Child Assessment of Needs and Strengths (CANS)

An SDM tool used to evaluate the presenting needs and strengths of a child; see PSM 713-11, Assessments and FOM 722-09, Child Assessment of Needs and Strengths.

ONGOING SERVICES

Following investigation, the level of department response is based on category designation; Category I, Category II, Category III, Category IV, or Category V (MCL 722.628d). For information on categories; see PSM 711-4, CPS Legal Requirements and Definitions. The category designation is based on whether child abuse and/or neglect (CA/N) is confirmed, the level of future risk,

and the safety decision as determined in the Safety and Risk Assessments. For information on Safety and Risk Assessments; see PSM 713-11, Assessments.

This item will describe ongoing case requirements and case manager responsibilities for Category I, II, and III cases where children remain in the home.

Category III Cases

Category III means there is a preponderance of evidence of CA/N, and the risk of future harm is low or moderate. The case manager must refer the family to community-based services commensurate with the risk level and safety factors identified. If the family does not voluntarily participate in services, or the family voluntarily participates in services, but does not progress toward alleviating the child(ren)'s risk level, the department must consider reclassifying the case as category II; see *Reclassification of a Case* section in this item.

If the child(ren) is/are determined to be safe and ongoing CPS services and monitoring is not warranted, the case manager must:

- Utilize the open/close option in the electronic case record in the investigation.
- Refer the family to voluntary, community-based services.
- Complete an FTM; see *Family Team Meeting* section in this item.

If the child(ren) is/are determined to be safe with services, Category III cases may be opened to assist the family with voluntarily accessing community-based services and monitoring progress.

If opening the category III case, the case manager must:

- Open the case in the electronic case management system.
- Refer the family to voluntary prevention or community-based services.
- Make contact with the family according to the risk level; see *monthly service level and contact standards chart* in this item.

Category III cases should be closed within 90 days following the date of the referral unless a case extension is needed, or the category of the case is reclassified.

Extension of Category III Case

The 90-day period may be extended up to 90 additional days in limited circumstances, such as the service provider was unable to begin services during the first 90 days. The extension request must be submitted **prior** to the end of the initial 90-day period. Complete a safety reassessment and submit the request for supervisory approval of an extension by completing the extension request in the electronic case record.

Category II Cases

Category II means CA/N was confirmed, the risk assessment result indicated a high or intensive risk of future harm, and the child(ren) can remain safe in the home with services, as determined by the safety assessment. An ongoing case must be opened, and services offered to the family.

If the child(ren)'s family does not voluntarily participate in services, a petition must be filed, and the case reclassified as a Category I; see *Reclassification of a Case* section in this item.

For Category II cases, the role of the case manager varies depending on the availability and accessibility of community resources and supports. If resources are limited, the case manager may provide direct services to the family. If community resources or contracted services are available, the case manager may coordinate the delivery of various services provided by others. Absent effective preventative services, the planned arrangement for the child(ren) is/are foster care.

Category I Cases

Category I means CA/N was confirmed, the risk level was determined to be high or intensive, the safety decision was unsafe, and a petition must be filed. There are two types of Category I cases:

- In-home placement - The child(ren) remains in the home with the parents/caregivers and court mandates services.

- Out of home placement - The child(ren) has/have been removed and placed out of the home.

CPS ongoing maintains responsibility for case management when the child(ren) remains in the home, while out of home placement cases are transferred to foster care.

RECLASSIFICATION OF THE CASE

Category III

When the family does not voluntarily participate in services or the family does not make progress toward reducing the child(ren)'s risk level, the department must consider reclassifying a Category III case as a Category II case.

Category II

A court petition is required if the department previously classified the case as Category II and the child(ren)'s family does not voluntarily participate in services.

Cases that are reclassified must be served with contact standards applicable to their new risk level.

Example: If a Category III, moderate-risk case, is reclassified to a Category II, high-risk case, adhere to the contact standards for high-risk cases.

Process for Reclassification

To reclassify the case, the case manager must take the following steps in the electronic case record:

1. Select the case for reclassification.
2. Select program type history.
3. Select escalate CPS category.
4. Select appropriate escalation category option (escalate to Category I or Category II).
5. Enter escalation case conference date.

