

 WRAPAROUND MILWAUKEE POLICY & PROCEDURE	Date Issued: 6/27/01	Reviewed: 5/29/09 By: DT Last Revision: 7/30/09	Section: LIAISONS	Policy No: 035	Pages: 1 of 2 (10 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date: 1/1/10	Subject: FOSTER CARE PLACEMENT - TREATMENT		

I. POLICY

It is the policy of Wraparound Milwaukee that anytime a child is placed in a Treatment 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 Treatment Foster Home placement. This review must include the Bureau of Milwaukee Child Welfare (BMCW) Case Manager for all CHIPS children 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 file the Notice of Change in Placement and provide a copy to the Wraparound Care Coordinator before the child can be placed.**

1. The Care Coordinator, in collaboration with the BMCW Worker and/or Probation Officer, must explain to the Child & Family Team at this POC Review what a Treatment Foster Home will provide. This must include a description of the services the Treatment Foster Care Agency must provide. The Care Coordinator must have a Release of Information signed for all Treatment Foster Care Agencies in the Provider Network.
2. The Care Coordinator must complete the Wraparound Milwaukee TREATMENT FOSTER CARE REFERRAL FORM and the TREATMENT FOSTER REFERRAL-SUPPLEMENTAL INFO form, if there is no Plan of Care (*see Attachment 1*). Both forms are located under the Client Forms tab in Synthesis. The Care Coordinator should print the Referral and have their Supervisor review and sign the Referral. The Care Coordinator should then forward one copy of the completed Referral, the psychological evaluation, the WHAT YOU SHOULD KNOW ABOUT ME form (found on our website under "Frequently Used Forms" - *see Attachment 2*) and letters of introduction/support from team members to Diane Thompson. The Care Coordinator must maintain regular and consistent contact with all appropriate agencies until a home is found.
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 or Delinquency Management and the foster parents. **Specialized treatment foster care rates must be approved prior to placement in writing by Diane Thompson.**
5. The Care Coordinator must facilitate the inclusion of the Treatment Foster Care Parents and the Treatment Foster Care Worker into the Child & Family Team.

B. Required Legal Action and Required Forms.

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 3*)
- FOSTER / KINSHIP CARE INVOICE (*see Attachment 4*)
- FOSTER / KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 5*)
- FINANCIAL ASSESSMENT REFERRAL (FAR) (*see Attachment 6*), along with a copy of the ORDER FOR TEMPORARY PHYSICAL CUSTODY (TPC) (*see Attachment 7*), **if this placement removes the youth from the home of the parent or guardian.**

For a Delinquent or JIPS Youth, the Care Coordinator should complete the forms below as appropriate to the youth's situation:

- NOTICE OF CHANGE IN PLACEMENT (*see Attachment 3*)
- FOSTER / KINSHIP CARE INVOICE (*see Attachment 4*)
- FOSTER / KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 5*)
- FINANCIAL ASSESSMENT REFERRAL (FAR) (*see Attachment 6*), along with a copy of the ORDER FOR TEMPORARY PHYSICAL CUSTODY (TPC) (*see Attachment 7*), **if this placement removes the youth from the home of the parent or guardian.**

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 proceeding or by an Administrative Review Board (ARB). A typed SEMI-ANNUAL PERMANENCY PLAN CASE REVIEW (*see Attachment 8*) must be presented to this Board.

For a CHIPS Youth, the BMCW Case Manager will prepare this report. The Wraparound 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 may appear with the BMCW Case Manager at the ARB Hearing (Administrative 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 DELINQUENCY DIVISION PERMANENCY PLAN (*see Attachment 8*). The Wraparound 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 ARB Hearing (Administrative Review Board or Permanency Planning Review) or the Court hearing, at which the youth's permanent plan will be reviewed.

3. When placing a youth in Treatment Foster Care, the Care Coordinator must complete the FOSTER PARENT CHECKLIST (*see Attachment 9*) 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 Treatment 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.
4. When placing a youth in a Treatment Foster Home, the Care Coordinator must provide a copy of the INFORMATION FOR FOSTER PARENTS form (*see Attachment 10*) as required by Wisconsin State Statute 895.485(4)(a) and Wisconsin State Administrative Code Chapter HSS37 to the Treatment Foster Parents. The Treatment Foster Parents must sign and date the last page. The Care Coordinator must give a copy of the signed form to the Treatment Foster Parents. 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 Milwaukee file of the identified youth.
5. Placement of a youth in a Treatment Foster Care setting must be accomplished legally through the use of the legal NOTICE OF CHANGE IN PLACEMENT (*see Attachment 3*) 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 BMCW legal "Notice of Change in Placement" before the information is entered into Synthesis and before the youth can be moved. (*For more information on completing the Notice of Change in Placement – refer to Policy #005.*)
6. If you need assistance, please contact your assigned Wraparound Liaison.

