

 <b>WRAPAROUND MILWAUKEE POLICY &amp; PROCEDURE</b>	Date Issued:  9/1/98	Reviewed: <b>5/29/09</b> By: <b>CP</b> Last Revision: <b>6/17/08</b>	Section:  <b>LIAISONS</b>	Policy No:  <b>019</b>	Pages:  <b>1 of 3</b> (12 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date:  1/1/09	Subject:  <b>FOSTER CARE PLACEMENT – NON-AGENCY</b>		

## I. POLICY

It is the policy of Wraparound Milwaukee that anytime a youth is placed in a Foster Care setting, the following guidelines/criteria be followed.

## II. PROCEDURE

**A. A Plan of Care (POC) Review must occur with the entire Child & Family Team to determine that the youth's and family's needs would best be met by a Foster Home placement. This review must include the BMCW Case Manager for all CHIPS youth to ensure that this placement and this payment rate is transferable to the BMCW and that it meets State of Wisconsin Foster Home Payment Rate Review requirements.**

**The BMCW Case Manager must make the referral for a youth for a regular foster home.**

1. The Care Coordinator in collaboration with the BMCW worker must explain to the Child & Family Team at this POC Review what a Foster Home will provide. This must include a description of the services the Foster Care Agency must provide.
2. The Care Coordinator must facilitate the inclusion of the Foster Care Parents and the Foster Care Consultation Worker into the Child and Family Team.
3. The Care Coordinator must arrange for the youth's pre-placement visit(s) at the identified home.
4. The Care Coordinator must ensure that the agreed upon payment rate meets the requirements of the State of Wisconsin, BMCW, Delinquency Management and the foster parents.

### B. When Placing a Youth in a Licensed Foster Home Setting:

Placement of a youth in an unlicensed home is illegal unless a court has specifically ordered the placement, or the BMCW Case Manager has successfully completed the BMCW Pre-Placement Screening Plan (which includes a criminal and background clearance check), the Caregiver Child Placement Plan and the Plan to Support Permanency for Unlicensed Relative or Non-Relative Potential Caregivers.

1. **For a CHIPS Youth**, the Care Coordinator must secure a copy of the official BMCW legal Notice of Change in Placement before the youth is moved.

The Care Coordinator should then complete the forms below as appropriate to the youth's situation:

- NOTICE OF CHANGE IN PLACEMENT (*see Attachment 1*)
- FOSTER/KINSHIP CARE INVOICE (*see Attachment 2*)
- FOSTER/KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 3*)
- FINANCIAL ASSESSMENT REFERRAL (FAR) (*see Attachment 4*) along with a copy of the TEMPORARY PHYSICAL CUSTODY ORDER (TPC) (*see Attachment 5*).

**If this placement removes the youth from the home of the parent or guardian, then a court hearing MUST occur before the move can take place.**

**For a Delinquent or JIPS Youth**. Contact your WM Liaison immediately if the Delinquent or JIPS youth requires a regular foster home placement. Regular foster homes are established for use by CHIPS youth primarily and special arrangements will be required to place a Delinquent or JIPS youth in a regular foster home. The Care Coordinator should then complete the forms below as appropriate to the youth's situation:

- NOTICE OF CHANGE IN PLACEMENT (*see Attachment 1*)
- FOSTER/KINSHIP CARE INVOICE (*see Attachment 2*)
- FOSTER/KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 3*)

- FINANCIAL ASSESSMENT REFERRAL (FAR) (*see Attachment 4*) along with a copy of the TEMPORARY PHYSICAL CUSTODY ORDER (TPC) (*see Attachment 5*)

**If this placement removes the youth from the home of the parent or guardian, then a court hearing MUST occur before the move can take place.**

**\* Note: Care Coordinator should provide Foster Parent with the INVOICE form to be completed and explain to the Foster Parent how to complete the Invoice and submit it to the Wraparound Finance Office at the end of the month for every service month.**

2. All youth that are in substitute care placements for six months or more will be required to have their case reviewed by a Court official in a court review or by an Administrative Review Board (ARB). A typed SEMI-ANNUAL PERMANENCY PLAN CASE REVIEW must be presented at this review. **For a CHIPS Youth**, the BMCW Case Manager will prepare this report. The WM Care Coordinator should assist by providing information about the youth and family to the Case Manager on a continuous, regular and ongoing basis. The Care Coordinator should also maintain contact with the BMCW Case Manager to remain aware of this scheduled review, and should appear with the BMCW Case Manager at the Annual Review Board or Permanency Planning Review, or the Court hearing, at which the youth's permanent plan will be reviewed.

**For a Delinquent or JIPS Youth**, the Care Coordinator will prepare this report called a DELINQUENCY DIVISION PERMANENCY PLAN (*see Attachment 6*). The WM Care Coordinator should, however, be providing this information about the youth and family to the Probation Officer on a continuous, regular and ongoing basis. The Care Coordinator should also maintain contact with the Probation Officer to remain aware of this scheduled review, and will appear with the Probation Officer at the Annual Review Board or Permanency Planning Review, or the Court hearing, at which the youth's permanent plan will be reviewed.

3. **For a CHIPS Youth**, the BMCW Ongoing Case Manager (OCM) must put in a referral to Children's Service Society of Wisconsin (CSSW) to secure a foster home placement.

4. When placing a youth in foster care, the Care Coordinator must complete the FOSTER PARENT CHECKLIST (*see Attachment 7*) prior to placing a youth or, if an emergency placement, within one (1) week of the placement. The Checklist must be signed by both the foster parent(s) and the Care Coordinator to indicate that it has been completed. A copy of the Checklist should be left with the foster parent(s), a copy should be kept by the Care Coordinator for their Agency file for the youth, and the original should be kept in the Wraparound file of the identified youth.

5. When placing a youth in a foster home, the Care Coordinator must provide a copy of the INFORMATION FOR FOSTER PARENTS form (*see Attachment 8*) as required by Wisconsin State Statute 895.485(4)(a) and Wisconsin State Administrative Code Chapter HSS37 to the foster parents. The foster parents must sign and date the last page. The Care Coordinator must then supply a copy of the signed form to the foster parents and place a copy in the Agency file for the youth. The original should be kept in the Wraparound file for the identified youth.

If the BMCW Worker for a CHIPS youth has already provided this form to the foster parent, the Care Coordinator must get a copy of the form signed by the foster parent and place a copy in the agency file.

6. **Prior to the actual placement of the youth in a foster home**, the BMCW Worker, in collaboration with the WM Care Coordinator for all CHIPS youth, must determine the foster care rate with the foster parent, using the UNIFORM FOSTER CARE RATE pamphlet (*see Attachments 9*) or the Foster Care Uniform Rate Setting Form (*see Attachment 10*) as a guideline.

For CHIPS youth, this mutually agreed upon rate must be reflective of communication and collaboration with the BMCW to ensure that the rate is transferrable to the BMCW, and that it meets State of Wisconsin Foster Home Payment Rate Review requirements. The Care Coordinator should clearly explain this to the foster parents. The Care Coordinator should then submit a SERVICE AUTHORIZATION REQUEST (SAR) to Wraparound Milwaukee reflecting the indicated rate as well as the foster parents' complete address and phone number (service code is 5390). The Care Coordinator is also responsible for explaining the Invoice procedures done through the Wraparound Finance Office. For questions related to the SAR or Invoice Procedure, please contact the

Wraparound Finance Office at 257-6176.

**C. Emergency Placement:**

1. In the event of an emergency situation after normal business hours:

**For a CHIPS Youth**, if the BMCW Case Manager or Supervisor are unavailable, the Care Coordinator must call the BMCW emergency phone line at 220-SAFE (220-7233). The BMCW emergency response system will then direct any further action. The Care Coordinator must then take all appropriate actions related to a Change in Placement and complete and submit all Change in Placement forms (as detailed in Policy 005), no later than 48 hours after the youth's placement has been achieved.

**For a Delinquent or JIPS Youth**, if the Probation Officer or their Supervisor are unavailable, the Care Coordinator can remove a youth from their current placement, if the safety of the youth, family or placement resource is threatened. In this event, the Care Coordinator is then responsible for informing the Probation Officer of the youth's current whereabouts and the reason for the removal by noon of the following business day. The Care Coordinator must also take all appropriate actions related to a Change in Placement and complete and submit all Change in Placement forms (as detailed in Policy 005) no later than 48 hours after the placement has been achieved.

If there are any objections by either the Judge, District Attorney, Public Defender, Guardian ad Litem, Parent, Child Guardian or Native American Tribe, Probation Officer to the placement change, a hearing must be held in Court for the objections to be presented and a determination made by the Judge regarding the youth's placement.

2. If the move is contested, the Care Coordinator must then ascertain the court date for the hearing on the matter by contacting the **Clerk of Courts at 257-7700**. At the time of the court hearing the Care Coordinator must be prepared to explain his or her involvement with the youth, how the decision for the change in placement was arrived at, who was consulted regarding the decision, and be able to speak to what is in the best interest of the youth. A CHILDREN'S COURT ORDER PROGRESS REPORT (*see Attachment 11*) is required. The child should NOT then be moved, except in an emergency, until the Court has heard the objection and made a ruling.
3. Placement of a youth in a foster or substitute care setting must be accomplished legally through the use of the legal NOTICE OF CHANGE IN PLACEMENT (*see Attachment 1 – refer to Policy #005*) being completed in Synthesis and submitted to your assigned Wraparound Liaison within the legally required time frames. For a CHIPS youth, the Care Coordinator must secure a copy of the official BMCW legal Notice of Change in Placement before the youth can be moved.
4. The Care Coordinator will need to submit a COURT LETTER - REQUEST FOR REVISION AND/OR EXTENSION OF DISPOSITIONAL ORDER (*see Attachment 12*) to the WM Liaison per Wraparound Court Extension Policy (#013), if it is determined by the Child and Family Team that the youth's out-of-home placement and/or Court involvement must be continued beyond the duration of the existing Order.

