

 WRAPAROUND MILWAUKEE POLICY & PROCEDURE	Date Issued: 6/27/01	Date Revised: 6/17/08	Section: LIAISONS	Policy No: 035	Pages: 1 of 2 (9 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date: 1/1/09	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, 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 (*see Attachment 1*) with the signature of the Supervisor and necessary attachments and forward one copy of the Referral, the Psychological Evaluation and letters of introduction/support to Diane Thompson. The Care Coordinator must maintain regular and consistent contact with all appropriate agencies until a placement 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 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 2*)
- FOSTER / KINSHIP CARE INVOICE (*see Attachment 3*)
- FOSTER / KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 4*)
- FINANCIAL ASSESSMENT REFERRAL (FAR) (*see Attachment 5*), along with a copy of the ORDER FOR TEMPORARY PHYSICAL CUSTODY (TPC) (*see Attachment 6*), **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 2*)
- FOSTER / KINSHIP CARE INVOICE (*see Attachment 3*)
- FOSTER / KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 4*)



TREATMENT FOSTER CARE REFERRAL

Youth's Name _____ DOB _____

Care Coordinator's Name _____ Phone _____ Cell/Pager _____

Supervisor's Name _____ Phone _____

Target Date for TFC Home Placement _____ Anticipated Length of TFC Home Placement _____

Permanency Plan _____

Current Living Situation _____ Date Placed _____

What is the desired outcome from the Treatment Foster Home? _____

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

Please share some strengths/supports of the Child & Family Team. _____

PHYSICAL / MEDICAL INFORMATION

Gender: ___ Male ___ Female Ethnicity _____

Approximate Height _____ Weight _____

Date of Last Physical Exam _____

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

Current Medications: ***(REQUIRED ONLY IF this information has changed since the time of the last POC.)***

Test Results *(list and attach forms signed by M.D.):* _____

Medical Concerns / Physical Limitations / Allergies: _____

MATCH FACTORS

Special Supervision Pattern Required? ___ Yes ___ No (i.e., safety, risk issues, etc.)

Explain _____

Please check all that apply:

___ Within Milwaukee County

___ Roommate

___ Outside Milwaukee County

___ Race _____

___ 2 Parent

___ Younger Children in Home

___ Single-Parent, Female

___ Older Children in Home

___ Single-Parent, Male

___ No Children in Home

___ Same Gender Partner Households

___ No Pets

Which factors are negotiable? _____

VISITATION

Indicate whether visitation will be supervised or not, include any court order requirements, frequency of contact or no contact orders. Please include parents, siblings and relatives.

Contact Allowed

<u>Name</u>	<u>Phone</u>	<u>Relationship</u>	<u>Contact Type</u>	<u>Time Frames</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Types of Contact: Supervised, Unsupervised, Phone Only, Therapy.)

(Time Frames: Hours, Days, Overnights)

NO Contact Allowed (per No Contact Court Order)

<u>Name</u>	<u>Phone</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach letter of introduction from youth and/or letters of support from the Team.

Care Coordinator's Supervisor's Signature _____ Date _____



TREATMENT FOSTER CARE REFERRAL

Supplemental Information

DO NOT SUBMIT THIS FORM IF A PLAN OF CARE EXISTS

Court Information

Type of Order: ___ CHIPS ___ Delinquent ___ JIPS ___ ProSe

Expiration Date _____

Medical Information

Current medication(s) and dosage _____

Prescribing Physician's Name _____ Phone _____

Pediatrician's or Health Clinic's Name _____ Phone _____

Psychiatric Diagnoses

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V _____

Primary Contacts

Parent/Caretaker's Name _____

Address _____

Phone Numbers: Home _____ Work _____

Parent/Caretaker's Name _____

Address _____

Phone Numbers: Home _____ Work _____

Guardian (*if other than above*) _____

Address _____

Phone Numbers: Home _____ Work _____

Child & Family Team List

<u>Name</u>	<u>Relationship</u>	<u>Phone</u>
_____	Probation Officer	_____
_____	Bureau Worker	_____
_____		_____
_____		_____
_____		_____

Family History

Coping strategies, resiliency and resources that have proven most helpful to this family in meeting their challenges.

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. 99JV0000000

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 Ave #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

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. 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

Jill Saen
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 how to fill out the form, please feel free to call Bonnie Lewitke at (414) 257-6176.

