**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Safety and Permanence

**INFORMATION FOR OUT-OF-HOME CARE PROVIDERS**

**PART A**

Dear Out-of-Home Care Provider:

RE:

The attached forms and information are provided to you according to ss. 48.37 and 895.485 (4)(a) Wisconsin Statutes, and ch. DCF 37, Adm. Code. We have tried to provide all of the information indicated on the forms, but we often do not have complete information at the time of placement.

This first section, Part A, contains information that is critical for the care of the child when he / she first enters placement. Some of the material is repeated elsewhere on other forms. This form should be provided within two days of the child’s placement.

The second section, Part B, contains information that is critical for out-of-home care providers to know as soon as the child first enters placement, but this section contains information that can be more difficult to obtain. Therefore, Part B may be received at a separate time from Part A. This form should be provided within seven days of the child’s placement.

Together we are partners in the provision of services for this child. Therefore, we must both try to gather and share information about 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 if we were not able to obtain it at the time of placement or learn about it at a later time.

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

All of the information regarding this 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 there are any questions regarding what information may be shared with any party (e.g., health care providers, schools, etc.), contact the child's caseworker.

**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Safety and Permanence

**INFORMATION FOR OUT-OF-HOME CARE PROVIDERS – PART A**

**Use of form:** The information contained in this form must be provided to the out-of-home care provider before the prospective out-of-home care provider agrees to placement of the child or no later than two days after the child is placed with the out-of-home care provider. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]. If additional space is needed when completing this form, attach additional sheet(s).

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| **I. GENERAL INFORMATION** |
| Date Form Filled Out (mm/dd/yyyy)      | Date Child Placed in Out-of-Home Care (mm/dd/yyyy)      |
| **A. Child Information** |
| Name (Full Legal)      | Birthdate (mm/dd/yyyy)      | Nickname(s)      |
| Primary Language      | Second Language      | Third Language      |
| Tribal Affiliation and Membership      |
| Spiritual or Religious Affiliation – Child or Family      | Preferred Place of Worship      |
| Physical Description ( e.g. clothing, glasses, hairstyle/color, teeth, braces, scars, tattoos, body piercing(s), acne, freckles, birthmarks, discolorations, injuries, etc.):      |
| [ ]  Yes | [ ]  No | The child was previously under a guardianship. |
| [ ]  Yes | [ ]  No | The child was previously adopted. |
| **B. Parent / Guardian Information** |
| Name – **Parent / Guardian 1**       | Relationship to Child      |
| Address (Street, City, State, Zip Code)      | Telephone Number – Home/Cell      | Telephone Number – Work      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |
| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?       |
| Name – **Parent / Guardian 2**       | Relationship to Child      |
| Address (Street, City, State, Zip Code)      | Telephone Number – Home/Cell      | Telephone Number – Work      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |
| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?       |
| Name – **Parent / Guardian 3**      | Relationship to Child      |
| Address (Street, City, State, Zip Code)      | Telephone Number – Home/Cell      | Telephone Number – Work      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |
| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?       |
| Name – **Parent / Guardian 4**      | Relationship to Child      |
| Address (Street, City, State, Zip Code)      | Telephone Number – Home/Cell      | Telephone Number – Work      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |

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| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?       |

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| **II. ALL ABOUT ME** |
| **The child or youth should complete this section, if he or she would like to. Completion of this section is not required**. |
| In my free time I like to (i.e. play sports, hang out with friends, visit family, play games, go outside, etc.):      |
| My best friends are:      |
| Some of my favorite foods and meals are:      |
| Some foods and meals I really dislike are:      |
| Some of my favorite books, stories, and movies are:      |
| I am closest to the following family members:      |
| I am close to these other important adults:      |
| I am in the following clubs, sports, and activities:      |
| I work at or would like to work at (this can include babysitting, lawn mowing, and more formal employment):      |
| My pets are:      |
| I like to be alone when:      |
| At night before going to bed, my favorite thing to do is:      |
| The thing that scares me the most about foster care is:      |
| Things I like about my family are:      |
| I think it’s important that you know the following about me:      |
| More than anything I hope:      |