**If you need assistance, please contact your assigned Wraparound Liaison.**

Reviewed & Approved by: Bruce Kamradt

**Bruce Kamradt, Director**

**WRAPAROUND MILWAUKEE  
Foster Care Non-Agency Policy  
Attachment 1**

**STATE OF WISCONSIN, CIRCUIT COURT, MILWAUKEE COUNTY**

*For Official Use*

IN THE INTEREST OF

Smith, John  
Name

**Notice of  
Change in Placement**

- Out of Home to Out of Home  
 Out of Home to In Home  
 In Home to In Home

12/11/90  
Date of Birth

Case No. 99JV000000

This placement  was  will be changed on (date) 6/25/08 as follows:

This change  was  was not authorized by the original dispositional order.

Give reason for new placement, why it is preferable and how it satisfied treatment plan:

Youth is transitioning home from Lad Lake. Wraparound Milwaukee will continue to provide ongoing case management services.

Name and address of new placement:

Mary Smith  
3035 W. Wisconsin Avenue #207  
Milwaukee, WI 53208

If placement continues to be outside the home, the parents/guardian/legal custodian/trustee will be required to pay support for the placement.

**Hearing Rights**

If you object to the change in placement:

- A written request for a hearing must be filed with the court listed above within 10 days of your receipt of this notice. Copies of this request should be sent to all concerned parties.
- The change of placement is authorized in the current dispositional order. Therefore, your request for a hearing must allege new information which affects the advisability of that dispositional order.

Distribution:

1. Original - Court
2. Child/Juvenile
3. Parents/Guardian/Legal Custodian/Trustee
4. Social Worker/District Attorney/Corporation Counsel
5. Juvenile's Attorney

Signature of Case Worker/District Attorney/Corporation Counsel

Owen Felix for Skyla Roper  
Name Printed or Typed

6/9/08  
Date

JD-1754, 04/07 Notice of Change of Placement (Out of Home to Out of Home/Out of Home to In Home/In Home to In-Home) ss48.357 and 938.357, Wisconsin Statutes

**This form shall not be modified. It may e supplemented with additional material.**

**WRAPAROUND MILWAUKEE  
INTEGRATED PROVIDER NETWORK INVOICE**

FOSTER/KINSHIP NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE #: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

CLIENT SS#: \_\_\_\_\_

SERVICE MONTH/YEAR: \_\_\_\_\_

SERVICE CODE: 5390/5392

SERVICE NAME: FOSTER/KINSHIP

PROVIDER NAME: \_\_\_\_\_

PLEASE ENTER THE NUMBER OF UNITS PROVIDED BY DATE IN THE APPROPRIATE BOX:

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

TOTAL DAYS \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE CONTACT BONNIE LEWITZKE (414) 257-6176 WITH ANY QUESTIONS

PLEASE MAIL INVOICE TO:

MILWAUKEE COUNTY - BHD - WRAPAROUND  
9201 WATERTOWN PLANK ROAD  
MILWAUKEE, WI 53226

**WRAPAROUND MILWAUKEE  
 INTEGRATED PROVIDER NETWORK INVOICE**

FOSTER/KINSHIP NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE #: \_\_\_\_\_  
 CLIENT NAME: \_\_\_\_\_  
 CLIENT SS#: \_\_\_\_\_  
 SERVICE MONTH/YEAR: \_\_\_\_\_  
 SERVICE CODE: 5390/5392  
 SERVICE NAME: FOSTER/KINSHIP  
 PROVIDER NAME: \_\_\_\_\_

SAMPLE

PLEASE ENTER THE NUMBER OF UNITS PROVIDED BY DATE IN THE APPROPRIATE BOX:

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

TOTAL DAYS 31

SIGNATURE: John Smith

DATE: 1/31/07

PLEASE CONTACT BONNIE LEWITZKE (414) 257-6176 WITH ANY QUESTIONS

PLEASE MAIL INVOICE TO:

MILWAUKEE COUNTY - BHD - WRAPAROUND  
 9201 WATERTOWN PLANK ROAD  
 MILWAUKEE, WI 53226





# Wraparound Milwaukee Foster / Kinship Care Initial Service Authorization

Youth's Name: Emily Meyer DOB: 5-7-1990

Type of Service Requested: Foster Care  Kinship Care   
(circle one)

### Foster/Kinship Provider Information

Name: Mary Smith

Address: 222 W. 2<sup>nd</sup> Street

City, State, Zip: Milwaukee, WI 53222

Phone Number(s): (home) (414) 555-1234

(work) (414) 555-5678

Service Month: May 2008

Daily Rate Authorized: \$5,000

Number of Days Requested: 31

Jill Saren  
Care Coordinator Signature

4-22-08  
Date Signed

Phillip Jones  
Supervisor Signature

4-22-08  
Date Signed

### SUBMIT THIS SERVICE AUTHORIZATION REQUEST TO:

Wraparound Milwaukee Billing Department  
Milwaukee County Behavioral Health Division  
9201 Wauwatosa Plank Road  
Wauwatosa, WI 53226

If you have any questions on how to fill out the form, please feel free to call Bonnie Lewitke at (414) 257-6176.

SAMPLE

**FINANCIAL ASSESSMENT REFERRAL**

Date of Referral	Name - Worker	Telephone Number - Worker
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1. Enter the following information on the child for whom Title IV-E / Medicaid benefits are being requested.

Name - Child	Birthdate - Child	Social Security Number - Child
Race - Child	Gender - Child [D8]	eWiSACWIS Case Number
Court Case Number	Date of Petition	Next Court Date
Date of Removal	Type of Order that Removed Child	Date of Placement
Was the removal: <input type="checkbox"/> Voluntary Placement Agreement <input type="checkbox"/> Court Ordered		VPA / Order Date
Name - Provider		Address - Provider

Child removed from home of:

- Biological / Adoptive Mother  
 Adjudicated / Adoptive Father  
 Both Biological / Adoptive Mother and Adjudicated / Adoptive Father  
 Other      Name of other: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Complete the following information regardless of who the child was removed from:

**Mother Information**

Name - Biological / Adoptive Mother	Telephone Number - Biological / Adoptive Mother
Address - Biological / Adoptive Mother	

**Father Information**

Name - Adjudicated / Adoptive Father	Telephone Number - Adjudicated / Adoptive Father
Address - Adjudicated / Adoptive Father	

2. Complete all the information for each person in the home from which the child was removed.

Name	Relationship to Child	SSN	Birthdate	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No

3. Complete all the income and assets information for each person in the home from which the child was removed.

Name	Income	Source of Income	Assets

4.  Yes    No      Did the child reside with any relative during the six months prior to the month the petition was filed, other than those listed in number 2?

Name - Relative	Relationship to Child
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5. Deprivation

- a.  Yes    No      Is the child deprived for any reason?
- b. Reason deprived: \_\_\_\_\_
- c.  Mother    Father    Both      Is the child deprived of Mother, Father, or Both?

6.  Yes    No      In the month the petition was filed was the child receiving AFDC-MA or was the child removed from an AFDC-MA home?

Complete the following information on the parent(s) or step-parent if applicable, who resided in the home the child was removed from.

If both biological parents were not residing in the home the child was removed from do not include both parents in this section.

**Mother Information**

Name - Mother / Step-Mother	Social Security Number	Birthdate	Race
Address			Telephone Number
Name - Employer		Health Insurance	
Work Address			Telephone Number - Work

**Father Information**

Name - Father / Step-Father	Social Security Number	Birthdate	Race
Address			Telephone Number
Name - Employer		Health Insurance	
Work Address			Telephone Number - Work

7. Family Court

Support Number	Paternity Number
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8. Comments

9. **SIGNATURES**

_____ Name - Worker	_____ Date Completed
_____ <b>SIGNATURE</b> - Worker	_____ Date Signed
_____ Name - Supervisor	_____ Date Completed
_____ <b>SIGNATURE</b> - Supervisor	_____ Date Signed



MILWAUKEE COUNTY CHILDREN'S COURT CENTER

DELINQUENCY DIVISION PERMANENCY PLAN

A Permanency Plan is to be completed for all juveniles who are in or are about to be placed in Out-Of-Home Care (i.e. Foster Home, Group Home, RCCY, or Relative Placement). The plan must be filed with the court within 60 days of the juvenile first being removed from the home and being placed in shelter, with a relative or an out of home care facility.