SAMPLE

Financial Assessment Referral



State of Wisconsin

Referral Date: _____

1. Enter the following information on the child for whom Title IV-E/Medicaid benefits are being requested:

Child's Name: _____ DOB: _____ SSN: _____
 Race: _____ Sex: _____ Date of Petition: _____
 F#: _____ CC# _____ Next CT Date: _____
 Child Placed At: _____ Address: _____
 Date of Placement: _____ Voluntary Court Ordered VPA/Order Date: _____
 Child Removed From the Home Of: Mother: Other: Name: _____
 Father: Relationship to Child: _____
 Mother: Phone: _____
 Name: _____ Address or LKA: _____
 Father: Phone: _____
 Name: _____ Address or LKA: _____
 Date of Removal: _____ Worker's Name: _____ Phone: _____

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

Name	Relationship to Child	SSN	DOB	US Citizen	Source of Income

3. Did the child reside with any relative during the six months prior to the month the petition was filed, other than those listed in #2?

No Yes Name/Relationship to Child: _____

4. Is the child deprived of one or both parents due to one of the following reasons:

	No	Yes	Mother	Father
Continued Absence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please enter the following information if known:

5. Was the child in receipt of AFDC-MA in the month the petition was filed or in one of the six months prior to the month the petition was filed, or was the child removed from an AFDC-MA household?

Yes No

6. Complete the following chart on the parent(s) that are absent. If both, complete both charts.

Mother's Name: _____	SSN: _____	Telephone: _____
Address: _____	DOB: _____	Race: _____
Employer's Name: _____	Telephone: _____	
Address: _____		
Health Insurance: _____		

Father's Name: _____	SSN: _____	Telephone: _____
Address: _____	DOB: _____	Race: _____
Employer's Name: _____	Telephone: _____	
Address: _____		
Health Insurance: _____		

7. Family Court Support No./Paternity No.:

Worker Signature

Date

Supervisor Signature

Date

MILWAUKEE COUNTY CHILDREN'S COURT CENTER

ORDER FOR TEMPORARY PHYSICAL CUSTODY

SECURE

NON-SECURE

IN THE INTEREST OF:

DATE OF BIRTH:

JUVENILE ID:

CCAP CASE #:

A request for temporary physical custody has been filed with the court. A hearing for temporary physical custody was held on ... which is the effective date of this order. The juvenile was represented by:

THE COURT FINDS the child/juvenile is in the jurisdiction of this court and probable cause exists to believe that the:

- 1. Juvenile will commit injury to person or property of others
2. Child/Juvenile will Cause injury to self Cause injury to others
3. Parent, guardian, legal custodian or other responsible adult is Neglecting Refusing Unable Unavailable to provide adequate supervision and care.
4. Child/Juvenile will run away or be taken away, making the child/juvenile unavailable for further court proceedings.
5. Child/juvenile is not subject to the federal Indian Child Welfare Act.
6. Parent has relinquished custody of the child.

For secure custody, the court further finds that probable cause exists to believe that:

- 1. The juvenile has committed a delinquent act and there is substantial risk of Physical harm to another Running away
2. The juvenile is a Fugitive from another state Runaway from a secure correctional facility and there has been no reasonable opportunity to return the juvenile.
3. A protective order has been issued and the child/juvenile consents in writing to the custody.
4. The child/juvenile has run away or committed a delinquent act while in non-secure custody.
5. The juvenile is alleged/adjudicated delinquent and is a runaway from another county and would run away from non-secure custody.
6. The juvenile is subject to adult criminal court jurisdiction and is under 15 years of age.

For secure custody in a jail, the court further finds that:

- 1. No other secure detention facility approved by DOC or the county is available.
2. The juvenile presents a substantial risk of physical harm to others in the secure detention facility.

For all custody outside of the home, the court further finds that:

- 1. Continuation of residence in the home at this time is contrary to the child's/juvenile's welfare because:
2. Reasonable efforts to prevent removal and return child/juvenile safely home were:
Made by the department or agency responsible for providing services while on/in: Probation Deferred Prosecution Agreement JIPS Order CHIPS Order After Care OR Alternative Programming Considered and Not Appropriate
Specifically:
Custody Intake screening process determined return home is inappropriate given seriousness of situation/offense
Specifically:
Not required under 938.355(2d) because:
Required, but good cause has been shown why sufficient information is not available to enable the court to make the necessary findings. This hearing is continued until (date): (Not to exceed 5 days)
Required, but the department or agency responsible for providing services failed to make reasonable efforts.

