**Statement of Support**

**Use of form:** Wisconsin Admin. Code s. DCF 57.485(2)(a) requires prospective group home licensees to obtain a statement of support from a public child placing agency (one or more counties, the Division of Milwaukee Child Protective Services, or the Department of Corrections) to document need for the proposed facility. Use of this form is voluntary but strongly recommended to help provide the Department of Children and Families with information contributing to an accurate assessment of the need for the proposed placement resource. By submitting this form, your agency is stating that the specific proposed additional placement resource is needed. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)m), Wisconsin Statutes].

**Instructions:** Complete each section of this form in detail regarding the proposed provider. Please be aware that, aligned with the Family First Prevention Services Act (FFPSA) and Wisconsin’s commitment to putting families first, DCF’s focus is on serving children with their families and in their communities, not on increasing congregate care placements. Prior to applying for a group home or residential care center license, the Department must assess and determine the need for such a facility. Therefore, we are asking that you provide the following information in your statement of support of this proposed facility. If a statement of support is provided by a county, it should be signed by the county human/social services director or their designee, who attests that this has been reviewed and supported by the agency director. Submit completed forms to the Department via email at dcfcwlneedsdetermination@wisconsin.gov.

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| **PROPOSED PROVIDER** |
| Name – Proposed Provider       |
| **AGENCY PROVIDING STATEMENT OF SUPPORT** |
| Agency Name – (County Name, DMCPS, DOC)      |
| Number of current Out of Home (OHC) placements:      |
| Describe the specific service or placement gaps you are seeking to address through placement with this specific proposed provider:      |
| Describe your understanding of the proposed provider’s plan, service array, and how this particular facility would address your need for OHC placements:      |
| [ ]  Yes [ ]  No Is the proposed location within your county?If “no” discuss how this will impact your use of this potential placement resource:      |
| Additional information considered when making the decision to support this specific proposed provider:      |
| [ ]  Attach program description provided by potential provider. |
| **PERSON COMPLETING STATEMENT** |
| **Full Name**      | **Title**      |
| **Email Address**       | **Telephone Number**      |
| **Signature**       | **Date** (mm/dd/yyyy)      |