Honorable Judge \_\_\_\_\_ Branch: \_\_\_\_\_

Hearing Date (if applicable): \_\_\_\_\_ CCAP Number: \_\_\_\_\_

Juvenile's ID Number: \_\_\_\_\_ Probation Number: \_\_\_\_\_

Juvenile's Name: \_\_\_\_\_ D. O. B.: \_\_\_\_\_

Is Juvenile Currently AWOL?  Yes Effective: \_\_\_\_\_

Is there any CHIPS history on this juvenile?  Yes  No Currently on Concurrent Order?  Yes  No

Is there a pending CHIPS action?  Yes  No If Yes, what is the CHIPS CCAP #: \_\_\_\_\_

Initial Date Out of Home Placement by Court Order, for the Current Referral: \_\_\_\_\_

Date of Current Placement Order: \_\_\_\_\_ Current Placement Order Expires: \_\_\_\_\_

Type of Placement Order:  Delinquency - Temporary Physical Custody Order  Delinquency - Disposition Order
 JIPS  Concurrent  CHIPS

Most Serious Offense on Current Referral: \_\_\_\_\_

Wraparound Enrollment Date (if applicable): \_\_\_\_\_

Permanency Plan Submitted To-Court:  Yes Date: \_\_\_\_\_  No.

The Permanent Plan goal for this Juvenile is (check one):

- Return Home  Relative Placement  Independent Living  Long Term Out of Home Care
 Other (specify): \_\_\_\_\_

The target date for achieving this plan is: \_\_\_\_\_

Intake Specialist / Probation Officer / Care Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

Intake Specialist / Probation Officer / Care Coordinator's Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

FAMILY / GUARDIAN / CARE COORDINATOR INFORMATION

Mother: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Mother's Telephone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Father: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Father's Telephone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Who is Guardian? (Mother? Father? Both?) \_\_\_\_\_

If the parent(s) is/are not the guardian, who is:

Guardian: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Guardian's Telephone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship: \_\_\_\_\_

If the juvenile has been out of the home for 15 months or more of the last 22 months, has a referral been made to the District Attorney's office regarding possible TPR proceedings?  Yes  No

If "Yes", on what date? \_\_\_\_\_

If "No", please indicate why no referral was made.

- Child is placed with a relative and the relative will provide permanency. (Provide supporting information.)  
\_\_\_\_\_  
\_\_\_\_\_

- Termination of Parental Rights is not in the juvenile's best interest. (Provide supporting information.)  
\_\_\_\_\_  
\_\_\_\_\_

- Reasonable efforts to reunify the family have not been made. (Provide supporting information.)  
\_\_\_\_\_  
\_\_\_\_\_

- Other  
\_\_\_\_\_  
\_\_\_\_\_

**JUVENILE EDUCATION AND MEDICAL INFORMATION**

Name and location of most recently enrolled school: \_\_\_\_\_

Is/was the juvenile in any special programs? (describe) \_\_\_\_\_

Current grade: \_\_\_\_\_

Summarize any information from school records. (Include such things as assessments, current and past academic performance, behavior issues, progress records, and current and past educational difficulties.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What consideration was given in making the current/proposed placement to continuing the school program juvenile was enrolled in before placement. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the most recent grade report attached?       Yes       No

LIST THE NAME AND ADDRESS OF JUVENILE'S HEALTH CARE PROVIDERS:

Primary Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Last Seen: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Last Seen: \_\_\_\_\_

Other Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Last Seen: \_\_\_\_\_

Other Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Last Seen: \_\_\_\_\_

Other Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Last Seen: \_\_\_\_\_

Other Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Last Seen: \_\_\_\_\_

Summarize significant issues related to juvenile's medical history and medical problems. (Include any conditions for which juvenile recently treated and all serious injuries or illnesses received treatment for in the past, immunization records, etc.)

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LIST ALL CURRENT MEDICATIONS:

Name of Medication	Dosage	Date First Prescribed	Purpose

Is juvenile cooperating with taking their current medications?  Yes  No

If known, has the juvenile been on other medications in the past? (List and indicate what these were for, and when and why the juvenile stopped taking them.)

Name of Medication	Purpose	When Terminated	Why Terminated

If known, list any allergies or negative reactions to any medications.

Allergies / Reactions	Name of Medication (if any)

PLACEMENT INFORMATION

CURRENT PLACEMENT:

Lives With: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address/City/State/Zip (unless not to be disclosed): \_\_\_\_\_

Juvenile's Phone: Current Placement: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Current Placement: \_\_\_\_\_ Type of Placement: \_\_\_\_\_

List Prior Placements (*Name, Address, Dates, Types*) prior to current placement since the last referral to Children's Court Center:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Check all factors considered in the decision to remove and place the juvenile:

- Juvenile without parent or guardian
- Abandonment
- Abuse, or history of abuse
- Juvenile uncontrollable
- Runaway
- Emotionally disturbed
- Parental absence
- Parent unwilling to provide care
- Neglect, or history of neglect
- Juvenile requests care
- Juvenile needs special treatment in areas not available in home
  - Educational
  - Behavioral
  - Emotional
  - Developmental
  - Medical
  - Chemical dependency or abuse
- Needed support to protect juvenile in home is unavailable
- Best interest of juvenile
- Community protection

- ( ) Lack of adequate / appropriate supervision in the home
- ( ) Juvenile at risk of potential harm from own behavior or behavior of others
- ( ) Juvenile at risk of retaliation
- ( ) Parent is unable to provide care due to:
  - ( ) Mental status
  - ( ) Substance abuse
- ( ) Other: \_\_\_\_\_

Give a brief description of circumstances surrounding the removal and placement of this juvenile.

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Were there any problems with the juvenile's adjustment to the prior or current placement?

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PROPOSED PLACEMENT:

Name: \_\_\_\_\_

Address (unless not to be disclosed): \_\_\_\_\_

Type of Home / Institution: \_\_\_\_\_

Explain why the out-of-home care placement (*current and proposed*) best meets the needs of the juvenile at this time. (*Address issues of appropriateness and safety.*)

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Is this placement within 60 miles of the parental home?       Yes       No

If no, why was the juvenile not placed within 60 miles of the parental home.

- ( ) Specialized institutional treatment not available within 60 miles
- ( ) Specialized treatment foster home not available within 60 miles
- ( ) Recommendation that child be removed from the community by \_\_\_\_\_
- ( ) Court ordered away from the community
- ( ) Parent(s) moved after juvenile was placed
- ( ) Foster parent(s) moved after juvenile was placed
- ( ) Other: \_\_\_\_\_

Authority to Place (*check one*):

- ( ) Signed Voluntary Agreement      Date Signed: \_\_\_\_\_
- ( ) Detention Authorization      Date of Authorization: \_\_\_\_\_
- ( ) Disposition Order      Date of Order: \_\_\_\_\_

RELATIVE PLACEMENT POSSIBILITY:

Is a safe and appropriate placement with a relative available?  Yes  No

If there was a decision made to not place the juvenile with an available relative, why was the placement perceived as not safe or appropriate? \_\_\_\_\_

If a Native American juvenile:

Tribal authority to place:  Yes Date: \_\_\_\_\_  
 No Reason: \_\_\_\_\_

Name of Tribe: \_\_\_\_\_

Address: \_\_\_\_\_

SERVICES CONSIDERED, OFFERED, PROVIDED TO JUVENILE/FAMILY TO PREVENT REMOVAL OR RETURN HOME  
 (Check all that apply and write date next to service):

	Offered/Refused	Referred	Provided	Unavailable	Not Appropriate
Deferred Prosecution					
Consent Decree					
Parenting Education					
Probation Services					
Day Treatment					
First Time Offender Program					
Education / Vocational Services					
Emergency Out of Home Care (Respite)					
Temporary Shelter (Short Term)					
Health Services Referral					
Financial Assistance					
Diversion Programs					
Anger Management					
Recreation Program					
Monitoring					
Mentoring					
Family Counseling / Therapy / Evaluation					
Individual Counseling / Therapy / Evaluation					
Placement with Relative (Short Term)					
AODA Counseling / Evaluation					
Visitation – Supervised					
Visitation – Unsupervised					
Transportation Coordination / Funding					
Other (Explain):					

Must discuss services considered, offered, and provided to prevent removal of juvenile from home and their appropriateness on meeting child and family needs.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SERVICES TO BE PROVIDED DURING THE DURATION OF THE ORDER

(If a service is needed, but not available, please indicate by checking the text describing that particular service):

To insure proper care and treatment of the juvenile including social, emotional and physical needs:

- Placement with relative
- Placement in licensed foster home
- Placement in licensed group home
- Supervision of placement by probation and services through Wraparound
- Probation services
- Day Treatment
- Counseling / Therapy for the juvenile (may include foster parents)
- Anger Management
- Referral to appropriate medical care providers
- Family planning
- Independent living skills
- Day Care
- Respite Care
- AODA counseling / evaluation
- Recreational program
- Mentoring
- Monitoring
- Other: \_\_\_\_\_

Services to meet the juvenile's educational and vocational needs:

- Enrollment in public education system
- Special education plan within public school system – IEP
- Educational / vocational plan funded / coordinated by Wraparound
- Enrolled in special vocational programming
- Day Treatment
- Alternative school program
- Other: \_\_\_\_\_

Independent living services (age 15 and over -- check at least one):

- Not appropriate - returning to parents
- Not appropriate – DD child
- Not appropriate – under 15
- Job readiness
- Referral to school social worker
- Educational planning
- Living arrangement
- Financial planning / assistance
- Other: \_\_\_\_\_

Briefly discuss appropriateness of the above services (i.e. why are these services suitable for this juvenile):

