**Preapproval to Begin Child Specific Planning for Level 5 Foster Home**

**Use of Form:** This form should be submitted to the DCF Level 5 Exceptions Panel when requesting approval to start the development and planning of a Level 5 Exceptional Treatment Foster Home. Completion of this form fulfills requirements under Ch. DCF 56.13(7)(b) Admin. Code to clarify specific and limited circumstances prior to submitting an application for certification of or placement in a Level 5 Exceptional Treatment Foster Home Personal. Information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Information:** Creation of and placement into a Level 5 Exceptional Treatment Foster Home requires a demonstration of need by the placing agency. This includes all of the following: a child whose behaviors or conditions require a high degree of supervision and overnight awake care that is provided by program staff who rotate shifts within a 24-hour period; the child will benefit from a home-like environment that has fewer children than a group home or residential care center for children and youth; and the child is expected to need long-term care into adulthood, or the child has needs agreed to by the department.

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| Placing Agency Name | | | | | Date of Request | | |
| Child Welfare Professional Full Name | | | | | | | |
| Child Welfare Professional Email Address | | Child Welfare Professional Phone Number | | | | | |
| Supervisor Full Name | | | | | | | |
| Supervisor Email Address | | Supervisor Phone Number | | | | | |
| **Child Specific Information:** | | | | | | | |
| Child Full Name | | | Date of Birth | | | eWiSACWIS ID Number | |
| Identify the category that best describes the needs of the child to be served:  Long-term Care (The child has severe intellectual and/or developmental disabilities, or intensive medical needs)  Other needs to be reviewed by the department. Describe: | | | | | | | |
| List the child’s Level of Need from CANS Assessment: | | Date CANS was completed: | | | | | |
| Yes  No Has the child been referred to the Children’s Long-Term Support (CLTS) Program?  If Yes, provide the following information: | | | | | | | |
| Yes  No Has the child been screened for eligibility for the CLTS Program? | | | | | | | |
| Describe the child’s eligibility determination: | | | | | | | |
| If No, describe why not: | | | | | | | |
| Describe the child’s strengths. | | | | | | | |
| Describe the child’s behaviors. | | | | | | | |
| Describe the child’s diagnosis and medications. | | | | | | | |
| Describe the supervision and care needs of the child. | | | | | | | |
| Describe why awake overnight care is necessary to meet the needs of this child. | | | | | | | |
| Describe the child’s permanency goal and long-term care needs as they transition into adulthood. | | | | | | | |
| Describe the services, programs, and placements that have been provided to the child and family. | | | | | | | |
| Describe the services, programs, and placements that were assessed and determined to be unavailable or not in the best interest of the child. Include a timeline of when those services, programs and placements were considered. | | | | | | | |
| Describe why placement in a Level 5 Foster Home the best and most appropriate placement option to meet the child’s specific needs. | | | | | | | |
| Describe any restrictive measures that are being used in the current placement and what the plans are to address any behavioral needs to avoid the use of restrictive measures in the Level 5 Exceptional Treatment Foster Home. | | | | | | | |
| I understand that this is a request to move forward with consideration of placement or the operation of a Level 5 Exceptional Treatment Foster Home. Further approval, following a full application (form DCF-F-2559-E), is required prior to certification of or placement in a Level 5 Exceptional Treatment Foster Home. | | | | | | | |
| I understand that an approval is only an approval for the proposed placement and is not connected to any decisions regarding Children’s Long-Term Support (CLTS) Program requests for additional funding. Requests for additional CLTS funding must be approved through another process with the Department of Health Services (DHS). | | | | | | | |
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|  | **SIGNATURE** –Child Welfare Professional | | |  | | Date Signed |  |
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|  | **SIGNATURE** –Supervisor | | |  | | Date Signed |  |
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| **FOR DEPARTMENT USE ONLY:** | | | | | | |
| Request to Move Forward with Application is:  Approved  Denied | |  | If approved, approval is valid for 1 year from date of signature.  Date of Decision: | | | |
| Additional Notes, if applicable: | | | | | | |
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|  | **SIGNATURE** – DCF Level 5 Exceptions Panel Chairperson | | |  | Date Signed |  |
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