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| **III. SIGNIFICANT CONTACTS** |
| **A. Agency Contacts** |
| Name – Child's Caseworker | Telephone Number – Caseworker |
|       | Regular Hours | After Hours |
|  |       |       |
| Name – Caseworker's Agency      | Telephone Number – Agency |
| Regular Hours | After Hours |
|  |       |       |
| Name – Caseworker’s Supervisor | Telephone Number – Supervisor |
|       | Regular Hours | After Hours |
|  |       |       |
| Name – Tribal Worker      | Telephone Number – Tribal Worker |
| Regular Hours | After Hours |
|       |       |
| **B. Emergency Contact Person** |
| Name      | Relationship      | Telephone Number      |
| Name      | Relationship      | Telephone Number      |
| **C. Persons Allowed to have Contact with Child** |
| Name      | Relationship      | Type of Contact      |
| Name      | Relationship      | Type of Contact      |
| Name      | Relationship      | Type of Contact      |
| **D. Prohibited or Restricted Contacts and Visitors** |
| Name      | Relationship      |
| Type of Restriction      | Rationale (e.g., court order, parent's / guardian’s wishes)      |
| Name      | Relationship      |
| Type of Restriction      | Rationale (e.g., court order, parent's / guardian’s wishes)      |
| Name      | Relationship      |
| Type of Restriction      | Rationale (e.g., court order, parent's / guardian’s wishes)      |
| **E. Child’s Siblings** |
| Name      | Birthdate (mm/dd/yyyy)      | Telephone Number      |
| Lives: [ ]  With parent / caregiver | [ ]  Group home | [ ]  Residential Care Center |
| [ ]  With a relative | [ ]  Foster home | [ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction? |       |
| Name      | Birthdate (mm/dd/yyyy)      | Telephone Number      |
| Lives: [ ]  With parent/ caregiver | [ ]  Group home | [ ]  Residential Care Center |
| [ ]  With a relative | [ ]  Foster home | [ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction? |       |
| Name      | Birthdate (mm/dd/yyyy)      | Telephone Number      |
| Lives: [ ]  With parent / caregiver | [ ]  Group home | [ ]  Residential Care Center |
| [ ]  With a relative | [ ]  Foster home | [ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction? |       |
| Name      | Birthdate (mm/dd/yyyy)      | Telephone Number      |
| Lives: [ ]  With parent / caregiver | [ ]  Group home | [ ]  Residential Care Center |
| [ ]  With a relative | [ ]  Foster home | [ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction? |       |
| **IV. MEDICAL INFORMATION** |
| **A. Primary Medical Providers** |
| Physician / Clinic |
| Name – Physician / Clinic      | Date of last exam      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| Dentist / Dental Clinic |
| Name – Dentist / Dental Clinic      | Date of last exam      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| Mental Health Provider(s) |
| Name – Mental Health Provider      | Date of last exam      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| [ ]  Yes | [ ]  No  | [ ]  N/A | Is the out-of-home care provider expected to participate in therapy with the child? |
| Other Physical or Mental Health Specialists or Clinics |
| Name – Other Physical or Mental Health Specialist or Clinic      | Specialty      | Telephone Number      |
| Name – Other Physical or Mental Health Specialist or Clinic      | Specialty      | Telephone Number      |
| Name – Other Physical or Mental Health Specialist or Clinic      | Specialty      | Telephone Number      |
|  |  |  |
| **B. Preferred Hospital/ Clinic Note: Use of a hospital may be dictated by insurance company / plan** |
| Name      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| Name      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| **C. Health Insurance Coverage** |
| Medicaid Assistance (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.      |
| Other Health Insurance Provider |
| Name      |
| Telephone Number      | Insurance Policy Number      | Insurance Policy Group Number      |
| **D. Medical Diagnoses** |
| [ ]  Yes | [ ]  No | The child has chronic physical, mental or emotional needs. | Specify:      |
| [ ]  Yes | [ ]  No | The child has had a hospitalization, surgery, emergency medical need, or significant illness in the last six months. | Specify:      |
| [ ]  Yes | [ ]  No | The child has identified special health care needs. | Specify:      |
| **E. Medications** |
| [ ]  Yes | [ ]  No | The child is currently prescribed medication(s). Specify: |
| Name – Medication      | Dosage / Frequency      |
| Reason for Medication      | Name – Prescribing Physician      |
| Length Prescribed      | Address – Prescribing Physician      |
| [ ]  Yes | [ ]  No | Is this a psychotropic medication? |
| [ ]  Yes | [ ]  No | Has this medication been provided to the out-of-home care provider?  | Specify:      |
| Name – Medication      | Dosage / Frequency      |
| Reason for Medication      | Name – Prescribing Physician      |
| Length Prescribed      | Address – Prescribing Physician      |
| [ ]  Yes | [ ]  No | Is this a psychotropic medication? |
| [ ]  Yes | [ ]  No | Has this medication been provided to the out-of-home care provider?  | Specify:      |
| Name – Medication      | Dosage / Frequency      |
| Reason for Medication      | Name – Prescribing Physician      |
| Length Prescribed      | Address – Prescribing Physician      |
| [ ]  Yes | [ ]  No | Is this a psychotropic medication? |
| [ ]  Yes | [ ]  No | Has this medication been provided to the out-of-home care provider? | Specify:      |
| Name – Medication      | Dosage / Frequency      |