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Services to improve home so juvenile can return home or obtain alternative permanent placement:

- Day Care
- Respite Care
- Parenting Education
- Transportation coordination / funding
- Homemaking assistance
- Educational / Vocational services
- Health services referral
- Financial assistance
- Employment services
- Family planning services
- Legal services
- Recreation program
- Housing
- Counseling / Therapy / Evaluation
- AODA Counseling / Evaluation
- Visitation / Supervised visitation
- Exploration of relative resources, including referral to out of state agency through Interstate Compact, if necessary
- Other: \_\_\_\_\_

Services to substitute care provider:

- Case management / coordination of services provided
- Participation in permanency planning review
- Consultation
- Transportation reimbursement
- Fiscal reimbursement for care / medical care of child
- Education and training of foster parents to meet special needs of child
- Other: \_\_\_\_\_



**When placing a child in foster care, please provide the following information to the foster parent(s):**

- Child's name / nicknames.
- Child's date of birth.
- Reason for placement outside of the home (i.e., CHIPS / delinquency).
- Child's strengths/needs.
- Child's interests.
- Biological family's strengths and expected level of involvement.
- Significant behavioral challenges presented in the home, school and community.
- Medical history of child:
  - Physical health (including dental, eye exam information and family specific health problems).
  - Emotional health.
  - Mental health diagnosis.
  - Medications taken both past and present.
  - Allergies (food / medication).
  - Immunization record.
  - Hospitalizations (within the last 12 months and reasons for admission).
  - Physician's name and telephone number, if known.
  - Mental health providers.
- Expected length of placement of child in foster home.
- Identify the Permanency Plan for the child.
- Provide foster parents with the names of the parent(s) and / or siblings.
- Provide foster parents with the Care Coordinator's name, agency name and phone numbers.
- Provide foster parents with the Plan of Care highlighting the details of the Crisis Plan, including necessary contacts.
- Provide expectations for involvement in Child and Family Team and further Plan of Care meetings.
- Provide foster parents with Safety Plan including MUTT pamphlet.
- Explain the Wraparound T19 medical card to be issued.
- Provide Wraparound Milwaukee Family Handbook.
- Provide information on Wraparound philosophy and process.

---

**Responsibilities of Care Coordinator and Foster Parent:**

- Foster parents should schedule a routine medical exam within the next 30 days for the child.
- Foster parents should keep a record of the foster child's school, medical, dental and immunization information.
- Care Coordinator should negotiate the monthly foster care rate with the foster parent and Wraparound Liaison and explain:
  - Payment timeline, SAR, and Invoice process.
  - Prorated payment if child is in CCI.
- Care Coordinator should explain that the monthly foster care rate includes:
  - Food, clothing, furniture, housing, personal care and other expenses related to the care of child.
- Care Coordinator should determine an allowable initial clothing allowance, not to exceed \$250 without special permission from Wraparound Administration.
- Care Coordinator will usually arrange parental visitation, but the foster parent can also schedule parental visitation with the Care Coordinator's approval, if not prohibited by the Court Order.
- Care Coordinator should explain that travel with the foster child is permissible, but requires written parental/guardian permission if traveling outside the state.
- Foster parents must carry liability/homeowner's insurance.

**I have reviewed the above information with my Care Coordinator prior to having a foster child placed in my home.**

---

**Signature of Foster Parent**

---

**Signature of Care Coordinator / Witness**

## INFORMATION FOR FOSTER PARENTS

### PART A

Dear Foster Parent:

The attached forms and information are provided to you according to s. 895.485(4)(a), Wis. Stats., and ch. HFS 37, Adm. Code. We have tried to give you all of the information indicated on the forms, but we often do not have complete information at the time of placement.

Together we are partners in the provision of services for this child. Therefore, we must both try to gather and share information on this child. Add information to this form whenever you gather it; e.g., from the child or his / her family or from a physician. We shall also continue to provide you with information.

During our later visits, we will share with each other any new information that becomes available.

All of the information regarding this foster child provided to you on these forms and in any other manner, is done so with the expectation that you will maintain the information in confidence. State and federal statutes require that this information be kept confidential. If you have any questions regarding what information you may share with any party (e.g., health care providers, schools), please contact the child's social worker.

This first section, Part A, Face Sheet, contains information that is critical for foster parents to know as soon as the child first enters placement. Some of the material is repeated elsewhere in the form.

Note: If the space provided on the form is not adequate, make a note that information is continued on the back or a separate sheet of paper. Clearly indicate which section or item number any supplemental information pertains to.

## INFORMATION FOR FOSTER PARENTS - PART A FACE SHEET

**Use of form:** The information contained in this form must be provided to the foster parent at the time of placement unless there is no way to gather the information prior to the child's placement. Information not provided at the time of placement must be provided within 48 hours. If additional space is needed when completing this form, attach separate sheet(s).

<b>I. GENERAL INFORMATION (Critical Facts to Know)</b>			
Date Form Filled Out (mm/dd/yyyy)		Date Child Placed in Foster Care (mm/dd/yyyy)	
<b>A. Child Information</b>			
Name - (Full Legal)		Nicknames(s)	
Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number	
Height	Weight	Religious Belief or Affiliation - Child or Family	
<b>B. Parent Information</b>			
Name - Mother		Mother is Child's <input type="checkbox"/> Birth mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Adoptive mother	
Address (Street, City, State, Zip Code)			
Telephone Number - Home		Telephone Number - Work	
Name - Father		Father is Child's <input type="checkbox"/> Birth father <input type="checkbox"/> Stepfather <input type="checkbox"/> Adoptive father	
Address (Street, City, State, Zip Code)			
Telephone Number - Home		Telephone Number - Work	
<b>C. Placement Reason (Allegation)</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No    The child was previously in the child welfare system. <input type="checkbox"/> Yes <input type="checkbox"/> No    The child was removed from his or her own home. <input type="checkbox"/> Yes <input type="checkbox"/> No    The child was removed from another foster home.			
<b>D. Emergency Contact Person</b>			
Name		Telephone Number	
<b>E. Social Worker / Agency / Agency Secondary Contact</b>			
Name - Child's Social Worker With Whom Foster Parent Will Have Contact		Telephone Number - Social Worker	
Name - Social Worker's Agency		Telephone Number - Agency	
Name - Agency's Secondary Contact (e.g. supervisor)		Telephone Number - Secondary Contact <u>Regular Hours</u>	Telephone Number - Secondary Contact <u>After Hours</u>

---

**F. MA Card**

Yes  No Has the out-of-home care provider been given the child's MA card (regular or temporary)?  
If "No", describe how and when it will be provided.

---

**G. Prohibited Contacts and Visitors**

Name	Relationship

---

**H. a. Physician - Child's**

Name	Telephone Number
------	------------------

---

**b. Mental Health Provider**

Name	Telephone Number
------	------------------

---

**I. School Currently Attending or Most Recently Attended**

Name

---

Address (Street, City, State, Zip Code)

---

**J. Physical Characteristics - Child**

Describe; e.g., scars, tattoos, birthmarks, discolorations, etc.

---

**K. Behavioral Issues - Child**

Describe; e.g., fire setting, physically abusive, sexually abusive, etc.

---

**L. a. Medical or Mental Health Diagnoses**

Yes  No Child has been diagnosed with a medical / developmental or mental health problem.  
If "Yes", specify.

---

---

**L. b. Non-Medical or Mental Health Diagnoses**

Yes  No Child is believed to have a medical / developmental or mental health problem. If "Yes", specify.

---

**M. Medications**

Yes  No Child is currently taking medication(s). If "Yes", specify.

1. Name of Medication	Dosage / Frequency
Reason for Medication	Prescribing Physician
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you provided this medication to the care provider? If "No", explain.	

2. Name of Medication	Dosage / Frequency
Reason for Medication	Prescribing Physician
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you provided this medication to the care provider? If "No", explain.	

3. Name of Medication	Dosage / Frequency
Reason for Medication	Prescribing Physician
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you provided this medication to the care provider? If "No", explain.	

4. Name of Medication	Dosage / Frequency
Reason for Medication	Prescribing Physician
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you provided this medication to the care provider? If "No", explain.	

---

---

**N. Special Medical Equipment Needs - Child**

Yes  No Child has special medical equipment needs; e.g., feeding tubes, respirator, wheelchair, prosthetics.  
If "Yes", specify.

---

**O. Allergy(s) - Child**

Yes  No Child has allergies. If "Yes", check all applicable allergies.

<input type="checkbox"/> Animals	<input type="checkbox"/> Insect bites	<input type="checkbox"/> Stings	<input type="checkbox"/> Soap
<input type="checkbox"/> Food	<input type="checkbox"/> Drugs	<input type="checkbox"/> Dairy products	<input type="checkbox"/> Wool
<input type="checkbox"/> Other - Specify:			

---

Allergy(s) Details; e.g., if you checked "Animals", is the allergy to all animals, or a specific type? Specify type.

---

Noticeable Allergy Reactions - Describe.

---

**P. Formula and Feeding Restrictions**

Yes  No Child is currently fed with formula. If "Yes", specify brand and type.

---

Yes  No The child has feeding restrictions; e.g., solids, cups or bottles, swallowing problems.  
If "Yes", specify.

---

**Q. Therapeutic Exercises / Activity Restrictions**

Yes  No Child is required to participate in any therapeutic exercises. If "Yes", specify nature of those exercises.

