DEPARTMENT OF CHILDREN AND FAMILIES

Office of Legal Counsel

Instructions

Rehabilitation Review Panel Decision Report

# I. INTRODUCTION

* Sections 48.685(5g) and 48.686(5g), Wis. Stats., require the Department of Children and Families to report annually, beginning January 1, 1999, to the legislature the number of persons in the previous year who have requested to demonstrate to the Department that they have been rehabilitated, the number of persons who successfully demonstrated that they have been rehabilitated and the reasons for the success or failure of a person who has attempted to demonstrate that he or she has been rehabilitated.
* Sections DCF 12.13(6)(b) and 13.13(6)(b), Wis. Admin. Code, requires reviewing agencies to report decisions on rehabilitation review requests to the Department on forms developed by the Department.
* The Department has developed the “Rehabilitation Review Panel Decision Report” (DCF-F-418-E) and the “Rehabilitation Review Appeals Report” (DCF-F-2857-E) for this purpose.

* Information in these reports will be entered into the Office of Legal Counsel’s computer database. The required reports for the legislature will be generated from this database. The database may also be used to answer questions that may be asked concerning rehabilitation review applications or applicants.
* Copies of the “Rehabilitation Review Panel Decision Report” (DCF-F-418-E) and the “Rehabilitation Review Appeals Report” (DCF-F-2857-E) may be obtained by contacting the Rehabilitation Review Coordinator at 608-422-7041 or by mailing a written request to: Attn: Rehabilitation Review Coordinator, Department of Children and Families, Office of Legal Counsel, 201 West Washington Avenue, P.O. Box 8916, Madison, WI 53708-8916. Requests may also be emailed to DCFMBREHAB@wisconsin.gov.
* Because there are numerous counties, school boards and child placing agencies that will be reporting to the Department, a numbering system consistent across reviewing agencies will be used. The term for the numbering system is Rehabilitation Review Request Number (RRRN).The RRRN consists of:
* the 4 digit year in which the application was received;
* a 3 digit number in sequential numerical order;
* an agency acronym; and
* the agency number.

For example: The first rehabilitation review request in Milwaukee County in 1999 would be numbered: 1999-001-C-40.

The first rehabilitation review request received by Adoption Advocates Inc., a child placing agency, in 1999 would be numbered: 1999-001-CPA-180035.

The first rehabilitation review request received by the Abbotsford School District would be numbered: 1999-001-LEA-0007.

The Department of Children and Families will not have an agency number.

# II. GENERAL INFORMATION

* The “Rehabilitation Review Panel Decision Report” (DCF-F-418-E) is required by s. DCF 12.13(6)(b) and 13.13(6)(b), Wis. Admin. Code, to be submitted to the Department within 10 days after the rehabilitation decision is issued to the applicant.
* Completed reports can be mailed to: Attn: Rehabilitation Review Coordinator, Department of Children and Families, Office of Legal Counsel, 201 West Washington Avenue, P.O. Box 8916, Madison, WI 53708-8916. Please attach a copy of the decision letter issued to the requester along with a copy of the application.
* Questions concerning form DCF-F-418-E may be directed to 608-422-7041.
* One reporting form should be sent to the Department for each application. If the panel changes its initial decision after the form is submitted, the panel should send a copy of the original form to the Department with changes or amendments to the initial decision clearly indicated. For example: a grant or denial of approval after a deferral, requests to transfer approval or withdrawal of approval. A copy of the original form including the new decision and a copy of the decision letter should be sent to the Department.
* A RRRN must be assigned to each application. If the same applicant files a rehabilitation review request that is for a different job, etc., each request is required to be assigned a RRRN. If the same applicant files a rehabilitation review request that is for the same or similar job, etc., the request should be considered a request for a transfer of the previous rehabilitation approval and a new RRRN should not be assigned.
* The “Entity Type” section on page 3 of form DCF-F-418-E lists the entity types covered by s. 48.685 Stats and s. 48.686 Stats. These entity types are Wisconsin Administrative Code references that must be marked in the box provided when granting a rehabilitation review approval. For example: DCF 250 should be marked in the “Entity Type” box when an applicant receives regulatory approval for a Family Child Care Center.
* Please type or print the information entered on the reports.

## COMPLETING THE “REHABILITATION REVIEW PANEL DECISION REPORT” (DCF-F-418-E)

* For each section, enter the information requested. Enter the Rehabilitation Review Request Number (RRRN) that was assigned to the rehabilitation review application when it was received by the reviewing agency.