| Reason for Medication      | Name – Prescribing Physician      |
| Length Prescribed      | Address – Prescribing Physician      |
| [ ]  Yes | [ ]  No | Is this a psychotropic medication? |
| [ ]  Yes | [ ]  No | Has this medication been provided to the out-of-home care provider? | Specify:      |
| **F. Medical or Mental Health Appointments** |
| [ ]  Yes | [ ]  No | The child has currently scheduled medical or mental health appointments | Specify:      |
| **Date (mm/dd/yyyy)** | **Time** | **Name – Provider** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| When is the child due for a periodic well child care exam? (Per DCF 56, children in out-of-home care must receive well child medical examinations in accordance with the schedule of the Wisconsin EPSDT/HealthCheck program): |
| [ ]  | Birth – 1 month |
| [ ]  | 2 months |
| [ ]  | 4 months |
| [ ]  | 6 months |
| [ ]  | 9 months |
| [ ]  | 12 months |
| [ ]  | 15 months |
| [ ]  | 18 months |
| [ ]  | 24 months |
| [ ]  | 30 months |
| [ ]  | 36 months |
| [ ]  | Annually from 3 – 6 years |
| [ ]  | Every other year from 6 – 21 years |
| **G. Immunizations** |
| [ ]  Yes | [ ]  No | The child’s immunizations are up-to-date. | Specify:      |
| **Immunization Record** |
| Immunization | Date(s) Administered |
|       |       |
|       |       |
|       |       |
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| **V. ADDITIONAL INFORMATION** |
| **A. School / Child Care Information** |
| **School / Child Care Currently Attending or Most Recently Attended** |
| Name      | Telephone Number      |
| Address (Street, City, State, Zip Code)      | Grade Level      |
| School Contact Individual      | Contact Information      |
| [ ]  Yes | [ ]  No | The school district has been notified of the child’s placement (if age two or older). | Specify:      |
| [ ]  Yes | [ ]  No | The child is less than age five and attends child care that is not early education, pre-school, or 4K. | Specify:      |
| [ ]  Yes | [ ]  No | The child is less than age five and does not attend early education or day care. | Specify:      |
| [ ]  Yes | [ ]  No | The child is in an early intervention program. | Specify:      |
| [ ]  Yes | [ ]  No | The child is in pre-school. | Specify:      |
| [ ]  Yes | [ ]  No | The child is in kindergarten. | Specify:      |
| [ ]  Yes | [ ]  No | The child is in regular education. | Specify:      |
| [ ]  Yes | [ ]  No | The child is in special education. | Specify:      |
| [ ]  Yes | [ ]  No | The child has an individualized education plan (IEP). | Specify:      |
| [ ]  Yes | [ ]  No | The child has a support plan (i.e. behavioral, academic, etc.). | Specify:      |
| [ ]  Yes | [ ]  No | The child is in day treatment. | Specify:      |
| [ ]  Yes | [ ]  No | The child was attending school but is currently listed as missing from out-of-home care placement. | Specify:      |
| [ ]  Yes | [ ]  No | The child is of school age but is not attending school. | Specify:      |
| **Previous School(s) Attended** |
| Name      | Telephone Number      |
| Address (Street, City, State, Zip Code)      | Grade(s) Attended      |
| Name      | Telephone Number      |
| Address (Street, City, State, Zip Code)      | Grade(s) Attended      |
| **B. Emotional / Behavioral Information** |
| [ ]  Yes | [ ]  No | The child is believed to have emotional or behavioral needs. | Specify:      |
| [ ]  Yes | [ ]  No | [ ]  Unknown | Does the child have any existing behavioral health / mental health diagnosis? | Specify:      |
| [ ]  Yes | [ ]  No | [ ]  Unknown | Has the child received behavioral or emotional health services in the past? | Specify:      |
| **C. Life Functioning Information** |
| **Formula and Feeding Restrictions** |
| [ ]  Yes | [ ]  No | The child is currently fed with formula. | Specify brand, type, amount, and current feeding schedule:      |
| [ ]  Yes | [ ]  No | The child has feeding restrictions; e.g., solids, cups or bottles, swallowing problems, allergies, or dietary restrictions or issues. | Specify:      |
| [ ]  Yes | [ ]  No | The child is fed by G-tube. | Specify:      |
| **Special Medical Equipment Needs** |
| [ ]  Yes | [ ]  No | The child has special medical equipment needs; e.g., monitor, feeding tube, oxygen, ventilator, wheelchair, splints / braces.  | Specify:      |
| **Allergies** |
| [ ]  Yes | [ ]  No | The child has allergies, such as allergies to: Medications, animals, insect bites / stings, foods (including nuts and / or dairy), fabrics, soaps, grass, trees, ragweed, wool, etc. |
| Allergy Type: | Specify details, including reactions. |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| If the child has an allergy, is there an emergency protocol for exposure?  | Specify for each Allergy Type:       |
| **Asthma** |
| [ ]  Yes | [ ]  No | Does the child have asthma? | Describe the conditions that trigger an asthma attack and any emergency protocol.      |
| **Therapeutic Exercises / Activity Restrictions** |
| [ ]  Yes | [ ]  No | Frequent therapeutic exercises done by the child with the provider’s help. | Specify nature of those exercises.      |
| [ ]  Yes | [ ]  No | The child is restricted from certain activities; e.g., strenuous exercise, climbing stairs, etc. | Specify activity(s).      |
| **Other** |
| Describe any life functioning needs not previously mentioned. |       |
| **D. Additional Information** |
| Describe any additional information critical to the care of the child. |       |
| **VI. REASONABLE AND PRUDENT PARENTING CONSIDERATIONS** |
