**Information for Out-Of-Home Care Providers**

**Part A**

Dear Out-of-Home Care Provider:

RE:

The attached forms and information are provided to you pursuant to Wis. Stat. s. 48.37 and 895.485 (4)(a), and pursuant Wis. Admin Code ch. DCF 37. The placing agency has provided all of the information available at the time of completing this form.

This first section, Part A, contains information that is critical for the care of the child when they first enter placement. This form should be provided within two days of the child’s placement.

The second section, Part B, contains information that is critical for out-of-home care providers to know as soon as the child first enters placement, but this section contains information that can be more difficult to obtain. Therefore, Part B may be received at a separate time from Part A. Part B should be provided within seven days of the child’s placement.

The child welfare professional will partner with you in the provision of services for this child. Therefore, the child’s treatment team must gather and share information about this child and add information as it is obtained, e.g., from the child or their family or from a physician. The child’s child welfare professional will also continue to provide you with information as it is learned throughout the duration of the child’s placement.

All of the information regarding this child provided on this form and in any other manner is done so with the expectation that it remains confidential. State and federal statutes require that this information be kept confidential. If there are any questions regarding what information may be shared with any party (e.g., health care providers, schools, etc.), contact the child's child welfare professional.

**Information for Out-Of-Home Care Providers – Part A**

**Use of form:** The information contained in this form must be provided to the out-of-home care provider before the prospective out-of-home care provider agrees to placement of the child or no later than two days after the child is placed with the out-of-home care provider. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]. If additional space is needed when completing this form, attach additional sheet(s).

