**DCF 12 NEGATIVE ACTION NOTICE**

**Use of form:** Use of this form is voluntary. However, the information requested on this form must be provided pursuant to s. DCF 12.07, Wis. Admin. Code. Information collected on this form will be entered into the Department of Children and Families' Children's License Denial database which lists individuals whose application for a license, or adoption is denied or whose license is revoked or not renewed (negative actions) for reasons specified in the list of offenses affecting caregiver eligibility, DCF 12, Adm. Code, Appendix A. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes]. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay.

**Instructions:** Complete a separate form for each person subject to the negative action taken. Send the completed form to the address listed at the bottom of the form.

|  |
| --- |
| **Action Requested:** |
| [ ]  Add New Record | [ ]  Modify Previously Created Record | [ ]  Delete Previously Created Record |
| [ ]  Appeal Has Overturned Finding | [ ]  Other:       |
| **I.** | **Individual Against Whom the Negative Action Was Taken** |
|  | Name (Last, First, Middle)      | Social Security Number      | Birthdate (mm/dd/yyyy)      |
| **II.** | **License / Certification Type (Check one)** |
|  | [ ]  Adoption [ ]  Foster Home |
| **III.** | **Negative Action Taken** |
|  | Check appropriate box below[ ]  Denial [ ]  Revocation [ ]  Non-Renewal | Date action taken (mm/dd/yyyy)      |
|  | Reason action taken[ ]  Substantiated finding of child abuse or neglect [ ]  Criminal conviction [ ]  Misappropriation of client's property |
|  | If criminal conviction, cite statute indicating specific crime(s) from Offenses List (DCF 12–Appendix A). For example: 940.01.      |
| **IV.** | **Agency Taking the Negative Action** |
|  | Agency Type (Check one)[ ]  Child Placing Agency (CPA) [ ]  County [ ]  Tribe |
|  | Name – CPA      | Facility ID Number      |
|  | Name – County / Tribe      | County / Tribe Number      |
| **V.** | **Person Completing Form** |
|  | Name      | Telephone Number      |
|  | Title      |
|  | Email Address [ ]  Check if no email address.      |
|  |  |  |  |  |
|  | **SIGNATURE** –Person Completing Form | Date Signed |

Immediately send completed forms to :

|  |  |  |  |
| --- | --- | --- | --- |
| **Mail:** | DCF/DSPOut-of-Home Care SectionP.O. Box 8916Madison, WI 53708-8916 | **Fax:** | 608-422-7157 |