| “Reasonable and prudent parent standard” means a standard for an out-of-home care provider to use in making decisions concerning a child’s participation in age or developmentally appropriate extracurricular, enrichment, cultural, and social activities that is characterized by careful and sensible parental decisions that maintain the health, safety, best interests, and cultural, religious, and tribal values of the child while at the same time encouraging the emotional and developmental growth of the child. |
| **A. Cultural, Religious, and Tribal Considerations** |
| For this child take into account the following cultural, religious, and tribal considerations when making prudent parenting decisions: | Specify:       |
| **B. Recreational Activities** |
| This child engages in or would like to participate in the following recreational activities, sports, and / or extra-curricular activities (e.g. birthday parties, movies, volunteering, dances, etc.): | Specify:       |
| For this child, consider the restrictiveness of the placement and whether he / she has the necessary training and safety equipment to safely participate in the activity under consideration. | Specify:       |
| For this child, consider his / her age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions: | Specify:       |
| This child is prohibited from participating in the following recreational activities (i.e. prohibited due to his / her age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.): | Specify:       |
| **C. Transportation** |
| This child engages in or would like to participate in the following activities related to transportation (e.g. obtaining his / her driver’s license, driving / carpooling with peers and other adults, etc.): | Specify:       |
| For this child, consider the restrictiveness of the placement and whether he / she has the necessary training and safety equipment to safely participate in the activity under consideration. | Specify:       |
| For this child, consider his / her age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions: | Specify:       |
| This child is prohibited from participating in the following activities related to transportation (i.e. prohibited due to his / her age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.): | Specify:       |
| **D. Employment** |
| This child engages in or would like to participate in the following activities related to employment (e.g. informal employment, babysitting, lawn mowing, formal employment, banking and bank accounts, etc.): | Specify:       |
| For this child, consider the restrictiveness of the placement and whether he / she has the necessary training and safety equipment to safely participate in the activity under consideration. | Specify:       |
| For this child, consider his / her age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions: | Specify:       |
| This child is prohibited from participating in the following activities related to employment (i.e. prohibited due to his / her age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.): | Specify:       |
| **E. Peer Relationships** |
| This child engages in or would like to participate in the following activities related to peer relationships (e.g. visiting friends, having friends over, overnight stays with friends, dating, etc.): | Specify:       |
| For this child, consider the restrictiveness of the placement and whether he / she has the necessary training and safety equipment to safely participate in the activity under consideration. | Specify:       |
| For this child, consider his / her age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions: | Specify:       |
| This child is prohibited from participating in the following activities related to peer relationships (i.e. prohibited due to his / her age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.): | Specify:       |
| **F. Personal Expression** |
| This child engages in or would like to participate in the following activities related to personal expression (e.g. haircuts, hair dying, clothing choices, explicit material, R-rated movies, games or music, etc.): | Specify:       |
| For this child, consider the restrictiveness of the placement and whether he / she has the necessary training and safety equipment to safely participate in the activity under consideration. | Specify:       |
| For this child, consider his / her age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions: | Specify:       |
| This child is prohibited from participating in the following activities related to personal expression (i.e. prohibited due to his / her age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.): | Specify:       |
| **G. Other** |
| Other activities the child engages in or would like to engage in: | Specify:       |
| For this child, consider the restrictiveness of the placement and whether he / she has the necessary training and safety equipment to safely participate in the activity under consideration. | Specify:       |
| For this child, consider his / her age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions: | Specify:       |
| This child is prohibited from participating in the following activities (i.e. prohibited due to his / her age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.): | Specify:       |

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|   **SIGNATURES** |

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|       |  |       |
|  **SIGNATURE** – Placing Caseworker |  | Date Signed |

|  |  |  |
| --- | --- | --- |
|       |  |       |
|  **SIGNATURE** – Out-of-Home Care Provider |  | Date Signed |

|  |  |  |
| --- | --- | --- |
|       |  |       |
|  **SIGNATURE** – Out-of-Home Care Provider |  | Date Signed |