---

Yes  No Child is restricted from certain activities; e.g., strenuous exercise, climbing stairs, etc. If "Yes", specify activity(s).

---

**R. Medical or Mental Health Appointments**

Yes  No Does the child have any currently scheduled medical or mental health appointments?  
If "Yes", specify.

Date (mm/dd/yyyy)	Time	Name - Provider

**II. SIGNATURES**

\_\_\_\_\_  
**SIGNATURE** - Placing Social Worker

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
**SIGNATURE** - Foster Parent

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
**SIGNATURE** - Foster Parent

\_\_\_\_\_  
Date Signed

## INFORMATION FOR FOSTER PARENTS PART B

Dear Foster Parent:

The attached forms and information are provided to you according to s. 895.485(4)(a), Wis. Stats., and ch. HFS 37, Adm. Code. We have tried to give you all of the information indicated on the forms, but we often do not have complete information at the time of placement.

Together we are partners in the provision of services for this child. Therefore, we must both try to gather and share information on this child. Add information to this form whenever you gather it; e.g., from the child or his / her family or from a physician. We shall also continue to provide you with information.

During our later visits, we will share with each other any new information that becomes available.

All of the information regarding this foster child provided to you on these forms and in any other manner, is done so with the expectation that you will maintain the information in confidence. State and federal statutes require that this information be kept confidential. If you have any questions regarding what information you may share with any party (e.g., health care providers, schools), please contact the child's social worker.

The CFS 872-A is a separate document that contains information that is critical for foster parents to know as soon as the child first enters placement. Some of that material is repeated elsewhere in this form.

Note: If the space provided on the form is not adequate, make a note that information is continued on the back or a separate sheet of paper. Clearly indicate which section or item number any supplemental information pertains to.

## INFORMATION FOR FOSTER PARENTS PART B

**Use of form:** The information contained in this form must be provided to the foster parent at the time of placement unless there is no way to gather the information prior to the child's placement. Information not provided at the time of placement must be provided within 48 hours. If additional space is needed when completing this form, attach separate sheet(s).

Name - Child (Full Legal)	Date Child Placed in Foster Care (mm/dd/yyyy)
---------------------------	---

### I. PLACEMENT REASON(S)

<input type="checkbox"/> Yes <input type="checkbox"/> No Child abuse or neglect (CAN) <input type="checkbox"/> Yes <input type="checkbox"/> No Physical <input type="checkbox"/> Yes <input type="checkbox"/> No Sexual abuse <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional abuse <input type="checkbox"/> Yes <input type="checkbox"/> No Neglect <input type="checkbox"/> Yes <input type="checkbox"/> No Delinquent act(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Assaultive <input type="checkbox"/> Yes <input type="checkbox"/> No Non-assaultive <input type="checkbox"/> Yes <input type="checkbox"/> No Developmental disability <input type="checkbox"/> Yes <input type="checkbox"/> No Physical handicap <input type="checkbox"/> Yes <input type="checkbox"/> No AODA <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional disturbance (note related behaviors; e.g., fire starter) <input type="checkbox"/> Yes <input type="checkbox"/> No Behavioral issues (e.g., fire setting, physical abuse perpetrator) <input type="checkbox"/> Yes <input type="checkbox"/> No Learning disability	<input type="checkbox"/> Yes <input type="checkbox"/> No CHIPS, other than CAN? Type of CHIPS Nature of Offense(s) Placement is: <input type="checkbox"/> Voluntary OR <input type="checkbox"/> Court ordered Medical Assistance Number
---	--

Other Placement Reasons - Specify.

### II. SIGNIFICANT CONTACTS

#### A. Health Insurance Company

Name		
Telephone Number	Insurance Policy Number	Insurance Policy Group Number

#### B. Physician

Name	
Address (Street, City, State, Zip Code)	Telephone Number

#### C. Dentist

Name	
Address (Street, City, State, Zip Code)	Telephone Number

**D. Other Health Specialists / Therapists**

Name	Specialty	Telephone Number

Yes  No Is foster parent expected to participate in therapy with the child?

**E. Preferred Hospital Note: Use of hospital may be dictated by insurance company / plan.**

Name \_\_\_\_\_

**F. Child's Siblings**

1. Name	Birthdate (mm/dd/yyyy)	Telephone Number
Lives: <input type="checkbox"/> At home <input type="checkbox"/> Out of home If "Out of home", check one of the following: <input type="checkbox"/> With a relative <input type="checkbox"/> Residential Care Center <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other - Specify. _____		
2. Name	Birthdate (mm/dd/yyyy)	Telephone Number
Lives: <input type="checkbox"/> At home <input type="checkbox"/> Out of home If "Out of home", check one of the following: <input type="checkbox"/> With a relative <input type="checkbox"/> Residential Care Center <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other - Specify. _____		
3. Name	Birthdate (mm/dd/yyyy)	Telephone Number
Lives: <input type="checkbox"/> At home <input type="checkbox"/> Out of home If "Out of home", check one of the following: <input type="checkbox"/> With a relative <input type="checkbox"/> Residential Care Center <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other - Specify. _____		
4. Name	Birthdate (mm/dd/yyyy)	Telephone Number
Lives: <input type="checkbox"/> At home <input type="checkbox"/> Out of home If "Out of home", check one of the following: <input type="checkbox"/> With a relative <input type="checkbox"/> Residential Care Center <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other - Specify. _____		
5. Name	Birthdate (mm/dd/yyyy)	Telephone Number
Lives: <input type="checkbox"/> At home <input type="checkbox"/> Out of home If "Out of home", check one of the following: <input type="checkbox"/> With a relative <input type="checkbox"/> Residential Care Center <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other - Specify. _____		
6. Name	Birthdate (mm/dd/yyyy)	Telephone Number
Lives: <input type="checkbox"/> At home <input type="checkbox"/> Out of home If "Out of home", check one of the following: <input type="checkbox"/> With a relative <input type="checkbox"/> Residential Care Center <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other - Specify. _____		
7. Name	Birthdate (mm/dd/yyyy)	Telephone Number
Lives: <input type="checkbox"/> At home <input type="checkbox"/> Out of home If "Out of home", check one of the following: <input type="checkbox"/> With a relative <input type="checkbox"/> Residential Care Center <input type="checkbox"/> Foster home <input type="checkbox"/> Group home <input type="checkbox"/> Other - Specify. _____		

**G. Significant Extended Family Members**

Name	Relationship	Telephone Number

**H. Legal Custodian**

Name	Relationship
Address (Street, City, State, Zip Code)	Telephone Number

**I. Guardian ad litem / Legal Counsel**

Name	Relationship
Address (Street, City, State, Zip Code)	Telephone Number

**J. Significant individuals who may be having contact with the child**

Name	Relationship	Telephone Number

**K. Individuals whose contact with the child is forbidden or restricted; e.g., supervised visitation**

Name	Relationship
Type of Restriction	Rationale (e.g., court order, parent's wishes)
Name	Relationship
Type of Restriction	Rationale (e.g., court order, parent's wishes)
Name	Relationship
Type of Restriction	Rationale (e.g., court order, parent's wishes)
Name	Relationship
Type of Restriction	Rationale (e.g., court order, parent's wishes)

Name	Relationship
------	--------------

Type of Restriction	Rationale (e.g., court order, parent's wishes)
---------------------	--

Name	Relationship
------	--------------

Type of Restriction	Rationale (e.g., court order, parent's wishes)
---------------------	--

**L. Previous Placements (If no court order prohibiting release of name of previous foster home placement(s)).**

Placement Type (FH, GH, RCC / CCI, hospital, etc.)	Name	Placement Dates	
		From (mm/dd/yyyy)	To (mm/dd/yyyy)

**M. Intended Permanency Plan**

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Reunification with mother | <input type="checkbox"/> Yes <input type="checkbox"/> No TPR / Adoption        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Reunification with father | <input type="checkbox"/> Yes <input type="checkbox"/> No Long-term foster care |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kinship placement         | <input type="checkbox"/> Yes <input type="checkbox"/> No Independent living    |

What is the anticipated amount of time until the permanence goal is achieved? \_\_\_\_\_

**III. SCHOOL INFORMATION**

Name - School Currently Attending \_\_\_\_\_

Current Grade	Program <input type="checkbox"/> Reg. <input type="checkbox"/> ED <input type="checkbox"/> LD <input type="checkbox"/> CD <input type="checkbox"/> Other - Specify. _____
---------------	--

Name - School Contact Person	Telephone Number - School Contact Person
------------------------------	--

**A. Child currently has or previously had the following.**

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

**Poor grades**

**Difficulty making friends**

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Suspensions / expulsions from school**

---

**Foster parents need to spend extra time with study / school personnel**

---

**Physical / verbal aggression towards school personnel**

---

**B. Child's current or previous characteristics / behaviors.**

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Physical / verbal aggression towards children**

---

**Truancy**

---

**Stealing at school**

---

**Disruptions at school**

---

**Clings excessively to parent, teacher or other**

---

---

**IV. EMOTIONAL / BEHAVIORAL INFORMATION**

---

Child's current or previous characteristics / behaviors.