6. Enter a narrative.

7. Select the associated risk reassessment.

8. Select approval to route the request to the supervisor.

MONTHLY CONTACT STANDARDS

Monthly contact standards for open ongoing cases are dependent upon the risk level. Case managers may use the contact standards chart to determine required contacts for each calendar month. Case managers should consider additional contacts with the family dependent upon risk factors or needs of the family.

At onset of the case, the risk level is determined from the investigation and carries over to the ongoing case. A risk reassessment cannot be completed until contact has been made with the family.

Regardless of the risk level, each primary caregiver, victim, and non-victim child(ren) in the family must be seen at least once a calendar month where the family primarily resides.

ONGOING CALENDAR MONTH CONTACT STANDARDS CHART

Opening Month	
Day One = Day following disposition by the case manager	
7 business day requirement* (Business day 1-7)	1 F/F with each primary caregiver from a participating household 1 F/F with each victim (can occur in the same contact)
1st calendar month - any risk level	1 F/F with each primary caregiver from a participating household 1 F/F with each child victim (can occur in the same contact) 2 collateral contacts
3 or less business days in the opening month	Only 7 business day requirement (may occur in current month or subsequent calendar month, but within 7 business days)

<table>
<tr><th colspan="7">Opening Month</th></tr>
<tr><td colspan="2"></td><td colspan="5">Standard contact requirements are required the following calendar month</td></tr>
<tr><th colspan="7">2nd/Subsequent Calendar Month Until Closing Month</th></tr>
<tr><td>Risk Level</td><td>Total Contacts (Face-to-face)</td><td>Contract-ed Agency allowed contact</td><td>Contact with each victim/non-victim child</td><td>Contact with each caregiver per participating household</td><td>Collateral contacts</td><td>Data report contact requirements (CS-1302 and CW-1302)

Requirements are per participating household</td></tr>
<tr><td>Intensive</td><td>4</td><td>3</td><td>1</td><td>1</td><td>4</td><td rowspan="4">1 F/F with each primary caregiver

1 F/F with each child victim

1 F/F with each non-victim child</td></tr>
<tr><td>High</td><td>3</td><td>2</td><td>1</td><td>1</td><td>3</td></tr>
<tr><td>Moderate</td><td>2</td><td>1</td><td>1</td><td>1</td><td>2</td></tr>
<tr><td>Low</td><td>1</td><td>0</td><td>1</td><td>1</td><td>1</td></tr>
</table>

<table>
<tr><th colspan="2">Closing Month</th></tr>
<tr><td>Must occur within 30 calendar days prior to closure

Requirements are per participating household</td><td>1 F/F with each primary caregiver from a participating household
1 F/F with each victim
1 F/F with each non-victim child</td></tr>
</table>

Closing Month	
Standard calendar month contacts are not required for closing month	

Key
F/F = Face-to-face contact Participating = Household is participating a minimum of 1 day during the period * 7 business day requirement may meet opening month requirement in some cases

Face-to-Face Contact

A face-to-face contact is defined as an in-person contact with the perpetrator, victim, other child(ren), or other caregiver (parent, guardian, or other person responsible) for the purpose of engagement regarding substantive case issues. Contacts should allow case managers to gather information necessary for subsequent completion of the risk reassessment, reassessment of FANS and CANS, treatment planning, service agreement development and/or progress review. Each primary caregiver, victim, and non-victim child(ren) in the family must be seen at least once a calendar month where they primarily reside.

Collateral Contact

Collateral contacts refer to all other contacts the case manager may need to make, such as contacts with extended family, a relative, support persons, the school, any service providers, or other agencies. These contacts may be face-to-face, by telephone or email, among others.

Visit Requirements

Caregiver

A face-to-face contact must occur with the primary caregiver from each participating household each calendar month following

disposition. Safety planning with the family should occur during these monthly meetings and should be reviewed as needed.

When visiting with the caregiver, the case manager should allow the caregiver to lead discussions based on needs. Case managers should also engage with the caregiver to address topics such as the initial concerns from the investigation, the needs of the child(ren), and the ability of the caregiver to meet the child(ren)'s needs.

Identified Perpetrator(s)

Attempts to have at least quarterly contact with individuals confirmed as perpetrators should occur to address child(ren) safety concerns and the need for community-based services or supports.