Juvenile's Name: _____

CCAP #: _____

- 3. **As to the department or agency recommendation:**
 - The placement location recommended by the department or agency is adopted. **OR**
 - After giving bona fide consideration to the recommendations of the department or agency and all parties, the placement location recommended is not adopted.

THE COURT ORDERS:

- 1a. The child/juvenile be
 - held in temporary secure custody
 - remain in temporary secure custody awaiting non-secure placement at: (include name and address of placement)
 - Parental Home _____
 - Relative Home _____
 - Temporary Shelter _____
 - Other _____
- 1b. The child/juvenile be held in temporary non-secure custody at: (include name and address of placement)
 - Parental Home _____
 - Relative Home _____
 - Temporary Shelter _____
 - Other _____

Special Delinquency Programs: In-House Level II

Under the Following Conditions:

- Daily School Attendance
- Cooperate with Counseling
- No Passes
- Passes at Discretion of Intake Specialist/Probation Officer
- No Association with Victim(s)
- Obey Rules of the Home
- Curfew - 24 Hours Except School
- Curfew: _____ Weekdays; _____ Weekends
- No Association with Accomplices(s)
- No Further Violations Reaching Probable Cause
- Voluntary Inpatient at CATC
- Other: _____

The Child is Released to:

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Relative | <input type="checkbox"/> Upon Request | <input type="checkbox"/> Home |
| <input type="checkbox"/> Child Welfare | <input type="checkbox"/> Sheriff | <input type="checkbox"/> Immediately | <input type="checkbox"/> EAS / LHS / SOGS |
| <input type="checkbox"/> DJC | <input type="checkbox"/> Self | | <input type="checkbox"/> Temporary Shelter |
| <input type="checkbox"/> Intake Specialist/Probation Officer | <input type="checkbox"/> Shelter Staff | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | | | |

- 2. Other conditions of custody: _____
- 3. The parent(s)/guardian shall contribute toward the expenses of custody/services in the amount of:
 - \$ _____
 - to be determined by (agency): _____
- 4. The petition for temporary physical custody is denied.

NEXT HEARING: **Branch:** _____ **Date:** _____ **Time:** _____ **AM / PM**
Type: Initial Status Plea/Disp Disp Placement Sentence Contest Other: _____

Probation Officer's / Intake Specialist's Signature: _____
Name Date

Judge's/Commissioner's Signature: _____
Name Branch Date

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. An updated plan must be submitted to the Court and/or be reviewed through our Administrative Review Panel Process after the juvenile has been in placement 6 months, 12 months, and annually thereafter as long as the juvenile remains in an out of home care placement.

This is an: Initial Permanency Plan 6 Month Permanency Plan 12 Month Permanency Plan Ongoing Permanency Plan

Honorable Judge _____ CCAP Number: _____

Hearing Date (if applicable): _____

Juvenile's Name: _____ D. O. B.: _____

Juvenile's ID Number: _____ Probation Number: _____

Juvenile's Pending / Adjudicated Offense (s): _____

Is there a concurrent CHIPS order or a pending CHIPS action? Yes No

If so, what is the CHIPS CCAP Number: _____

Assigned Intake Specialist / Probation Officer / Care Coordinator: _____

Date of Permanent Plan: _____

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: _____

FAMILY / GUARDIAN INFORMATION

Mother's Name: _____

Address: _____

Telephone: _____

Father's Name: _____

Address: _____

Telephone: _____

Who is Guardian? (Mother? Father? Both?) _____

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

Guardian's Name: _____

Address: _____

Telephone: _____

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.)* _____

Was consideration 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 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 indicated what these were for, and when and why the juvenile stopped taking them.*)

Name of Medication	Purpose	When Terminated	Why Terminated

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

Allergies / Reactions	Name of Medication (<i>if any</i>)

PLACEMENT INFORMATION

CURRENT PLACEMENT:

Lives With: _____
 Relationship: _____
 Address (unless not to be disclosed): _____
 Type of Home / Institution: _____
 Date of Current Placement: _____