Reviewed & Approved by: _____



Bruce Kamradt, Director



TREATMENT FOSTER CARE REFERRAL FORM

Date: 8/6/08

Youth's Name: Sample, Client

DOB: 1/1/98

Care Coordinator Information

Name

Phone Number(s):

Email:

Current Placement:

<i>Date</i>	<i>Type</i>	<i>Location</i>
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Permanency Plan:

Youth / Mother / Father Addresses (if known)

Youth	Client Sample	88 S. 8th St. Milwaukee, WI 55555	Ph: Home 222-2222
Mother	Aggie Sample	<i>nothing entered</i>	Ph:
Father	Bill Hale	PO Box 123 Milw, Wi 53226	Ph:

Target Date for TFC Home Placement

09/30/2008

Anticipated Length of TFC Home Placement

XXXXX

What is the desired outcome from the Treatment Foster Home?

XXXXX

Please share some of the activities this youth enjoys and does well.

XXXXX

Please share some strenghts/supports of the Child & Family Team

XXXXX

PHYSICAL / MEDICAL INFORMATION

Gender: Female **Ethnicity:** Caucasian

Approximate Height / Weight

XXXXX

Date of last physical exam

(Attach Copy - MUST BE within the last 90 days or within 48 hours of placement.)

07/30/2008

Test Results

List and attach forms signed by M.D.

XXXX

Have there been any medication changes since the last POC?

Yes

If YES, list the changes to the medications.

XXXXX

Medical Concerns/Physical Limitations/Allergies

XXXXX

MATCH FACTORS

Is a special supervision pattern required?

Are there safety, risk issues, etc.?

Yes

Please check all that apply:

- Within Milwaukee County
- Outside Milwaukee County
- 2-Parent
- Single-Parent, Female
- Single-Parent, Male
- Same Gender Partner Households

- Roommate
- Race _____
- Younger Children in Home
- Older Children in Home
- No Children in Home
- No Pets

Which factors are negotiable? _____

If YES, explain what type of supervision is required.

XXXXX

VISITATION

Contact Allowed

Please include parents, siblings and relatives. Include the person's name, phone number, relationship to the youth, what type of contact is allowed [supervised or not, phone only, therapy] and time frames [hours, days, overnights]

XXXXXXX

NO Contact Allowed

List the name, relationship to youth and phone number of persons with a No Contact Order per the Court

XXXX

Required Attachments:

- _____ Letter of introduction from the youth
- _____ Letters of support from the team
- _____ Supplemental Referral Information document (if no POC available)
- _____ Copy of most recent psychological evaluation

Care Coordinator's Supervisor's Signature _____ Date _____

- [Demographics](#)
- [Payments](#)
- [Finances](#)
- [Referrals](#)
- [Associates](#)
- [Client Surveys](#)
- [Client Forms](#)
- [Placements](#)
- [Court Orders](#)
- [COP](#)
- [Temp COP](#)
- [School Stats](#)
- [Transfer](#)
- [Juvenile Justice](#)

Scheduling

Tx Foster Referral-Supplemental Info > Client Sample Insert

Form Entered for

Form Date **Client Name:** Client Sample **DOB:** 1/1/1998

FORM ELEMENTS

Current Medication(s) and dosage

Prescribing Physician's Name and Phone Number

Pediatrician's or Health Clinic's Name and Phone Number

Psychiatric Diagnoses (List all five axes)

Family History (Coping strategies, resiliency and resources that have proven most helpful to this family in meeting their challenges. Include relevant AODA, mental illness, domestic violence and corresponding treatment history of parents and adult family and how this may have or continues to influence this youth and family.)

Cultural / Spritual Preferences

Abuse / Neglect History (Describe and date any alleged or substantiated incidents of abuse (physical, emotional, sexual or neglect))

Cognitive / Emotional / Behavioral Functioning (Describe any special intellectual, emotional and/or behavioral

challenges faced by this youth and the strategies that have proven most helpful in meeting the youth's special needs at home, at school and in the community.)

Current School and Grade Placement

Is the youth receiving special education services?

Yes No

If YES, list the types of special education needs that were identified. (CD, ED, LD or Other (if Other - please describe))

Is the youth's IEP current?

Yes No

List academic strengths, needs and the strategies that have proven most helpful in meeting those needs.

