**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Milwaukee Child Protective Services

**Intensive In-Home Services Extension Request**

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| Date of Request | | | |
| Name – IIHS Agency | | | Case Transfer Staffing Date |
| Name – IIHS Supervisor | | | W Number |
| Name – IIHS Specialist | | Case Head | |
| Name – Program Manager | | | |
| Date of Request Approval by Program Manager | | | |
| Yes  No Does the family agree with extension of services? | | | |
| Date of CANS Reassessment | | Child’s Level of Need | |
| Reason for Request. Provide a brief description of progress to date and remaining safety concerns. | | | |
| Specify remaining goals and current barriers. | | | |
| Describe plan to resolve barriers. Include services / providers currently in place that need to continue or new service(s) to be added and how they will alleviate remaining safety concerns. | | | |
| **To be completed by Division of Milwaukee Child Protective Services pogram evaluation manager or designee** | | | |
| **Date Request Received** | | | |
| **Review Decision**  Approved  Staffing Required  Denied | **Review Decision Date** | | **Extension Date** |
| **COMMENTS** | | | |