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Difficulty establishing attachment to caregiver**

---

**Difficult to soothe**

---

**Over or underreacts to separation from parents**

---

**Has difficulty focusing or sustaining attention**

---

**Accident-prone**

---

**Sexual behavior is harmful / disruptive**

---

**Eating disturbance**

---

**Lies habitually**

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Relationship difficulties; e.g., peers, authority figures, siblings.**

---

**Gorges / hoards food**

---

**Uses caffeine / how much?**

---

**Refuses to follow instructions / rules**

---

**Displays social / cultural conflicts**

---

**Suicidal threats or gestures**

---

**Hyperactive / needs close or constant supervision**

---

**Unexplained crying spells, emotions inappropriate to situation**

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Child has fears / phobias. Check and explain.**  
 Darkness  Water  Animals  Cars  Heights  Others

---

**Psychiatric diagnosis**

---

**Auditory hallucinations**

---

**Diagnosed with depression**

---

**Diagnosed eating disorder - Specify.**

---

**Eats non-food items**

---

**Diagnosed chemically dependent**

---

**Shows bizarre / severely disturbed behavior / thoughts - Specify.**

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Any involvement of the child as victim or perpetrator in sexual intercourse, sexual contact, prostitution (s. 944.30), sexual exploitation of a child, causing a child to view or listen to sexual activity (948.055) if the information is necessary for the care of the child or for the protection of any person living in the home.**

---

**Needs structured behavior management**

---

**Assaulted or abused animals**

---

**Fire setting - Provide details.**

---

**Excessively / inappropriately seeks attention**

---

**Temper tantrums**

---

**Lethargic, apathetic, withdrawn, unresponsive**

---

**Takes unusual risks with personal safety**

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Self-injurious**

---

**Verbally aggressive**

---

**Assaulted anyone physically? Who and severity - Specify.**

---

**Destructive to property**

---

**Steals**

---

**Alcohol / drug use - Specify.**

---

**History of abusing or not taking prescribed medications**

---

**Runs away - frequency, where, and with whom - Specify.**

---

---

**V. HEALTH AND DEVELOPMENTAL INFORMATION**

---

Child's current or previous characteristics / behaviors.

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Trauma as the result of association with a gang or any other group**

---

**Any involvement of the child in activities that are harmful to the child's physical, mental or moral well-being**

---

**Down's syndrome, autism, mental retardation**

---

**Cerebral Palsy, Muscular Dystrophy**

---

**Positive for cocaine / alcohol at birth**

---

**Fetal alcohol effect syndrome**

---

**Reflux / choking problems / heartburn / ulcer**

---

**Colic**

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Chronic diaper rash, impetigo**

---

**Special diet; e.g., special formula, severe food allergies, tube feeding**

---

**Chronic ear infections**

---

**Asthma - Describe severity.**

---

**Seizure disorder / Epilepsy - Describe.**

---

**Smokes cigarettes**

---

**Pregnant**

---

**Had an abortion**

---

**AIDS / HIV**

Date of test: \_\_\_\_\_  
(mm/dd/yyyy)

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Sexually transmitted disease**

---

**Hepatitis B**

Date of test: \_\_\_\_\_  
(mm/dd/yyyy)

---

**Frequent doctor visits / hospitalizations**

---

**Other medical condition(s) - Specify.**

---

**Medication, including birth control - Name and dosage of the medication, reason prescribed and prescriber - Specify.**

---

**Has lice, scabies, worms**

---

**Incontinent / Encopretic**

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

**Sleep disturbance / sleeping pills / general sleeping pattern**  
Check appropriate descriptions / explain.

<input type="checkbox"/> Sleeps alone	<input type="checkbox"/> Lights on	<input type="checkbox"/> Sleepwalks	<input type="checkbox"/> Usual hours of sleep
<input type="checkbox"/> Naps	<input type="checkbox"/> Lights off	<input type="checkbox"/> Sleeps with toy	<input type="checkbox"/> Sleeps with number of pillows
<input type="checkbox"/> Cold room	<input type="checkbox"/> Door open	<input type="checkbox"/> Sleeps in pajamas	<input type="checkbox"/> Other
<input type="checkbox"/> Warm room	<input type="checkbox"/> Door shut	<input type="checkbox"/> Wakes during night	

**Limitations in verbal skills, non-verbal**

**History of drug dependency / AODA issues in family**

**History of mental / physical health problems in family; e.g., anxiety, mood swings, suicide attempts, etc.**

**Frequent therapeutic exercises done by child with foster parent's help**

**Considering the age of the child, his / her abilities are NOT age-appropriate for:**  
Check appropriate descriptions / explain.

<input type="checkbox"/> Bathing	<input type="checkbox"/> Learning	<input type="checkbox"/> Receptive language	<input type="checkbox"/> Capacity for independent living
<input type="checkbox"/> Dressing	<input type="checkbox"/> Toileting	<input type="checkbox"/> Danger awareness	<input type="checkbox"/> Other
<input type="checkbox"/> Feeding	<input type="checkbox"/> Mobility	<input type="checkbox"/> Social / emotional functioning	

---

**VI. MEDICAL HISTORY**

---

Child's current or previous characteristics / behaviors.

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Hospitalizations, serious illness or injuries; anesthesia**

---

**Medical tests; e.g., CAT scan, EEG, EKG, MRI, chest x-ray, Pap test, TB skin test**

---

**Immunizations: DPT (Diphtheria, Pertussis, Tetanus)**

---

**Polio Immunization**  
 TOPV-oral OR  IPV-injectable

---

**MMR (Measles, Mumps, Rubella)**

---

**Flu, Pneumonia**

---

**Hepatitis B**

---

**Check appropriate illness - Explain.**  
 7-day measles     Mumps     German measles     Strep throat  
 Chicken Pox     Scarlet fever     Rubella     Whooping cough

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Nausea / vomiting, jaundice, liver disease, abdominal pain, uses antacids**

---

**Constipation, diarrhea, blood in stool, uses laxatives**

---

**Headaches, migraines, dizziness / coordination / balance problems**

---

**Serious head injury or loss of consciousness**

---

**Numbness / loss of strength in hand, arm, or leg**

---

**Trouble swallowing, speaking / persistent hoarseness**

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**Hearing problems, ringing ears, discharge / infection, tubes**

---

**Blocking of nose, discharge, post-nasal drip, nosebleeds**

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---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Treatment for skin trouble, rashes, hives, acne, breaking out**

---

**Bursitis, sprain, or dislocation of bone or joint**

---

**Arthritis, backaches, cramps or pain in legs, polio**

---

**Thyroid problems / high or low blood pressure**

---

**Wheezing, bronchitis, cough / phlegm or blood, pneumonia**

---

**Heart trouble, heart murmur, rheumatic fever, chest pain**

---

**Irregular heartbeat, short of breath, swollen ankles**

---

**Urinary, prostate, gall bladder, kidney problems**

---

---

**Y N U** Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked "Yes".

---

**Anemia, blood problems, mononucleosis**

---

**Cancer, leukemia, or other malignancy**

---

**Is child menstruating / PMS / excessive cramping / yeast infection**

---

**Dental problems: braces, retainers, bridges, dentures**

---

**Glasses / contact lenses: blindness, blurred or double vision**

Date of last exam: \_\_\_\_\_  
(mm/dd/yyyy)

---

**Special diet needs (e.g., religious, medical, etc.)**

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**VII. OTHER NECESSARY INFORMATION**

A. Describe child's hobbies, special interests, favorite foods, clothing, toys, talents, etc.

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B. Describe any restriction of child's activities.

---

C. Comment on any other information necessary for the care of the child.

---

D. Placing agency has given the foster parent(s): Check all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Birth certificate (copy)                                    | <input type="checkbox"/> Placement agreement                          |
| <input type="checkbox"/> Court order*  | <input type="checkbox"/> School academic records*                     |
| <input type="checkbox"/> Court report / summary*                                     | <input type="checkbox"/> Information on diagnosis                     |
| <input type="checkbox"/> Dental record / summary*                                    | <input type="checkbox"/> Social history / summary*                    |
| <input type="checkbox"/> Medical records / summary*                                  | <input type="checkbox"/> MA card                                      |
| <input type="checkbox"/> Signed medical release for emergency health care            | <input type="checkbox"/> Summary of social / psychiatric evaluations* |
| <input type="checkbox"/> Permission to use firearms and / or other dangerous weapons | <input type="checkbox"/> Summary of mental health treatment*          |
| <input type="checkbox"/> Permission to operate hazardous machines                    | <input type="checkbox"/> School / community activity permissions      |
| <input type="checkbox"/> Social Security card  |   |

\*Summary is requested to ensure that materials can be interpreted by foster parents. Primary source documents can be provided if useful for clarification. This form and the information included herein have been shared with the foster parent(s).

Age Group	Initial Clothing Allowance
0 – 4	up to \$150.00
5 – 11	up to \$175.00
12 – 14	up to \$200.00
15 – 18	up to \$200.00

Periodic clothing allowances, such as for seasonal clothing, are not allowed. An amount is included in the Basic Maintenance Rate for this purpose each month.

**What if I don't agree with the rate?**

You may request that the rate be redetermined. You may discuss your concerns with the rate setter and the agency director. If you still disagree with the rate, you should consider appealing through the fair hearing process. Your agency director or Foster Care Coordinator will tell you how to request a fair hearing.