If a school change will be necessary as part of placement, what transition planning will be necessary to facilitate a smooth move?

WHAT

YOU

SHOULD

KNOW

ABOUT

ME!!!

Who Am I?

Name: _____

Age _____ Hometown(where I grew up) _____

This is what I want others to know about my family.

This is what I want other people to know about my education.

3 things that interest me.

1. _____
2. _____
3. _____

These are my **STRONG** points.

These are things I want or need to work on.

What are things that make me happy?

What are things that make me upset?

These are things that help me calm down when I am upset

What type of music do I enjoy?

What are my favorite foods?

What are my hobbies? (what do I do for fun)

The people who are supports for me now are.....

The people I look up to most are.....

Looking at my Future.....

What do I need for a positive future?

The type of community that would be best for me is.....

The type of place I want to live next is...

3 goals for my future are...

1.

2.

3.

The type(s) of job(s) I'm interested in would be....

The type of education I want for my future is.....

Looking at my concerns.....

My biggest mistakes have been.....

How I feel about my mistakes.....

Something I want someone to forgive me for is....

My biggest concerns or questions are....

When someone works with me its helpful if

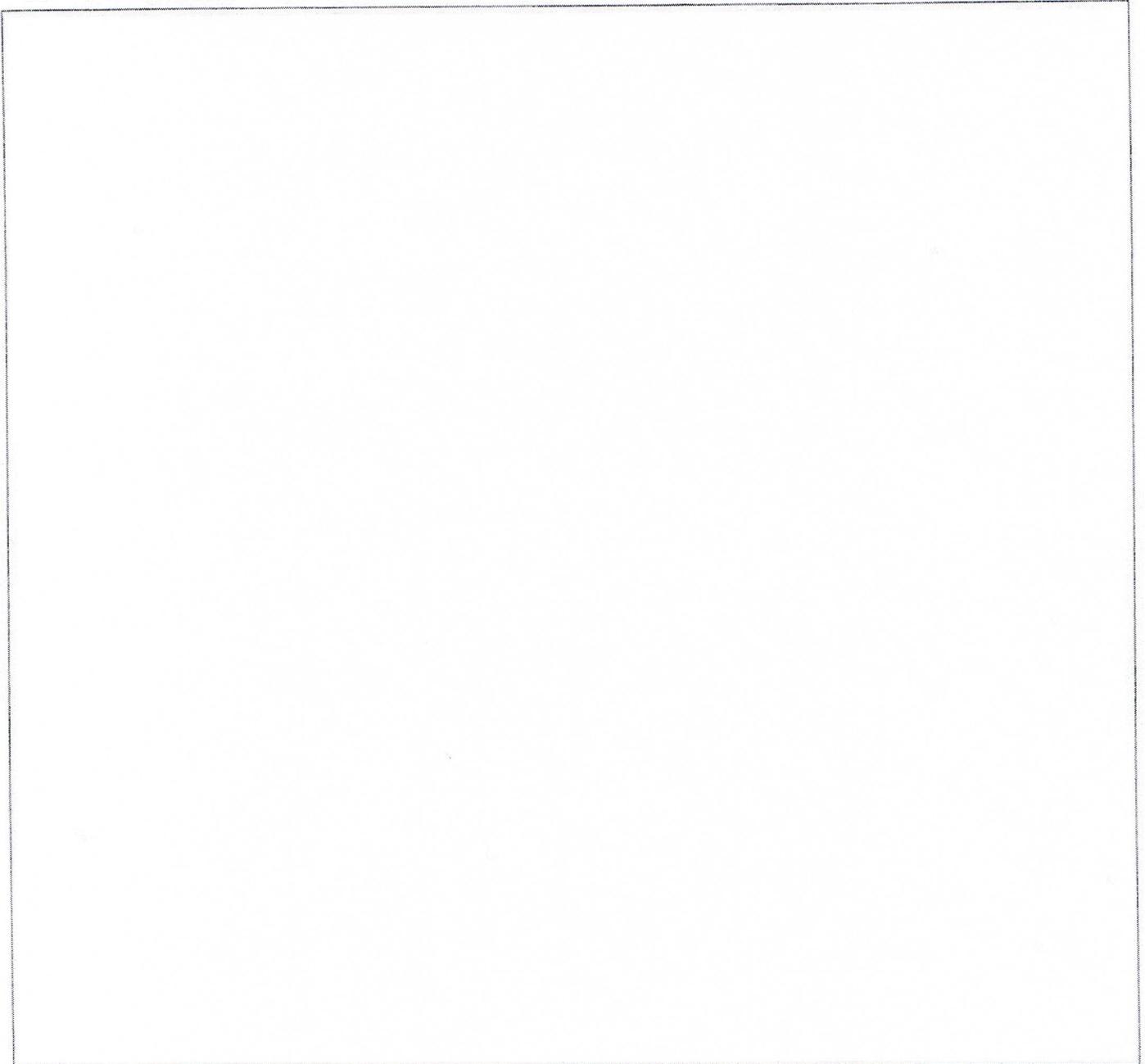
When someone works with me it is not helpful when....