|  |
| --- |
| **I. GENERAL INFORMATION** |
| Date Form Filled Out (mm/dd/yyyy)      | Date Child Placed in Out-of-Home Care (mm/dd/yyyy)      |
| **A. Child Information** |
| Full Name (Legal)      | Birthdate (mm/dd/yyyy)      |
| Nickname(s)      |
| Primary Language      | Second Language      | Third Language      |
| Tribal Affiliation and Membership      |
| Spiritual or Religious Affiliation – Child or Family      |
| Preferred Place of Worship      |
| Physical Description (e.g., clothing, glasses, hairstyle / color, teeth, braces, scars, tattoos, body piercing(s), acne, freckles, birthmarks, discolorations, injuries, etc.):      |
| [ ]  Yes [ ]  No The child was previously under a guardianship. |
| [ ]  Yes [ ]  No The child was previously adopted. |
| **B. Parent / Guardian Information** |
| **Parent / Guardian 1** Full Name      | Telephone Number – Home / Cell      |
| Relationship to Child      | Telephone Number – Work      |
| Address (Street, City, State, Zip Code)      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |
| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?      |
| **Parent / Guardian 2** Full Name      | Telephone Number – Home / Cell      |
| Relationship to Child      | Telephone Number – Work      |
| Address (Street, City, State, Zip Code)      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |
| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?      |
| **Parent / Guardian 3** Full Name      | Telephone Number – Home / Cell      |
| Relationship to Child      | Telephone Number – Work      |
| Address (Street, City, State, Zip Code)      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |
| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?      |
| **Parent / Guardian 4** Full Name      | Telephone Number – Home / Cell      |
| Relationship to Child      | Telephone Number – Work      |
| Address (Street, City, State, Zip Code)      |
| [ ]  Yes [ ]  No Is this person the child’s legal guardian? |
| [ ]  Yes [ ]  No Is contact with parent / guardian supervised? If yes, who is responsible for supervision?      |
| **II. ALL ABOUT ME** |
| **The child or youth should complete this section if they would like to. Completion of this section is not required**. |
| In my free time I like to (i.e., play sports, hang out with friends, visit family, play games, go outside, etc.):      |
| My best friends are:      |
| Some of my favorite foods and meals are:      |
| Some foods and meals I really dislike are:      |
| Some of my favorite books, stories, and movies are:      |
| I am closest to the following family members:      |
| I am close to these other important adults:      |
| I am in the following clubs, sports, and activities:      |
| I work at or would like to work at (this can include babysitting, lawn mowing, and more formal employment):      |
| My pets are:      |
| I like to be alone when:      |
| At night before going to bed, my favorite thing to do is:      |
| The thing that scares me the most about foster care is:      |
| Things I like about my family are:      |
| I think it’s important that you know the following about me:      |
| More than anything I hope:      |
| **III. SIGNIFICANT CONTACTS** |
| **A. Agency Contacts** |
| **Child's Child Welfare Professional** |
| Full Name      |
| Telephone Number During Regular Hours      | Telephone Number After Hours      |
| **Child Welfare Professional’s Agency** |
| Full Name      |
| Telephone Number During Regular Hours      | Telephone Number After Hours      |
| **Child Welfare Professional’s Supervisor** |
| Full Name      |
| Telephone Number During Regular Hours      | Telephone Number After Hours      |
| **Tribal Child Welfare Professional** |
| Full Name      |
| Telephone Number During Regular Hours      | Telephone Number After Hours      |
| **B. Emergency Contact Person** |
| **Emergency Contact 1** Full Name      |
| Relationship to Child      | Telephone Number      |
| **Emergency Contact 2** Full Name      |
| Relationship to Child      | Telephone Number      |
| **C. Persons Allowed to have Contact with Child** |
| **Allowed Person 1** Full Name      |
| Relationship to Child      | Type of Contact      |
| **Allowed Person 2** Full Name      |
| Relationship to Child      | Type of Contact      |
| **Allowed Person 3** Full Name      |
| Relationship to Child      | Type of Contact      |
| **D. Prohibited or Restricted Contacts and Visitors** |
| **Restricted Person 1** Full Name      |
| Relationship to Child      | Type of Restriction      |
| Rationale (e.g., court order, parent's / guardian’s wishes)      |
| **Restricted Person 2** Full Name      |
| Relationship to Child      | Type of Restriction      |
| Rationale (e.g., court order, parent's / guardian’s wishes)      |
| **Restricted Person 3** Full Name      |
| Relationship to Child      | Type of Restriction      |
| Rationale (e.g., court order, parent's / guardian’s wishes)      |
| **E. Child’s Siblings** |
| **Sibling 1** Full Name      |
| Birthdate      | Telephone Number      |
