**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**      |