Note: If the identified perpetrator of the child abuse and/or neglect is determined to be a caregiver, follow contact standards for a caregiver as instructed in the *Ongoing Calendar Month Contact Standards* in this item.

Children

Each child must have a face-to-face visit by the case manager a **minimum of once** every calendar month following disposition.

Note: At least once every calendar month, a private meeting must be held with the child in absence of the caregiver/perpetrator. A private meeting allows a case manager to meet individually with a child. The way a case manager conducts a private meeting will depend on the age and developmental ability of the child.

Case managers should engage with children through a child-led approach based on developmental capability. Case managers should tailor discussions to preference of the child(ren) and should include efforts to assess child(ren) safety.

Case managers must not enter a home without permission from an adult or speak to a child who is home alone. If an adult is not present at the home, case managers may not request the child(ren) step outside to speak with them, even if the child(ren) agrees or suggests this solution.

Case Manager Visit Tool

Two optional tools are available to assist case managers with gathering information during the monthly visit:

- DHS-903-A, Children's Protective Services Caseworker/Child Visit Tool. This tool may be used to take notes during the visit.
- DHS-903, Children's Protective Services Caseworker/Child Visit Quick Reference Guide. This tool contains information that should be covered in a monthly visit but is not intended for recording notes.

Social Work Contacts

All contacts must be documented in social work contacts. Social work contacts should reflect the following pertinent themes:

- Engagement with the person or family.
- Level of family engagement and progress with services.
- Safety concerns regarding the child(ren).
- Safety plans and any necessary updates.
- Any other information pertinent to the case.

Contacts by Contracted Agencies

If a family is referred to prevention services contracted by MDHHS for the purpose of reducing risk to the child(ren), face-to-face contacts by the contracted provider with the client may be counted as a face-to-face contact to replace a case manager's contact, as outlined in the *ongoing calendar month contact standards chart* in this item. Contacts the family has with other local agencies which are not under contract with MDHHS, such as a public health department or community mental health, may not be counted as face-to-face contacts to replace the case manager's contacts.

If MDHHS employs service providers such as parent aides, homemaker aides, or others to work with clients for the purpose of reducing risk to the child(ren), face-to-face contact by the MDHHS-employed service provider with the client may be counted as a face-to-face contact to replace a case manager's contact as outlined above in the *ongoing calendar month contact standards chart*.

If the case manager becomes aware the service provider(s) have not been able to meet the required number of contacts, the case manager must ensure the safety of the children by completing the required contacts. Until the issue is resolved, the case manager is responsible for meeting all required contact standards.

The initial FANS and CANS outcomes and the development of the service agreement must be discussed during the initial planning conference between the case manager, the service provider, and family. The service provider must obtain the case manager's approval of the proposed service plan prior to implementation. For more information on completion of the FANS and CANS and application of the assessment, see PSM 713-11, Assessments, FOM 722-09A, Family Assessment of Needs and Strengths, and FOM 722-09, Child Assessment of Needs and Strengths.

Families First and Families Together/Building Solutions

Families First and Families Together/Building Solutions must comply with all required service standards in referred cases. The case manager must have a minimum of one contact per month with the Families First or Families Together/Building Solutions case manager, either face-to-face, by telephone, or teleconferencing; see PSM 714-2, Supportive Services.

Scheduled and Unscheduled Home Visits

Scheduled and unscheduled visits should be considered based on the unique circumstances of the case. Scheduled home visits may be preferred to allow better coordination of visits between the case manager and family. Unscheduled visits should be considered when:

- New concerns are brought to the attention of the case manager.
- Assessment of child safety could be impacted by a scheduled visit.

SERVICING AND ENGAGEMENT

Case Manager Responsibilities

Case manager responsibilities for post-investigation cases include development of a prevention plan with the family to address safety concerns or needs identified in the risk assessment/reassessment and the FANS and CANS.