Sometimes people misjudge me and what I want people to know about me is...

Showing my talents.....

I am talented.... My talents are.....

USE THE SPACE BELOW TO CREATE SOMETHING THAT TELLS ABOUT YOU (POEM, PICTURE, SONG, STORY, ETC....)



**WRAPAROUND MILWAUKEE
Foster Care Treatment Policy
Attachment 3**

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 Provider Network Invoice

Foster/Kinship Name: _____

Address: _____

City, State, Zip: _____

Phone Number(s): (Home) _____

(Work) _____

Client Name: _____

Client Soc. Sec. #: _____

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 MAIL INVOICE TO:

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

If you have any questions on this form, please call Bonnie Lewitzke at (414) 257-6176.



Wraparound Milwaukee Provider Network Invoice

SAMPLE

Foster/Kinship Name: John Smith

Address: 1111 Any Street

City, State, Zip: Milwaukee, WI 53255

Phone Number(s): (Home) (414) 555-1234
 (Work) (414) 555-5678

Client Name: Jane Doe

Client Soc. Sec. #: 399-99-9999

Service Month/Year: January 2008

Service Code: 5390 / 5392

Service Name: FOSTER / KINSHIP

Provider Name: John Smith

Please enter the Number of Units provided by Date in the Appropriate Box:

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

Total Days _____

John Smith 2/1/08
 Signature Date

PLEASE MAIL INVOICE TO:

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

If you have any questions on this form, please call Bonnie Lewitzke at (414) 257-6176



Wraparound Milwaukee Foster / Kinship Care Initial Service Authorization

Youth's Name _____ DOB _____

Type of Service Requested: Foster Care Kinship Care

Foster/Kinship Provider Information

Name: _____

Address: _____

City, State, Zip: _____

Phone Number(s): (Home) _____

(Work) _____

Service Month: _____

Daily Rate Authorized: _____

Number of Days Requested: _____

Care Coordinator Signature

Date Signed

Supervisor Signature

Date Signed

SUBMIT THIS SERVICE AUTHORIZATION REQUEST TO:

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

If you have any questions on this form, please call Bonnie Lewitzke at (414) 257-6176.



Wraparound Milwaukee Foster / Kinship Care Initial Service Authorization

Youth's Name _____ Emily _____ DOB _____ 5/7/1990 _____

Type of Service Requested: Foster Care Kinship Care

Foster/Kinship Provider Information

Name: _____ Mary Meyers _____

Address: _____ 222 W. 2nd 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 _____

SAMPLE

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 Watertown Plank Road
Wauwatosa, WI 53226

If you have any questions on this form, please call Bonnie Lewitzke at (414) 257-6176.

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
-----------------	-----------------------

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
_____ SIGNATURE - Worker	_____ Date Signed
_____ Name - Supervisor	_____ Date Completed
_____ SIGNATURE - Supervisor	_____ Date Signed