| Lives:[ ]  With parent / caregiver [ ]  With a relative [ ]  Group home [ ]  Foster home [ ]  Residential Care Center[ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when, and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction?      |
| **Sibling 2** Full Name      |
| Birthdate      | Telephone Number      |
| Lives:[ ]  With parent / caregiver [ ]  With a relative [ ]  Group home [ ]  Foster home [ ]  Residential Care Center[ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when, and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction?      |
| **Sibling 3** Full Name      |
| Birthdate      | Telephone Number      |
| Lives:[ ]  With parent / caregiver [ ]  With a relative [ ]  Group home [ ]  Foster home [ ]  Residential Care Center[ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when, and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction?      |
| **Sibling 4** Full Name      |
| Birthdate      | Telephone Number      |
| Lives:[ ]  With parent / caregiver [ ]  With a relative [ ]  Group home [ ]  Foster home [ ]  Residential Care Center[ ]  Other – Specify:       |
| Sibling Interaction Plan: How, when, and at what frequency sibling interactions will occur. Is the out-of-home care provider responsible to facilitate this interaction?      |
| **IV. MEDICAL INFORMATION** |
| **A. Primary Medical Providers** |
| **Physician / Clinic** |
| Name      | Date of last exam (mm/dd/yyyy)      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| **Dentist / Dental Clinic** |
| Name      | Date of last exam (mm/dd/yyyy)      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| **Mental Health Provider(s)** |
| Name      | Date of last exam (mm/dd/yyyy)      |
| Address (Street, City, State, Zip Code)      | Telephone Number      |
| [ ]  Yes [ ]  No [ ]  N/A Is the out-of-home care provider expected to participate in therapy with the child? |
| **Other Physical or Mental Health Specialists or Clinics** |
| **Other Specialist or Clinic 1** Name      | Telephone Number      |
| Specialty      |
| **Other Specialist or Clinic 2** Name      | Telephone Number      |
| Specialty      |
| **Other Specialist or Clinic 3** Name      | Telephone Number      |
| Specialty      |
| **B. Preferred Hospital / Clinic Note: Use of a hospital may be dictated by insurance company / plan** |
| **Preferred Hospital or Clinic 1** Name      | Telephone Number      |
| Address      |
| **Preferred Hospital or Clinic 2** Name      | Telephone Number      |
| **C. Health Insurance Coverage** |
| **Medicaid Assistance (MA) Card** |
| [ ]  Yes [ ]  No Has the out-of-home care provider been given the child's MA card (regular or temporary)? If no, describe how and when it will be provided.      |
| **Other Health Insurance Provider** |
| Name      |
| Telephone Number      | Insurance Policy Number      | Insurance Policy Group Number      |
| **D. Medical Diagnoses** |
| [ ]  Yes [ ]  No The child has chronic physical, mental or emotional needs. If yes, specify:      |
| [ ]  Yes [ ]  No The child has had a hospitalization, surgery, emergency medical need, or significant illness in the last six months. If yes, specify:      |
| [ ]  Yes [ ]  No The child has identified special health care needs. If yes, specify:      |
| **E. Medications** |
| [ ]  Yes [ ]  No The child is currently prescribed medication(s). If yes, specify: |
| **Medication 1** Name      | Dosage / Frequency      |
| Reason for Medication      | Length Prescribed      |
| Full Name – Prescribing Physician      | Address – Prescribing Physician      |
| [ ]  Yes [ ]  No Is this a psychotropic medication? |
| [ ]  Yes [ ]  No Has this medication been provided to the out-of-home care provider? If yes, specify:      |
| **Medication 2** Name      | Dosage / Frequency      |
| Reason for Medication      | Length Prescribed      |
| Full Name – Prescribing Physician      | Address – Prescribing Physician      |
| [ ]  Yes [ ]  No Is this a psychotropic medication? |
| [ ]  Yes [ ]  No Has this medication been provided to the out-of-home care provider? If yes, specify:      |
| **Medication 3** Name      | Dosage / Frequency      |
| Reason for Medication      | Length Prescribed      |
| Full Name – Prescribing Physician      | Address – Prescribing Physician      |
| [ ]  Yes [ ]  No Is this a psychotropic medication? |
| [ ]  Yes [ ]  No Has this medication been provided to the out-of-home care provider? If yes, specify:      |
| **Medication 4** Name      | Dosage / Frequency      |
| Reason for Medication      | Length Prescribed      |
| Full Name – Prescribing Physician      | Address – Prescribing Physician      |
| [ ]  Yes [ ]  No Is this a psychotropic medication? |
| [ ]  Yes [ ]  No Has this medication been provided to the out-of-home care provider? If yes, specify:      |
| **F. Medical or Mental Health Appointments** |
| [ ]  Yes [ ]  No The child has currently scheduled medical or mental health appointments. If yes, specify:      |
| **Date (mm/dd/yyyy)** | **Time** | **Full Name – Provider** |
|       |       |       |
|       |       |       |
|       |       |       |
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|       |       |       |