List 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: _____

Name: _____
 Address: _____
 Date Placed: _____ Type of Placement: _____

Name: _____
 Address: _____
 Date Placed: _____ Type of Placement: _____

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 (<i>Respite</i>)					
Temporary Shelter (<i>Short Term</i>)					
Health Services Referral					
Financial Assistance					
Diversion Programs					
Anger Management					
Recreation Program					
Monitoring					
Mentoring					
Family Counseling/Therapy/Evaluation					
Individual Counseling/Therapy/Evaluation					
Placement with Relative (<i>Short Term</i>)					
AODA Counseling/Evaluation					
Visitation - Supervised					
Visitation - Unsupervised					
Transportation Coordination/Funding					
Other (<i>Explain</i>):					

Must discuss services considered, offered, and provided to prevent removal of to return juvenile 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: _____

CONDITIONS TO BE MET FOR THE JUVENILE TO RETURN HOME

(Mark all that apply, using M for Mother, F for Father, and B for Both)

Parent to:

- Comply with court orders, including any items in the court order which do not appear in this document
- Attend psychological evaluation / therapy
- Participate in parent education program
- Participate in therapy
- Abstain from alcohol and other drug use / abuse
- Participate in AODA counseling / support groups
- Locate housing acceptable to social worker / court
- Improve / maintain health and sanitation standards
- Participate in education / vocational skills programming
- Maintain stable living arrangement (*adequate furniture and appliances*)
- Terminate associations deemed not in a juvenile's / family's best interest
- Maintain adequate food supply
- Make / keep medical appointments and other appointments
- Cooperate with juvenile visitation plan (*regular and successful visits*)
- Be available to social worker and other service providers, including notifying of change in address and / or phone number
- Abstain from law violations
- Complete and sign necessary papers, such as consent forms, program referrals, etc.
- Cooperate in plan for rehabilitation of the child
- Other: _____

Juvenile to:

- Comply with all conditions of court orders
- Attend psychological evaluation / therapy
- Comply with rules of probation as set forth in the court order
- Comply with rules of treatment center / group home or foster home
- Attend school regularly
- Participate in AODA counseling / support groups
- Abstain from alcohol or other drug use / abuse
- Abstain from law violations
- Show evidence of improvement in special need area as a result of therapy / treatment
- Other: _____

Agency to:

- Provide services as specified
- Make referral to provider of necessary services
- Facilitate client utilization of identified services

Intake Specialist / Probation Officer Signature

Date

Supervisor's Signature

Date

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

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Community Services
DCS-872 (3/95)

WISCONSIN

INFORMATION FOR FOSTER PARENTS

TO: Foster Parent

The attached forms and information are provided to you according to s. 895.485(4)(a), Wis. Stats., and ch. HSS 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 to this child. Therefore, we must both try to gather and share information on this child. Please add information to this form whenever you gather it (for example, 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 shall 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.

Note: If the space provided on the form is not adequate, please make a note that information is continued on the back or on a separate sheet. On the back or on a separate sheet, please clearly indicate to which section or item number this information applies.

**INFORMATION FOR FOSTER PARENTS
FACE SHEET**

Date of Placement: / /

Child's Name: _____	Nickname(s): _____
DOB: <u> </u> / <u> </u> / <u> </u>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female SS#: _____
Cultural Identification (as indicated by child if old enough): _____	
Height: _____	Weight: _____ lbs.
Religious Preference (of child or family): _____	
Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations): _____	

Child's Social Worker With Whom Foster Parent Will Have Contact:	
Name: _____	Title: _____
Agency: _____	
Agency Secondary Contact (if social worker not available): _____	
Telephone: Regular Hours: () _____	After Hours: () _____

Reason(s) for Placement	
<input type="checkbox"/> Delinquent Act(s) <input type="checkbox"/> Assaultive <input type="checkbox"/> Non-Assaultive	Nature of Offense(s):
<input type="checkbox"/> CHIPS, other than CAN	Type of CHIPS:
<input type="checkbox"/> CAN <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Neglect	Relationship of Alleged Perpetrator(s) Does the child exhibit any inappropriate sexual behaviors?
<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Handicap <input type="checkbox"/> AODA <input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter) <input type="checkbox"/> Learning Disability	

This is a:

Voluntary Placement

Court-ordered Placement

Medical Assistance #: _____

Insurance Company (if any): Name _____

Telephone: () _____

Policy #: _____ Group #: _____

Physician: _____

Type: _____

Address: _____

Telephone: () _____

Dentist: _____

Address: _____

Telephone: () _____

Other Health Specialists/Therapists

Name: _____ Telephone: () _____

Specialty: _____

Name: _____ Telephone: () _____

Specialty: _____

Preferred Hospital: _____

(Note: Use of hospital may be dictated by insurance company/plan)

