[To see "INSTRUCTIONS," click paragraph symbol ¶ on "Home" tab at top of your computer screen.]

CHILD WELFARE COMMUNICATION

PART A: ***Please complete <u>one form for each child</u> for whom assistance is requested.***

Please select program: ☐ Relative Caregiver Program (RCP) ☐ Non-Relative Caregiver Financial Assistance (NCFA)
☐ Foster Care Board Payment ☐ Other: _____

Date: _____ Region/Circuit: _____ Case Number: _____

Child's Name: _____ DOB: _____

Race: _____ SSN: _____ Sex: _____

Caregiver's Name: _____ Phone Number: _____

Address: _____

PART B: Child's Information (To be completed by CBC/Contracted Provider)

Date Child Adjudicated Dependent: _____

Date Home Study Completed in FSFN: _____

Date Court Approved Placement: _____ FSFN Child ID: _____

<u>Has the family been assessed for Level I Licensure and/or GAP</u>? ☐ YES ☐ NO

PART C: Complete only for RCP when the child in Part "B" above is a <u>half-sibling</u> who is not related to the caregiver.

Name of the child in the placement who is related to the Caregiver: _____

DOB: _____ Race: _____ Sex: _____ SSN: _____

Date Child Adjudicated Dependent: _____ Date Home Study Completed: _____

Date Court Approved Placement: _____ FSFN Child ID: _____

☐ Check if this child who is related to the caregiver has a Relative Caregiver Program payment or application.

PART D: Complete for Caregivers who receive a Foster Care Board Payment.

Foster Care Payment Begin Date: _____ Amount of Payment: _____

PART E: Request to END a Placement with a Caregiver receiving NCFA.

FSFN Child ID: _____

Placement End Date: _____ Placement End Time: _____

<u>Please select one of the below:</u>

☐ Ending Purpose: Admin Change Within Removal Epsd Ending Reason: _____

☐ Ending Purpose: Discharge from Removal Epsd Ending Reason: _____

☐ Ending Purpose: Placement Change w/in Removal Epsd End'g Reason: _____

PART F: Request to update Permanency Goal.

Parent's Name (Print): _____ SSN: _____ DOB: _____

Current Permanency Goal: _____

PART G: To be completed by Office of CBC/Contracted Provider.

Name (Print): _____ Date: _____

Phone: _____ Office Location/Unit: _____

Other Comments: _____

Signature: _____

CBC/Contracted Provider fax to 1-866-886-4342