| When is the child due for a periodic well child exam? (Children in out-of-home care must receive well child medical examinations in accordance with the schedule of the Wisconsin EPSDT / HealthCheck program pursuant to Wis. Admin. Code ch. DCF 56 ): |
| [ ]  Birth – 1 month | [ ]  8 months | [ ]  24 months |
| [ ]  2 months | [ ]  9 months | [ ]  30 months |
| [ ]  4 months | [ ]  12 months | [ ]  36 months |
| [ ]  6 months | [ ]  15 months | [ ]  Annually from 3 – 6 years |
|  |  | [ ]  Every other year from 6 – 21 years |
| **G. Immunizations** |
| [ ]  Yes [ ]  No The child’s immunizations are up to date. Specify:      |
| **Immunization Record** |
| **Immunization** | **Date(s) Administered (mm/dd/yyyy)** |
|       |       |
|       |       |
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| **V. ADDITIONAL INFORMATION** |
| **A. School / Child Care Information** |
| **School / Child Care Currently Attending or Most Recently Attended** |
| Name      | Telephone Number      |
| Address (Street, City, State, Zip Code)      | Grade Level      |
| School Contact Individual      | Contact Information      |
| [ ]  Yes [ ]  No The school district has been notified of the child’s placement (if age two or older). Specify:      |
| [ ]  Yes [ ]  No The child is less than age five and attends childcare that is not early education, pre-school, or 4K. Specify:      |
| [ ]  Yes [ ]  No The child is less than age five and does not attend early education or day care. Specify:      |
| [ ]  Yes [ ]  No The child is in an early intervention program. Specify:      |
| [ ]  Yes [ ]  No The child is in pre-school. Specify:      |
| [ ]  Yes [ ]  No The child is in kindergarten. Specify:      |
| [ ]  Yes [ ]  No The child is in regular education. Specify:      |
| [ ]  Yes [ ]  No The child is in special education. Specify:      |
| [ ]  Yes [ ]  No The child has an individualized education plan (IEP). Specify:      |
| [ ]  Yes [ ]  No The child has a support plan (i.e., behavioral, academic, etc.). Specify:      |
| [ ]  Yes [ ]  No The child is in day treatment. Specify:      |
| [ ]  Yes [ ]  No The child was attending school but is currently listed as missing from out-of-home care placement. Specify:      |
| [ ]  Yes [ ]  No The child is of school age but is not attending school. Specify:      |
| **Previous School(s) Attended** |
| **Previous School 1** Name      | Telephone Number      |
| Address (Street, City, State, Zip Code)      | Grade(s) Attended      |
| **Previous School 2** Name      | Telephone Number      |
| Address (Street, City, State, Zip Code)      | Grade(s) Attended      |
| **B. Emotional / Behavioral Information** |
| [ ]  Yes [ ]  No The child is believed to have emotional or behavioral needs. Specify:      |
| [ ]  Yes [ ]  No [ ]  Unknown Does the child have any existing behavioral health / mental health diagnosis? Specify:      |
| [ ]  Yes [ ]  No [ ]  Unknown Has the child received behavioral or emotional health services in the past? Specify:      |
| **C. Life Functioning Information** |
| **Formula and Feeding Restrictions** |
| [ ]  Yes [ ]  No The child is currently fed with formula. Specify brand, type, amount, and current feeding schedule:      |
| [ ]  Yes [ ]  No The child has feeding restrictions; e.g., solids, cups or bottles, swallowing problems, allergies, or dietary restrictions or issues. Specify:      |
| [ ]  Yes [ ]  No The child is fed by G-tube. Specify:      |
| **Special Medical Equipment Needs** |
| [ ]  Yes [ ]  No The child has special medical equipment needs; e.g., monitor, feeding tube, oxygen, ventilator, wheelchair, splints / braces. Specify:      |
| **Allergies** |
| [ ]  Yes [ ]  No The child has allergies, such as allergies to: Medications, animals, insect bites / stings, foods (including nuts and / or dairy), fabrics, soaps, grass, trees, ragweed, wool, etc. |
| **Allergy Type:** | **Specify details, including reactions.** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| [ ]  Yes [ ]  No If the child has an allergy, is there an emergency protocol for exposure? If yes, specify for each Allergy Type:       |
| **Asthma** |
| [ ]  Yes [ ]  No Does the child have asthma? If yes, describe the conditions that trigger an asthma attack and any emergency protocol.      |
| **Therapeutic Exercises / Activity Restrictions** |
| [ ]  Yes [ ]  No Frequent therapeutic exercises done by the child with the provider’s help. Specify nature of those exercises.      |
| [ ]  Yes [ ]  No The child is restricted from certain activities; e.g., strenuous exercise, climbing stairs, etc. Specify activity(s).      |
| **Other** |
| Describe any life functioning needs not previously mentioned.      |
| **D. Additional Information** |
| Describe any additional information critical to the care of the child.      |
| **VI. REASONABLE AND PRUDENT PARENTING CONSIDERATIONS** |
| “Reasonable and prudent parent standard” means a standard for an out-of-home care provider to use in making decisions concerning a child’s participation in age or developmentally appropriate extracurricular, enrichment, cultural, and social activities that is characterized by careful and sensible parental decisions that maintain the health, safety, best interests, and cultural, religious, and tribal values of the child while at the same time encouraging the emotional and developmental growth of the child. |