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

Name of

Child's

(Check most appropriate one)

Birth Mother:

Stepmother: _____

Adoptive Mother:

Address: _____

Telephone: () _____

Name of

Child's

(Check most appropriate one)

Birth Father:

Stepfather: _____

Adoptive Father:

Address: _____

Telephone: () _____

Child's

Siblings:

Name: _____ DOB: / / Phone: () _____

At home Out of home (where: _____)

Name: _____ DOB: / / Phone: () _____

At home Out of home (where: _____)

Name: _____ DOB: / / Phone: () _____

At home Out of home (where: _____)

Significant Extended Family Members (Name, Phone and Relationship):

Legal Custodian: _____

Relationship: _____

Address: _____ Phone: () _____

GAL*/Legal Counsel: _____

Address: _____

Telephone: () _____

*Guardian ad litem

Significant individuals who may be having contact with the child:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Individuals whose contact with the child is forbidden or restricted
(e.g., supervised visitation)

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

(Should you have any questions about contacts, please call the child's social worker.)

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

Type (FH, GH, RCC/CCL hospital, etc.)	Name	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Attending or Will Attend: _____

Telephone: () _____

Grade: _____

Is child enrolled in a special education program? _____ Yes _____ No

If yes, what type: _____

Contact Person: _____

Day Care or Respite Provider(s)

Phone: () _____

Phone: () _____

Does the child have specific hobbies or interests? Does the child have special abilities/talents (e.g., music, art, athletics)? Does the child prefer group or solitary activities?

Does the child have preferences that the foster parent may want to know about (e.g., favorite foods, clothing, toys, music)?

Placing agency has given the foster parent:

- Birth certificate (copy), if available
- Medical records/summary
- Social history/summary
- Court order
- Permission to operate hazardous machines
- Social Security Card
- Court report/summary
- Placement Agreement
- Summary of social/psychiatric evaluations
- Dental records/summary
- School academic records/summary
- Information on child's specific diagnosis and/or disability
- School and community activity permissions
- Summary of mental health treatment
- MA card
- Signed medical release for emergency health care

* Summary is requested to ensure that materials (e.g., psychological assessments) can be interpreted by foster parents. Primary source documents can be provided if useful for clarification.

**INFORMATION FOR FOSTER PARENTS
CHECKLIST**

				Yes	No	NK	If "Yes", please comment
Previous hospitalizations							
a. Was anesthesia used?							
b. Problems with anesthesia?							
2. Previous serious illnesses or injuries							
3. Has child had any other medical tests (e.g., CAT Scan, EEG, MRI)?							
4. Taking any medication including birth control pills or the use of birth control devices which require a prescription or other involvement of a physician? (If "Yes", name of medication, dosage, reason, prescription or over the counter, how given, by whom, who prescribed):							
5. Immunizations (Indicate date(s))							Dates (s)
DPT (infants)(Diphtheria, Pertussis, Tetanus)							
Polio (type: TOPV-Oral or IPV-Injectable)							
MMR (Measles, Mumps, Rubella)							
Flu							
Pneumonia							
Hepatitis B							
Significant biological family medical history: (e.g., cancer, heart problems)							
7. Medical needs							
Apnea monitor							
Gastrostomy							
Tracheotomy							
Ventilator							
Heart monitor							
Other (specify)							
8. Degenerative disorder							
9. Allergies, including animals, insect bites/stings, soap, wool, food, drugs, milk. (If "Yes", to what, symptoms, treatment)							
10. Child has or ever had the following: (If yes, date child had it)							Date(s)
7-day Measles							
3-day German Measles							
Chicken Pox							
Rubella							
Mumps							

		Yes	No	NK	If "Yes", please comment
	Whooping Cough				
	Scarlet Fever				
	Strep-Throat				
	Impetigo				
	Lice				
	Worms				
	Sexually Transmitted Disease				
	Hepatitis B				
	Polio				
	Pneumonia				
	Mononucleosis				
	Scabies				
	Other				
11.	Current dental problems				
	Braces or retainers?				
	Bridges or dentures?				
	Last dental exam date? _____				
12.	Appetite above or below normal				
	Balanced diet				
	Unusual eating patterns/habits (e.g., large sugar intake, no vegetables)				
13.	Abdominal Concerns				
	Has had an ulcer or heartburn				
	Child regularly uses Tums or other antacid				
	Frequent nausea or vomiting				
	Child drinks caffeinated coffee or cola. How much per day?				
	Has had "yellow jaundice" or liver disease				
	Gets abdominal pain				
	Child uses laxatives. How often?				
	Becomes constipated or gets diarrhea				
	Has had blood in stool recently				
	Special diet needs (religious, medical, philosophical, vitamin/mineral supplements, etc.)				
14.	Anorexia/bulimia/other eating disorders. Ever had treatment?				