Services offered should:

- Be culturally relevant.
- Be sufficient in frequency and duration.
- Be relevant to family needs and address the top three needs identified by the FANS that contributed to the maltreatment.
- Assist parents or caregivers in identification of goals for reducing risk to the child and enhance their ability to provide adequate care of their child(ren).
- Assist parents or caregivers with identification of resources within their community and extended family support system and facilitate access to and use of those resources.
- Support parent or caregiver efforts. Help the parents or caregivers assess and be responsive to the needs of their child(ren). Support and encourage the caregivers by helping them to recognize their own strengths and encourage them to apply these strengths to reach identified goals.
- Assist parents and caregivers in learning new skills in areas including childcare, household budgeting, preparation of nutritious meals, household organization, child development, discipline, and other necessary areas.
- Facilitate linkage of family to needed resources including financial assistance, medical assistance, family planning services, housing, legal aid, or employment.
- Include engagement with the family to evaluate the need for continued services.

See PSM 714-2, CPS Supportive Services for more information on services.

Court Involvement

Every effort must be made to keep families together whenever safely possible. When engagement efforts and service provision are insufficient to achieve and maintain child(ren) safety, a petition seeking court intervention may be necessary; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders. Whenever possible, case managers must request a FTM to discuss the concerns and attempt to resolve them before filing a petition; see *Family Team Meeting* section in this item.

A request for removal is not necessary in all situations. Relief requested should be the least intrusive necessary to protect the child(ren) or resolve the emergency.

The case record must demonstrate the following when filing a petition:

- Services provided and reasons for ineffectiveness.
- Imminent and substantial risk of harm to the child(ren).

The petition must state:

- The reason(s) why it is contrary to the welfare of the child(ren) to remain in the home.
- Reasonable efforts that were made to prevent the removal.

Note: Active efforts must be made to prevent removal for American Indian children; see NAA 205, Indian Child Welfare Case Management, and see NAA 235, Emergency Placement, for information on safety planning and removal of American Indian children.

Removal and placement

Non-custodial parents should always be considered first for placement of the child(ren). The case manager must work with the parents to identify relatives for placement when removal is being sought. When considering placement with the other parent, case managers should consider if a petition is necessary or if other means of engagement and safety planning would be effective for

voluntary placement with the other parent. See PSM 715-2, Court Intervention and Placement of Children, for information on placement with relatives or non-custodial parents.

Parents who are incarcerated should still be included in placement decisions for their children. Parental incarceration alone does not meet the criteria of abuse or neglect.

If a child(ren) is/are removed, but returned home within 7 days, face-to-face contact with the child(ren) is/are required within 7 days after the child(ren) is/are returned home.

Diligent Relative Search and Genograms

Diligent Relative Search

Case managers must continue to search for and identify relatives for the duration of an open case for purposes of placement and/or support. These activities should be reflected in each case service plan. Case managers must attempt to contact all known relatives and document those efforts. Relatives who are unable or unwilling to take placement may still be a source of support for the child(ren) and family.

Case managers may use the DHS-991, Relative Search Checklist, for suggestions of methods to complete a relative search.

Case managers must use the DHS-987, Relative Documentation, to document all the following when contacting relatives:

- All identified relatives.
- The relative's relationship to the child(ren).
- Contact information for the relative.
- The dates of contact by the case manager.
- The types of resources or supports the relative expresses interest in providing to the family.

Note: For an Indian child(ren), extended family members, as defined by the law or custom of the Indian child(ren)'s tribe, may be included as relatives for placement purposes. Ongoing, diligent search efforts must occur; see NAA 215, Placement/Replacement Priorities for Indian Child(ren).

Genograms

Genograms are a valuable tool that assist case managers with establishing rapport with families and gathering information on family relationships, dynamics, behavior patterns, and history. Genograms can also assist with locating, identifying, and engaging the family's relative network. For more information on genograms; see FOM 722-06, Case Planning.

A genogram must be completed during the first service period in all Category I, II, and III cases and documented in the initial updated service plan.

Case managers may hand draw genograms or use genogram software. MDHHS case managers may download the GenoPro Tool from the Software Center. Training materials and resources for genogram completion can also be found on the MDHHS Office of Workforce Development and Training (OWDT) Child Welfare Institute Student Guide, including standard symbols for genograms and a genogram example video.

Documentation

Case managers must document ongoing relative search efforts and results in the *Relative Search and Engagement* hyperlink in the electronic case record. Case managers must upload all relative search forms and genograms in the *case overview documents* hyperlink.

Early On®

The ongoing case manager must review the Early On evaluation results, recommendation for services, and ensure those services are incorporated into the case service plan. Services must be developed by engaging with the family and any service providers, to ensure services meet the family's needs.