**Is there liability insurance for foster parents?**

A statewide fund provides some protection when your own insurance policies do not. The state fund covers some property damage and personal injury caused by the foster child. The extent of coverage and exclusions is subject to change. The agency that licensed your foster home can give you up-to-date information.

**More questions?**

Contact your case worker or Foster Care Coordinator for further explanations. You can also visit our Foster Care website at <http://dhs.wisconsin.gov/children/foster>

If you have general questions about foster care or adoption in Wisconsin, you can also contact the Foster Care and Adoption Resource Center at [www.wifostercareandadoption.org](http://www.wifostercareandadoption.org) or 1-800-947-8074.

PFS-142 (Rev. 5/2007)

**MY FOSTER CHILDREN'S RECORDS**

CHILD'S NAME	PLACEMENT DATE	BASIC MAINTENANCE RATE	SUPPLEMENTAL RATE	EXCEPTIONAL RATE	MONTHLY RATE	LAST REVIEW RATE

**Understanding the  
 UNIFORM  
 FOSTER  
 CARE  
 RATE**

**Effective January 1, 2008 -  
 December 31, 2009**



Wisconsin Department of Health and Family Services  
 Division of Children and Family Services  
 Bureau of Programs and Policies

**What is the Uniform Foster Care Rate?**

The Uniform Foster Care Rate (UFCR) is a standard scale of monthly payments to foster parents for the cost of caring for a foster child. Because the rate is based on the needs of each child, it may also include extra payments (called Supplemental and Exceptional Rate payments) in addition to a BASIC MAINTENANCE RATE.

**What does the Basic Maintenance Rate include?**

The Basic Rate is intended to cover food, clothing, housing, basic transportation, personal care, and other expenses on a monthly basis.

The current Basic Rate for each child is listed below by age group.

Age of Child	Jan. 2008	Jan. 2009
0 – 4	\$333.00	\$349.00
5 – 11	\$363.00	\$381.00
12 – 14	\$414.00	\$433.00
15 – 18	\$432.00	\$452.00

When a foster child in your care turns 5, 12, or 15 years of age, you will receive the next highest rate effective the month after the child's birthday.

You will receive payment for your foster child for the day the child enters your home but not for the day the child leaves your home.

On the next page is a breakdown of the percentages typically spent on the basic necessities for children at various ages. This is intended as a guide. It is understood that your family will use the monthly Uniform Foster Care Rates in the manner which best meets your foster child's needs.

**Guidelines for use of the Basic Rate**

These specific breakdowns by food, clothing, housing, and personal care and other expenses are based on the cost of raising a child as calculated by the U.S. Department of Agriculture. Because the cost of raising a child is more than the amount provided through the Basic Maintenance Rate, these percentages provide only a guide for foster parents. The figures presented are percentages of the Basic Maintenance Rate received for a child in the designated age group.

**FOOD**

Age 0 to 4:	17 to 30%
Age 5 to 11:	26 to 33%
Age 12 to 14:	Approx. 33%
Age 15+:	Approx. 33%

**CLOTHING**

Age 0 to 4:	Approx. 6%
Age 5 to 11:	Approx. 8%
Age 12 to 14:	Approx. 11%
Age 15+:	Approx. 13%

**HOUSING**

Age 0 to 4:	48 to 58%
Age 5 to 11:	Approx. 43%
Age 12 to 14:	Approx. 39%
Age 15+:	Approx. 36%

**PERSONAL CARE AND OTHER EXPENSES\***

Age 0 to 4:	Approx. 18%
Age 5 to 11:	Approx. 19%
Age 12 to 14:	Approx. 17%
Age 15+:	Approx. 17%

\* Other expenses include but are not limited to haircuts, soap, shampoo, toothpaste, and school supplies.

**Is there an additional payment for children who have special needs?**

Yes. If your foster child has emotional, behavioral, or medical needs, you may request an additional monthly payment to cover the costs of caring for the child's special needs. When approved, this payment is called a SUPPLEMENTAL RATE.

**How is the Supplemental Rate determined?**

Within the first 30 days after a foster child is placed in your home, you and your case worker will discuss whether the child may qualify for a Supplemental Rate payment. If your foster child has needs that require special care or supervision, the case worker will submit a description of the child's problems or characteristics.

Evaluations from doctors, psychiatrists, therapists, or other specialists may be included with the case worker's report.

Using a point scale and all of the information regarding the child's emotional, behavioral, and medical problems, the placing agency determines the level of care the child requires.

This level of care establishes the Supplemental Rate.

**Can Supplemental Rates be changed?**

You and your case worker will review your foster child's progress at least every six months. At those reviews, the Supplemental Rate may be changed if the child's condition is changed. Inform your case worker of significant changes when they occur.

**What if a child needs constant care or supervision?**

If a child has extraordinary needs, you may receive an additional payment called an EXCEPTIONAL RATE. This payment may be provided if the child's placement in your home allows the child to be released from a more restrictive setting or prevents the child's placement in such a setting.

**You may receive an Exceptional Rate if, for example:**

- the child requires 24-hour medical care supervised by a doctor or nurse.
- the child has severe behavior problems.
- the child is diagnosed as having a severe mental illness such as schizophrenia, severe cognitive disability, brain damage, or autism.
- the child chronically abuses alcohol or other drugs and needs close supervision.

No monthly payment for the combined Basic Maintenance, Supplemental, and Exceptional Rates may exceed \$2,000.

**What if a child comes to my home with few or no clothes?**

You may be provided an INITIAL CLOTHING ALLOWANCE (see table below) if:

- it is your foster child's first placement; or
- it has been at least four months since the child was last in out-of-home care.

## FOSTER CARE UNIFORM RATE SETTING

Name – Child (Last, First, MI)		Birthdate – Child (mm/dd/yyyy)	Age – Child
Name – Foster Parent(s)			
Address – Foster Parent(s) (Street, City, State, Zip Code)			Telephone Number – Daytime
Date – Child Placed In This Foster Home (mm/dd/yyyy)		Date – Supplemental Request (mm/dd/yyyy)	
Type of Rate Evaluation			County

### DIFFICULTY OF CARE LEVELS

Check "Yes" or "No" to indicate whether each of the following minimal, moderate or intensive characteristics apply to the foster child now. Check "No" if the behavior or feeling is generally age appropriate for the child. Add a description of other similar characteristics that apply to the foster child at the appropriate locations.

### EMOTIONAL CARE NEEDS

**Not Applicable (0 points)** – Child does not exhibit unusual emotional characteristics for a foster child in this age group.

**Minimal (4 points)** – Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

**Yes**    **No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Demands excessive attention   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Nervous   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. High-strung   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Impulsive   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Displays temper tantrums  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Restless  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Hyperactive   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Short attention span  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Occasionally wets during the night  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Low self-esteem and confidence   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Periodically withdrawn and unresponsive; avoids feelings                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Occasionally whines, argues, swears, manipulates, etc.                         |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Exhibits other characteristics which correspond in extent or degree – Specify: |
-

**Moderate (8 points)** – Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Frequently requires close supervision  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Habitually resistive   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Frequent difficulty in communicating with others; avoids feelings                |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Frequent failure to do what is expected  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Responds with apathy to situations   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Difficulty establishing / maintaining relationships; serious attachment problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Displays cultural / social conflicts   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Frequent night bed wetter; occasionally soils or both                            |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Displays over-activity and over-excitedness                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Exhibits other characteristics which correspond in extent or degree – Specify:  |

---

**Intensive (12 points)** – Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Requires constant and intensive supervision; daily structure                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Infantile / immature personality  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Wets or soils during daytime hours, several times per week                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Severe hyperactivity to the point of frequent destructiveness or sleeplessness  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Chronically withdrawn / depressed / anxious                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Self-injurious; extremely accident prone  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Needs behavioral program(s) requiring parent training                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Bizarre or severely disturbed behavior, destructive                             |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has anorexia nervosa or other eating disorders                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Exhibits other characteristics which correspond in extent or degree – Specify: |
-

## BEHAVIORAL CARE NEEDS

**Not Applicable (0 points)** – Child does not exhibit unusual behavioral characteristics for a child in this age group.

**Minimal (4 points)** – Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Disappears or runs away occasionally for short periods of time with the intention of returning  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Occasionally skips classes or exhibits behavior affecting class achievement, requiring make-up and occasional parent / school contact, extra help with homework |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Occasionally acts out in a sexual manner; i.e., masterbates, or uses inappropriate sexual language.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Occasionally experiments with alcohol and drugs or both   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Infrequent hostile conflicts with parents, community, authority figures   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Occasional problems with stealing, petty theft, vandalism, destroying property  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Occasional inappropriate behavior with peers; infrequent conflicts with friends   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Occasional aggressive behavior toward people; i.e., biting, scratching, throwing objects at another, sexual aggressiveness                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Exhibits other characteristics which correspond in extent or degree – Specify:  |

---

**Moderate (8 points)** – Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Frequently runs away or disappears for longer periods of time requiring encouragement to return   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Frequently truant or exhibits behavior affecting class achievement; creates disturbance in the classroom, requires extra help with schoolwork from parents, frequent contact between parents and school |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Frequently exhibits sexual activity harmful to others; disruptive to family and community   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Frequently uses alcohol or drugs or both  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Occasionally involved in non-violent crimes / property which may bring contact with police / authorities; i.e., burglary  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Frequent aggressive behavior toward people; i.e., biting, scratching, throwing objects at another, sexual aggression  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Frequent self-abusive behavior; i.e., head banging, eye poking, kicking self, biting self   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Exhibits other characteristics which correspond in extent or degree – Specify:  |
-

**Intensive (12 points)** – Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

**Yes**    **No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Runs away for long periods of time (8 or more times per year and 5 or more days at a time), returning only as a result of initiative of others |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Habitually creates disturbance in the classroom or on the school bus; habitually truant; requires daily parent / school contact                |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Exhibits sexual deviance; i.e., that of a violent or unconsenting nature with others   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Habitually uses alcohol or drugs or both   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Repeated and uncontrollable social behavior resulting in delinquency status; i.e., property offenses, assault, arson                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Daily aggressive behavior; i.e., biting, scratching, throwing objects  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Constant self-abusive behavior; i.e., head banging, eye poking, kicking self, biting self  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Severe eating disorders, eats inappropriate items  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Child exhibits other characteristics which correspond in extent or degree – Specify:   |

---

## PHYSICAL AND PERSONAL CARE NEEDS

**Not Applicable (0 points)** – Child does not exhibit unusual physical or personal characteristics for a child of this age.