	Yes	No	NK	If "Yes", please comment
15. Headaches Migraine				
16. Coordination or balance problems/dizziness Has had serious head injury or loss of consciousness Numbness or loss of strength in hand, arm or leg Any trouble with swallowing or speaking				
17. Has had a seizure Has had epilepsy Type and frequency of seizures How to respond Controlled or uncontrolled Ever hospitalized for seizures Ongoing medicines for seizures				
18. Does child wear glasses? If yes, for how long? Last eye exam (date, Dr.'s name) Blurred or double vision Contact lenses				
19. Has hearing problem Ringing in ears Discharge or infection in ears Tubes(s) in ears				
20. Blocking of nose, discharge, post-nasal drip Nose bleeds Persistent hoarseness				
21. Treatment for skin trouble, rashes, hives, acne, or breaking out				
22. Has had bursitis, sprain or dislocation of bone or joint Cramps or pain in legs Backaches Arthritis				
23. Thyroid problems				
24. Child has had test for AIDS/HIV (If yes, date: _____)				Results:
25. Child has had test for Hepatitis (If yes, (date: _____)				Results:

	Yes	No	NK	If "Yes", please comment
26. Chest pain or discomfort/heart concerns				
Asthma or wheezing				
Cough, phlegm, bronchitis				
Has coughed up blood				
Smoke? If yes, how long? How much?				
TB skin test. If yes, when? Results?				
Heart trouble				
Rheumatic Fever				
Has had electrocardiogram (EKG)				
Has had chest X-ray. If yes, when was last one?				
Heart murmur				
High or low blood pressure. Last check up?				
Irregular heart beat				
Shortage of breath				
Swollen ankles				
How many pillows does child sleep on?				
27. Urinary or prostate problems/Gall bladder				
Incontinence, urine or fecal				
Bleeding or burning when urinating				
Abnormally frequent urination				
Has had kidney or gall bladder stone				
28. Anemia				
29. Blood problems				
30. Cancer, leukemia, or other malignancy				
31. History of abusing or not taking prescribed medications				
32. Alcohol use or abuse				
33. Other drug use or abuse				
AODA treatment				
34. Is child menstruating?				
Child understands menstruation				
Child's periods are normal				
Excessive cramping or pain				
PMS symptoms				
Medication for cramps. If yes, what medication?				

* NK = Not Known At This Time

		Yes	No	NK	If "Yes", please comment
Bleeding or discharge other than when menstruating					
Has had a "yeast" infection					
Has had a "Pap" test. If yes, when? Why? Abnormal results?					
35.	Child has physical or developmental disabilities				
	If yes, what type of disability?				
	Autism				
	Blindness				
	Cerebral Palsy				
	Deafness				
	Dyslexia				
	Emotional Disturbance				
	Epilepsy				
	Fetal Alcohol Effect				
	Fetal Alcohol Syndrome				
	Mental Retardation				
	Muscular Dystrophy				
	Neurological Impairment				
	Physical Impairment				
	Other (specify):				
	Restrictions on Activities (e.g., lifting, driving, riding bikes)				
	Special equipment (e.g., cane, walker, wheelchair)				
36.	Considering the age of the child, his/her abilities are not appropriate for:				
	Bathing				
	Feeding				
	Toileting				
	Dressing				
	Learning				
	Receptive Language				
	Mobility				
	Danger Awareness				