Referring Agency Case Number	Intake Case Number	Temporary Physical Custody Request	Court Case Number
Child's/Juvenile's/Expectant Mother's Name (Last, First, Middle)		<input type="checkbox"/> African American <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number	County of Residence
Child's/Juvenile's/Expectant Mother's Address			
Date and Time Taken Into Custody		Why was person taken into custody? (§§48.19, 48.193 48.195 or 938.19)	
Taken Into Custody By		<input type="checkbox"/> Warrant/capias <input type="checkbox"/> Child/juvenile suffering from illness, injury or other danger <input type="checkbox"/> Order by judge <input type="checkbox"/> Violation of terms of court-ordered supervision <input type="checkbox"/> Criminal act <input type="checkbox"/> Violation of conditions of temporary custody order <input type="checkbox"/> Runaway <input type="checkbox"/> Violation of civil law or ordinance <input type="checkbox"/> Relinquishment <input type="checkbox"/> Unexcused absence from school <input type="checkbox"/> Serious health risk to unborn child	
Agency			
Statute and Descriptor:			
Legal Father's Name and Address		Home Telephone Number	Work Telephone Number
Legal Mother's Name and Address		Home Telephone Number	Work Telephone Number
Legal Guardian's Name and Address		Home Telephone Number	Work Telephone Number
The parents notified by referring party? <input type="checkbox"/> Yes (Date and Time) <input type="checkbox"/> No		Was notification under 48.193(2) given? <input type="checkbox"/> Yes <input type="checkbox"/> No	Why was person not released?
The parents notified by intake worker? <input type="checkbox"/> Yes (Date and Time) <input type="checkbox"/> No		Was notification under 48.193(2) given? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were rights given? <input type="checkbox"/> Yes <input type="checkbox"/> No
Jurisdictional Finding: (§48.205 and §938.205)			
<input type="checkbox"/> 1. No jurisdiction. <input type="checkbox"/> 2. Juvenile will commit injury to person or property of others. <input type="checkbox"/> 3. Person will: <input type="checkbox"/> cause injury to self. <input type="checkbox"/> be subject to injury by others. <input type="checkbox"/> cause serious health risk to unborn child. <input type="checkbox"/> run away or be taken away so as to be unavailable for further court proceedings. <input type="checkbox"/> 4. Parent, guardian, legal custodian or other responsible adult is: <input type="checkbox"/> neglecting <input type="checkbox"/> refusing <input type="checkbox"/> unable <input type="checkbox"/> unavailable to provide adequate supervision and care .			
Custody decision:			
<input type="checkbox"/> 1. Person released. <input type="checkbox"/> 2. Nonsecure custody: (§48.207 and §938.207) <input type="checkbox"/> a. At the home of a <input type="checkbox"/> parent. <input type="checkbox"/> relative. <input type="checkbox"/> guardian. <input type="checkbox"/> person not a relative. <input type="checkbox"/> b. At licensed foster home, treatment foster home, or group home. <input type="checkbox"/> c. At non-secure facility operated by a licensed child welfare agency. <input type="checkbox"/> d. At licensed private or public shelter care facility (including holdover room). <input type="checkbox"/> e. For expectant mothers at _____ §48.207(1m). <input type="checkbox"/> 3. Secure custody because: (§48.208 and §938.208) <input type="checkbox"/> a. Juvenile has committed a delinquent act and there is a substantial risk of: <input type="checkbox"/> physical harm to another. <input type="checkbox"/> runaway. <input type="checkbox"/> b. Juvenile is a : <input type="checkbox"/> fugitive from another state. <input type="checkbox"/> runaway from a juvenile correctional facility. and there has been no reasonable opportunity to return the juvenile. <input type="checkbox"/> c. A protective order has been issued and the child/juvenile consents in writing to the placement. <input type="checkbox"/> d. Child/juvenile has run away or committed a delinquent act while in nonsecure placement. <input type="checkbox"/> e. Juvenile is alleged/adjudicated delinquent and is a runaway from another county and would run away from nonsecure placement. <input type="checkbox"/> f. Juvenile is subject to the jurisdiction of the adult criminal court and is under 15 years of age. <input type="checkbox"/> 4. This is a secure custody placement in a jail because: (§48.209 and §938.209) <input type="checkbox"/> a. No other approved juvenile detention facility is available. <input type="checkbox"/> b. Child/juvenile is a substantial risk of physical harm to others in a juvenile detention facility.			
Name of Placement		Address	Telephone Number
Special precautions/information concerning child/juvenile/expectant mother			
Signature of Intake Worker		Date and Time Custody Authorized	Date and Time of Custody Hearing
			Date and Time of Release

Requesting Agency Complete

Intake Worker Complete

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.)

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.

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

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.*)

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):

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: _____

FOSTER PARENT CHECKLIST

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).

I. GENERAL INFORMATION (Critical Facts to Know)

Date Form Filled Out (mm/dd/yyyy)	Date Child Placed in Foster Care (mm/dd/yyyy)
-----------------------------------	---

A. Child Information

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. Parent Information

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
-------------------------	-------------------------

C. Placement Reason (Allegation)

- Yes No The child was previously in the child welfare system.
- Yes No The child was removed from his or her own home.
- Yes No The child was removed from another foster home.

D. Emergency Contact Person

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

E. Social Worker / Agency / Agency Secondary Contact

Name - Child's Social Worker With Whom Foster Parent Will Have Contact	Telephone Number - Social Worker
--	----------------------------------

Name - Social Worker's Agency	Telephone Number - Agency
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Name - Agency's Secondary Contact (e.g. supervisor)	Telephone Number - Secondary Contact <u>Regular Hours</u> <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

Hearing problems, ringing ears, discharge / infection, tubes

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

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.)

VII. OTHER NECESSARY INFORMATION

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

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).