Monthly Case Consultation

At least one case conference between the case manager and their supervisor must occur monthly for every CPS case. The case conference must be documented in the electronic case record with supervision as the contact type. The narrative should only indicate that the conference occurred.

Safe Sleep

The case manager should discuss safe sleep practices with parents of infants under 12 months of age as needed and assist parents with items they may need, for example, pack n' plays and cribs.

Family Team Meetings

FTMs should be held according to the tables within policy; see FOM 722-06B Family Team Meeting, for more information on content, structure and frequency.

The DHS-1105, Family Team Meeting Report, is used to capture the following:

- Family demographics.
- FTM logistical information.
- Strengths and needs.
- Action steps.
- Safety concerns.
- Safety plans designed to help the parent address any identified safety concerns; see PSM 713-01, CPS Investigations - General Instructions.
- Recommendations made during the FTM.

The DHS-1105 may detail safety plans designed to help the parent(s) address any identified safety concerns; see PSM 713-01, CPS Investigations - General Instructions.

The case manager should develop and document goals and detailed action steps on the DHS-1105 based on family input as well as needs identified in the FANS and CANS. The goals and action steps should be specific, realistic, and clear to identify the expected and measurable outcomes. A copy of the completed form must be provided to the family and scanned and uploaded into the *FTM documents section* of the electronic case record.

The DHS-1105 serves as the service agreement for category II and III cases.

With family input, case managers must develop a strength-based service agreement which focuses on the safety concerns and the related issues identified on the risk and needs and strengths assessments. The overall goal of the service agreement should promote a reduction in the risk to the child(ren). Goals should be developed with the family to address needs and must be identified in the service agreement.

Case managers should identify the top three prioritized needs based on the FANS and CANS to promote services for these needs. A goal must be stated for each service based on the need. Goals should be developed to demonstrate that they are:

- Developed with family input.
- Specific.
- Realistic.
- Clear to identify the expected and measurable outcomes.

The service agreement must be printed, and a copy provided to the family.

CASE CLOSURE

See PSM 714-4, CPS Updated Services Plan and Case Closure.

SPECIAL CASE SITUATIONS

Cases Involving Multiple Counties

In cases involving multiple counties, the county of residence may request that another county make a service referral, supervise services, or conduct other case manager related activities in the other county. This is referred to as a courtesy request. Courtesy requests may happen for a variety of reasons such as:

- A family will be visiting another county and while there, verification of child(ren) safety or servicing for the family is needed.

- A custodial parent resides in the county of origin and the other parent resides in another county.

- A parent places their child(ren) in another county voluntarily.

- To verify relocation of a family to another county.

Requests for courtesy supervision, service referrals, and other case management activities must be honored. Courtesy case managers and supervisors should be assigned within the electronic case record. Disputes between counties must be referred to the respective Business Service Center (BSC) director(s) for resolution.

All activities completed by the courtesy case manager must be documented in social work contacts. The assigned primary case manager and courtesy case manager should ensure a flow of communication that addresses the status of the family as well as safety concerns and needs.

Transfer of Case Due to Relocation

If the primary assessment household moves to a new county, a request may be made to the new county to transfer the case after relocation has been verified.

Disputes between counties must be referred to the respective BSC director(s) for resolution.

Domestic Violence

Interventions in cases where domestic violence is a factor should be consistent with the following three principles:

1. Safety of the child(ren) and adult victim must be the primary consideration in all phases of the intervention.
2. The domestic violence offender must be held accountable for acts of violence and coercive and controlling behavior.
3. Safety and service plans should build on the survival strategies of the adult victim to increase their likelihood of remaining safe and protecting the child(ren).

Case managers should assist and support the non-offending caregiver in recognizing and furthering all safety efforts. If the child(ren) is/are at risk of harm by the domestic violence offender, safety planning should continue to support child(ren) safety as a priority. Separation from the perpetrator sometimes places the non-offending caregiver and the child(ren) at increased risk of harm.

Information necessary to develop an intervention in cases involving domestic violence include:

- Potential adverse impacts, including trauma on the child(ren) due to the domestic violence offender's behavior.
- The offender's assaultive and coercive conduct, and the impact on child(ren) safety.
- The role of substance use, mental health, culture, and other socio-economic factors on child(ren) safety.
- Protective factors available for use by the non-offending caregiver, such as use of protective orders, police involvement, family support, or shelters.