		Yes	No	NK	If "Yes", please comment
	Social/Emotional Functioning				
	Capacity for Independent Living				
	Other (specify):				
37.	Limitations in verbal skills. (If yes, also check a or b below)				
	a. Child is non-verbal				
	b. Child has very limited verbal skills				
38.	History of behavioral or emotional problems				
39.	History of treatment for behavioral or emotional problems at a clinic or hospital				
40.	Someone in child's immediate family has been treated or hospitalized for emotional or mental health problems. (If yes, also check below)				
	Depression				
	Anxiety				
	Mood swings				
	Suicide attempts				
	AODA				
	Mental Health				
41.	Has the child ever:				
	Felt hopeless or depressed				
	Had unexplained crying spells				
	Planned or attempted suicide				
	Had peculiar or bizarre thoughts				
	Had trouble eating or sleeping (either too much or too little)				
	Had an excess of energy or activity				
	Felt like hurting him/her self				
	Displayed reckless or dangerous behavior				
	Heard things no one else around him/her heard				
	Shown inappropriate emotions (reactions that didn't make sense in the situation).				
	Assaulted anyone physically (if yes, who, how recently, and how severely).				
	Assaulted anyone sexually (if yes, who, how recently, and how severely).				
	Assaulted or abused animals				

* NK = Not Known At This Time

		Yes	No	NK	If "Yes", please comment
42.	Child has had any of the following problems at home or in the community.				
	Withdrawing socially (doesn't want to be around other people)				
	Lying or stealing				
	Arguing or fighting with peers or siblings				
	Clinging excessively to a parent, teacher or other person				
	Problems with police				
	Setting fires				
	Refusing to follow instructions from parents or obey house rules, etc.				
43.	Child ran away in past. (If yes, answer below).				
	For how long?				
	From where did child run?				
	Where did child go?				
	How was child returned? (Voluntarily, law enforcement, social worker?)				
	Why did child run?				
	Did/does child run alone or with others?				
44.	Child has had any of the following problems at school				
	Poor grades				
	Difficulty making friends				
	Suspensions from school				
	Fighting or arguing with peers or teachers				
	Frequent lying or stealing				
	Frequent truancy (including cutting classes)				
45.	Child has trouble sleeping. If yes, answer below:				
	Child takes sleeping pills. If yes, how often?				
	General sleeping pattern (sleep alone, cold or warm room, lights on or off, door open or closed, usual hours of sleep, naps, sleep with toy, pajamas, sleep walk, wake during night, etc.) (Circle appropriate description or describe:				

46.	Child has fears/phobias. If yes, answer below:	Yes	No	NK	If "Yes", please comment
	Darkness				
	Animals				
	Cars				
	Loud noises				
	Heights				
	Water (e.g., swimming pools, baths, lakes)				
	Weather (e.g., wind, thunder, storms)				
	Other (specify)				
47.	Child has a history of making abuse allegations against care providers				

The information included herein and the form have been shared with the foster parent. The foster parents have been made aware of the laws regarding confidentiality and the limitations on sharing any of this information with individuals or agencies not involved in the case of this child and/or his/her parents.*

Signature of Staff Person Providing Information

Date

Signature of Foster Parent

Date

Signature of Foster Parent

Date

(Two copies should be made and signed. Foster parents should keep one copy in the child's file, and the placing agency should keep one copy in the child's case record.)

* In accordance with ss. 48.396, 48.78, 48.981(7) and other relevant sections of Wisconsin Statutes.

Understanding the UNIFORM FOSTER CARE RATE

Effective January 1, 2005 -
December 31, 2006



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

MY FOSTER CHILDREN'S RECORDS	PLACEMENT DATE	LAST REVIEW RATE				
	MONTHLY RATE					
	EXCEPTIONAL RATE					
	SUPPLEMENTAL RATE					
	BASIC MAINTENANCE RATE					
	CHILD'S NAME					

What if a child, 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.

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. See also our Foster Care website at <http://dhfs.wisconsin.gov/children/foster>

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 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. There will be a 5 percent increase to all levels for the basic rate effective January 1, 2006. The new rate amounts are also included below.

Age of Child	Effective Date	
	Jan. 2005	Jan. 2006
0 - 4	\$302.00	\$317.00
5 - 11	\$329.00	\$346.00
12 - 14	\$375.00	\$394.00
15 - 18	\$391.00	\$411.00

When a foster child in your care turns 5, 12, or 15 years of age, you will receive the next highest rate effective on 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 problems, 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 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 payment.

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 mental retardation, 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.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
 Division of Children and Family Services
 GF5-834 (Rev. 11/2005)

STATE OF WISCONSIN

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 soiled 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 of this age.

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 uses sexual acting out, masturbation; 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 deviancy; 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 2006</u>
0 - 4 years	\$317.00
5 - 11 years	\$346.00
12 - 14 years	\$394.00
15 - 18 years	\$411.00

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Children and Family Services

CFS-834 (Rev. 11/2005)

STATE OF WISCONSIN

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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