

ICPC SENDING STATE PRIORITY HOME STUDY REQUEST

Use of form: Complete this form to request priority home study for out-of-state placement of child(ren) per Regulation No. 7 of ICPC (s. 48.988, Wis. Stats.) Confidential information on this form will be used for identification purposes only. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Send completed form to: Department of Children and Families
 Division of Safety and Permanence
 Bureau of Permanence and Out-of-Home Care
 ATTN: ICPC Unit
 201 E. Washington Avenue, Rm. E200
 Madison, WI 53703

CHILD

| | | |
|---|--|---|
| Name – Child to be Placed (Last, First, MI) | Birthdate (mm/dd/yyyy) | Hispanic / Latino <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Race (Check one) | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White | |

PARENT

| | |
|---------------------------------|---------------------------------|
| Name – Mother (Last, First, MI) | Name – Father (Last, First, MI) |
|---------------------------------|---------------------------------|

PROPOSED CAREGIVER

| | | |
|---|---|---------------------------|
| Name (Last, First, MI) | Address (Street, City, State, Zip Code) | |
| Marital Status (Check one) | Name – Person Caregiver is Living With | Relationship to Caregiver |
| <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> M <input type="checkbox"/> Widowed <input type="checkbox"/> Sep. | | |
| Social Security Number | Best Time of Day to Contact Caregiver | Telephone Number – Home |
| | <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | |
| Caregiver's Relationship to Child | Name – Caregiver's Employer | Telephone Number – Work |

ALTERNATE CONTACT

| | |
|---|------------------|
| Name (Last, First, MI) | Telephone Number |
| Address (Street, City, State, Zip Code) | |

CHILD'S ASSESSMENT

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Case Plan is attached. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Financial / Medical Plan (CFS-2196) is attached. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child has special needs. If "Yes", describe. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child has handicaps - mental / physical. If "Yes", describe. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child has service needs / treatment requirements. If "Yes", describe. |

School Information

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other required, pertinent information regarding child and family will follow. |
|--|---|

| | |
|------------------------------|------------------|
| Name – Social Worker (Print) | Telephone Number |
|------------------------------|------------------|

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|---------------------------|-------------|
| SIGNATURE – Social Worker | Date Signed |
|---------------------------|-------------|

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| SIGNATURE – Supervisor (If required) | Date Signed | Telephone Number |
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