| **A. Cultural, Religious, and Tribal Considerations** |
| For this child take into account the following cultural, religious, and tribal considerations when making prudent parenting decisions. Specify:      |
| **B. Recreational Activities** |
| This child engages in or would like to participate in the following recreational activities, sports, and / or extra-curricular activities (e.g., birthday parties, movies, volunteering, dances, etc.). Specify:      |
| For this child, consider the restrictiveness of the placement and whether they have the necessary training and safety equipment to safely participate in the activity under consideration.Specify:       |
| For this child, consider their age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions. Specify:      |
| This child is prohibited from participating in the following recreational activities (i.e., prohibited due to their age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.). Specify:      |
| **C. Transportation** |
| This child engages in or would like to participate in the following activities related to transportation (e.g., obtaining their driver’s license, driving / carpooling with peers and other adults, etc.). Specify:      |
| For this child, consider the restrictiveness of the placement and whether they have the necessary training and safety equipment to safely participate in the activity under consideration. Specify:      |
| For this child, consider their age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions. Specify:      |
| This child is prohibited from participating in the following activities related to transportation (i.e., prohibited due to their age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.). Specify:      |
| **D. Employment** |
| This child engages in or would like to participate in the following activities related to employment (e.g., informal employment, babysitting, lawn mowing, formal employment, banking and bank accounts, etc.). Specify:      |
| For this child, consider the restrictiveness of the placement and whether they have the necessary training and safety equipment to safely participate in the activity under consideration. Specify:      |
| For this child, consider their age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions. Specify:      |
| This child is prohibited from participating in the following activities related to employment (i.e., prohibited due to their age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.). Specify:      |
| **E. Peer Relationships** |
| This child engages in or would like to participate in the following activities related to peer relationships (e.g., visiting friends, having friends over, overnight stays with friends, dating, etc.). Specify:      |
| For this child, consider the restrictiveness of the placement and whether they have the necessary training and safety equipment to safely participate in the activity under consideration. Specify:      |
| For this child, consider their age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions. Specify:      |
| This child is prohibited from participating in the following activities related to peer relationships (i.e., prohibited due to their age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.). Specify:      |
| **F. Personal Expression** |
| This child engages in or would like to participate in the following activities related to personal expression (e.g., haircuts, hair dying, clothing choices, explicit material, R-rated movies, games or music, etc.). Specify:      |
| For this child, consider the restrictiveness of the placement and whether they have the necessary training and safety equipment to safely participate in the activity under consideration. Specify:      |
| For this child, consider their age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions. Specify:      |
| This child is prohibited from participating in the following activities related to personal expression (i.e., prohibited due to their age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.). Specify:      |
| **G. Other** |
| Other activities the child engages in or would like to engage in. Specify:      |
| For this child, consider the restrictiveness of the placement and whether they have the necessary training and safety equipment to safely participate in the activity under consideration. Specify:      |
| For this child, consider their age and the following cognitive, emotional, physical, and behavioral capacities when making prudent parenting decisions. Specify:      |
| This child is prohibited from participating in the following activities (i.e. prohibited due to their age, cognitive, emotional, physical, and behavioral capacities, court orders, laws, etc.). Specify:      |
| **VII. SIGNATURES** |
|       |  |       |
|  **SIGNATURE** – Placing Child Welfare Professional |  | Date Signed |
|       |  |       |
|  **SIGNATURE** – Out-of-Home Care Provider |  | Date Signed |
|       |  |       |
|  **SIGNATURE** – Out-of-Home Care Provider |  | Date Signed |