**Minimal (4 points)** – Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

**Yes**    **No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Needs some help putting on braces or prosthetic devices and help with buttons or laces, but is basically self-caring and able to maintain own physical assisting devices |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Seizures, motor dysfunctions, controlled by medication   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Requires therapy for gross or fine motor skills  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Requires special diet preparation / supervision  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Child exhibits other characteristics which correspond in extent or degree – Specify:   |
-

**Moderate (8 points)** – Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Requires help with dressing, bathing and general toilet needs, including maintenance procedures; i.e., diapering and applying catheters; requires help of a person or a device to walk or get around |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Needs assistance to care and maintain physical assistance devices  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Exhibits eating, feeding problems; i.e., excessive intake, extreme messiness, extremely slow eating – requires help, supervision or both   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Requires tube or gavage feeding  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Requires frequent special care to prevent or remedy serious skin conditions; i.e., bedsores, severe eczema   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Requires daily administration of medication, preparation of special diets, prescribed physical therapies; i.e., for vision, hearing, speech, gross or fine motor skills, 1 or 2 hours per day        |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Child exhibits other characteristics which correspond in extent or degree – Specify:   |

---

**Intensive (12 points)** – Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Non-ambulatory   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Uncontrollable seizures  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Need appliances for drainage, colostomy, aspiration, suctioning, mist tent, etc.                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Impaired vision, speech, or hearing functions requiring parent training  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Requires home administration of daily prescribed exercise routines to improve or maintain gross or fine motor skills |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Requires prevention procedures; i.e., daily irrigation   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Requires excessive cleaning / laundry and control of body waste  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Orthotics care at this level demands excessive amount of time, care, and responsibility                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Requires intensive prescribed physical therapy up to 2-3 hours per day   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Child exhibits other characteristics which correspond in extent or degree – Specify:                                |
-

**Basic Rate**

<u>Age Group</u>	<u>Effective January 2009</u>
0 – 4 years	\$349.00
5 – 11 years	\$381.00
12 – 14 years	\$433.00
15 – 18 years	\$452.00

**Supplemental Payment Summary of Points**

Emotional	_____
Behavioral	_____
Physical and Personal Care	_____
TOTAL Points	_____

<u>Number of Points</u>	<u>Dollars / Month</u>	<u>Number of Points</u>	<u>Dollars / Month</u>
0	\$ 00.00	20	\$180.00
4	\$ 36.00	24	\$216.00
8	\$ 72.00	28	\$252.00
12	\$108.00	32	\$288.00
16	\$144.00	36	\$324.00

**Exceptional Payment**

Document here or refer to attached documentation which justifies an exceptions payment under HFS 56.11 (4) (a) Enable the child to be placed in a foster home or treatment foster home instead of being placed or remaining in a more restrictive setting, or HFS 56.11 (4) (b) Replace a child's basic wardrobe that has been lost or destroyed through other than normal wear and tear.

**Recommended UFCR Rate**

Basic	\$ _____
+	
Supplemental	\$ _____
+	
Exceptional	\$ _____
=	
Total	\$ _____

Effective Date: \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE – Worker**

\_\_\_\_\_  
 Date Signed

\_\_\_\_\_  
**SIGNATURE – Rate Setter**

\_\_\_\_\_  
 Date Signed

**Six Month Review** – If a review indicates no change in Basic, Supplemental or Exceptional payments, indicate that the above rate continues by signing below. Complete a new form if any rate factors have changed.

---

**SIGNATURE** – Worker

---

**SIGNATURE** – Rate Setter

---

Date Signed

---

**SIGNATURE** – Worker

---

**SIGNATURE** – Rate Setter

---

Date Signed

---

**SIGNATURE** – Worker

---

**SIGNATURE** – Rate Setter

---

Date Signed

(Date)

**The Honorable** (*Judge's full name here*)  
**Milwaukee County Children's Court Center**  
**10201 W. Watertown Plank Road**  
**Wauwatosa, WI 53226**

**Dear Judge** (*name*):

**RE: Request for Revision (and/or) Extension of Dispositional Order**

**Court No:** \_\_\_\_\_ **Case Type:** (*CHIPS or Delinquent or JIPS*)

**Order Expires:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Birthdate:** \_\_\_\_\_  
**Caretaker** (*name & relationship*): \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Mother:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Father:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**In the interest of** (*Child's Name*), **a person under the age of 18:**

**A Petition for** (*Revision/Extension, whatever is appropriate*) **is being filed in Milwaukee County Children's Court. Wraparound Milwaukee, under contract with** (*Delinquency Management Services and/or the Bureau of Milwaukee Child Welfare*) **is providing this report to the Court for its consideration in this matter.**

- I. **Public Safety:** This should include (but is not limited to) summary (with detail as needed) of Wraparound Milwaukee's Safety Plan. State the risk of the action you are

requesting. Explain how we will provide control for that risk. Define how Community/Public Safety is provided (how we will meet the community's safety needs). Address issues of the Child & Family Team regarding the placement, the school, the police and the community.

**II. Accountability:** Define the child's reintegration plan. What actions are the child (specifically), any members of the child's family that are specifically addressed in the court order, and the Child & Family Team planning and executing to satisfy court-ordered conditions. What progress has been achieved toward this satisfaction? State how we will meet the victim's (if applicable) safety and service needs. What actions/activities are prepared for the child to perform in the home, school and community? What has occurred that now enables this child to do what is acceptable in the community?

**III. Current Situation/Competencies:** *(This should contain 2 to 3 paragraphs).*  
Description of current situation should include the competencies and skills gained by the child and family. It should include progress toward meeting treatment needs, fulfillment of court-ordered conditions, the supports and services Wraparound Milwaukee has provided and the outcomes of those services.

**Based upon the information contained in this report, Wraparound Milwaukee is recommending** *(state your recommendation)*. **Wraparound Milwaukee requests that the Court consider this information in the process of its judicial determination of the** *(Revision/Extension)* **of the current** *(Delinquent/JIPS/CHIPS)* **order.**

**Signatures:**

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Care Coordinator

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Care Coordinator Supervisor

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Wraparound Milwaukee Liaison

(Date)

**The Honorable** (*Judge's full name here*)  
**Milwaukee County Children's Court Center**  
**10201 W. Watertown Plank Road**  
**Wauwatosa, WI 53226**

**Dear Judge** (*name*):

**RE: Children's Court Order Progress Report**

**Court No:**

**Case Type:** (*CHIPS or Delinquent or JIPS*)

**Order Expires:**

**Child's Name:**

**Birthdate:**

**Age:**

**Caretaker** (*name & relationship*):

**Address:**

**Phone:**

**Mother:**

**Address:**

**Phone:**

**Father:**

**Address:**

**Phone:**

Wraparound Milwaukee, under contract with (Delinquency Management Services and/or the Bureau of Milwaukee Child Welfare) is providing this report to the court for its consideration in the matter currently in front of this court.

- I. **Public Safety:** This should include (*but is not limited to*) summary (*with detail as needed*) of Wraparound Milwaukee's Safety Plan. State the risk of the action you are requesting, or the plan you are describing. Explain how we will provide control for

risk. Define how Community/Public Safety is provided (*how we will meet the community's safety needs*). Address issues of the Child & Family Team regarding the placement, the school, the police and the community.

**II. Accountability:** Define the child's reintegration plan. What actions are the child (*specifically*), any members of the child's family that are specifically addressed in the court order, and the Child & Family Team planning and executing to satisfy court-ordered conditions. What progress has been achieved toward this satisfaction? State how we will meet the victim's (*if applicable*) safety and service needs. What actions/activities are prepared for the child to perform in the home, school and community? What has occurred that now enables this child to do what is acceptable in the community?

**III. Current Situation/Competencies:** (*This should contain 2 to 3 paragraphs*). Description of current situation should include the competencies and skills gained by the child and family. It should include progress toward meeting treatment needs, fulfillment of court-ordered conditions, the supports and services Wraparound Milwaukee has provided and the outcomes of those services.

**Wraparound Milwaukee respectfully requests that the Court consider this information in the process of the current judicial review.**

**Signatures:**

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Care Coordinator

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Care Coordinator Supervisor

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Wraparound Milwaukee Liaison