Consideration should be made for separate service plans for the non-offending caregiver and the domestic violence offender. See *Case Manager Responsibilities* section for more information on the development of service agreements.

Domestic violence offenders may use manipulative tactics to use the child welfare system to further abuse and retaliate against the non-offending caregiver, or to gain leverage in possible custody disputes. Offenders may file allegations of CA/N against the other caregiver. This behavior may be a warning sign that the danger is increasing.

See PSM 712-6, CPS Intake-Special Situations, *Domestic Violence* section, and PSM 713-08, Special Investigative Situations, Domestic Violence section.

Firearm Assessment

A firearm assessment is intended to be used when a case manager becomes aware of a firearm in a home during an open case. The goal of this assessment is to evaluate the safety of the child, assist with ensuring child safety, and guide caregivers through the safe storage of firearms. See PSM 713-01, CPS Investigation - General Instructions for guidance on assessing firearm safety.

If an assessment was completed during the investigation, the ongoing case manager should be monitoring that all safety plans and/or steps taken to secure a weapon are being adhered to.

Note: Case managers must continue to utilize licensing rules for licensed foster homes. Case managers must also follow criteria regarding weapons, firearms, and/or ammunition outlined in the MDHHS-5770, Relative Placement Safety Screen, and MDHHS-3130-A, Relative Placement Home Study.

New Investigation During an Open Ongoing Case

If a new investigation is received during an open ongoing case, case managers should actively communicate with the assigned investigator to coordinate case requirements, visits, family progress, concerns, and case service plans. Both case managers can utilize relevant contacts from the new investigation and open ongoing case and incorporate those contacts into their respective cases. If a preponderance of evidence of child abuse and/or neglect is found on the new referral, the case manager must open or maintain the case with the higher risk level. If both cases result in Category I dispositions, the case manager must keep the case open that resulted in out of-home placement.

If there are any disputes regarding case services or case direction, insight should be sought from the program manager or director.

Screened Out Referrals

The case manager must review screened out referrals to determine if any new or additional safety planning may be needed based on screened out allegations.

The case manager must document in a social work contact the following:

- Intake ID(s) of screened out allegations.
- Acknowledgement that new allegations have been reviewed.
- Whether additional safety planning is needed.

Open Maltreatment in Care Cases

If there is a combination of confirmed victims, including biological/adoptive children of the identified perpetrator and foster children, the case must transfer to CPS ongoing in the county where services will be provided to the family.

If the identified victims are biological/adoptive children of the identified perpetrator and a foster child is not confirmed as a victim, the case must transfer to CPS ongoing in the county where services will be provided to the family.

CPS ongoing will oversee the provision of services for the family. Regular updates to the foster care agency of responsibility must occur to ensure suitability of continued placement. Preventative services must be initiated by CPS ongoing at case opening.

Note: If a foster child victim is moved to a new placement separate from the perpetrator, but the perpetrator is licensed, the case must transfer to CPS ongoing in the county where the licensee resides, to provide services that address the risks identified during the confirmation. This must occur even if no children remain in the home.

LEGAL BASE

Federal

Child Abuse Prevention and Treatment Act, 42 USC 5101 et. seq.

The Secretary of Health and Human Services may establish an office to be known as the Office on Child Abuse and Neglect.

The purpose of the Office established under subsection (a) shall be to execute and coordinate the functions and activities of this subchapter and subchapter III. In the event that such functions and activities are performed by another entity or entities within the Department of Health and Human Services, the Secretary shall ensure that such functions and activities are executed with the necessary expertise and in a fully coordinated manner involving intradepartmental and interdepartmental consultation with all agencies involved in child abuse and neglect activities.

A State plan submitted under paragraph (1) shall contain a description of activities that the State will carry out using amounts received under the grant to achieve the objectives of this subchapter, including- (xxi) provisions and procedures for referral of a child(ren) under the age of 3 who is/are involved in a confirmed case of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Education Act (20 U.S.C 1431 et seq.).

State

Child Protection Law, MCL 722.628d(c)-(e).

CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox Child-Welfare-Policy@michigan.gov.