### Section A – Rehabilitation Review Applicant Information

* Enter the applicant’s full name, telephone number, social security number (if provided), gender and date of birth as stated on the “Rehabilitation Review Application.”
* Enter the applicant’s full address as stated on the “Rehabilitation Review Application.”
* Enter the approval type(s) and the entity type(s) requested by the applicant.

### Section B – Rehabilitation Review Panel Information

* Enter the official name of the reviewing agency. Indicate the agency type by marking the appropriate box.
* Enter the name and telephone number of the person who may be contacted if questions arise about information in the report. NOTE: For child placing agencies and school boards this person may also be asked to help coordinate the receipt of documents and communication with review panel agency members during the appeal stages.
* Enter the reviewing agency’s full address as requested.
* Enter the offense(s) affecting caregiver eligibility. Include the statute number (if applicable), offense, date committed, date of conviction or finding, sentence and county. NOTE: Applicants may not always know which of their crimes, acts or offenses are barred. The reviewing agency will have to identify the barred crime, act or offense. All crimes, acts or offenses that the applicant has committed that are considered a bar should be entered and considered by the review panel.
* In the “Barred Offense(s) – Summary” section, indicate for each offense whether the applicant is eligible or ineligible for rehabilitation review. Be sure to differentiate between the different types of approval, i.e., employment, non-client residency, regulatory approval and contracting.
* Indicate whether the applicant has a non-barred offense(s) and the date the Caregiver Background Check was completed.
* A report must also be completed for the following: foster parent permanent bar; foster parent barred for five years; reviewing agency does not have jurisdiction; and applicant does not require rehabilitation review. If the rehabilitation panel did not review the application for any of these reasons, mark the appropriate box.

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* Enter the date the application was initially received at the reviewing agency.
* Enter the date the application was complete and the date of the panel meeting.
* Indicate whether the applicant appeared in person, by telephone or did not appear at all. NOTE: Entering the tape recording cassette number is optional.
* Indicate whether the panel is meeting after a deferral. If yes, enter the date of the deferral.

#### **Section C – Rehabilitation Review Deferral**

* Enter applicant’s name and the RRRN.
* Enter the date the approval was deferred in the space provided.
* Enter the date when the deferral period will end. NOTE: After the deferral period has ended the rehabilitation review panel must decide to either grant or deny rehabilitation approval.
* Indicate the reason(s) for the deferral by marking the appropriate box(es). In the “Comments” section write in the reason(s) when the pre-designated reasons are not applicable. NOTE: Deferring a decision may be used at the discretion of the review panel members to keep the applicant from having to re-apply for rehab approval. For example, a case may be deferred when additional information is needed.

* The lead panel member enters their name, title, signature, telephone number and date signed. All other panel members’ sign and date in the space provided.

##### **Section D – Rehabilitation Approval Decision**

* Enter the applicant’s name and the RRRN.
* Enter the date the approval was granted in the space provided.
* Indicate whether the applicant is approved for employment, regulatory approval, contracting or non-client residency by marking the appropriate box(es). Check each box that applies.
* Enter the entity type for which the applicant is approved. For each entity type, please indicate in the “Comments” section whether the applicant is approved for employment, contracting, regulatory approval or non-client residency.
* Indicate any conditions or limitations placed on the approval by marking all conditions or limitations that apply. For conditions or limitations that are not listed, indicate them in the “Comments” section. For example: Applicant is approved to work in a group child care facility, but only in a supervised position.
* Make comments as necessary.
* The lead panel member enters their name, title, signature, telephone number and date signed. All other panel members’ sign and date in the space provided.

**Section E – Rehabilitation Denial Decision**

* Enter the applicant’s name and the RRRN.
* Enter the date the approval was denied in the space provided.
* If the applicant did not demonstrate sufficient evidence of rehabilitation in one or both of the areas considered by the review panel, indicate the area of deficiency by marking either one or both of the pre-designated boxes. Specify in the “Comments” section the reason(s) the applicant was deficient.
* The lead panel member enters their name, title, signature, telephone number and date signed. All other panel members’ sign and date in the space provided.

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**Section F – Transfer Approval Decision**

* Enter applicant’s name and the RRRN.
* Enter the date of the decision authorizing the transfer.
* Indicate whether the transfer is approved or denied.
* If the transfer is approved, indicate the basis for that decision by checking the appropriate box(es). In the “Comments” section, write in the reason(s) when the pre-designated reasons are not applicable.
* If the transfer is denied, explain the reason(s) for the decision.
* Specify the name, address and telephone number of the entity or agency involved.
* The lead panel member enters their name, title, signature, telephone number and date signed. All other panel members’ sign and date in the space provided.

**Section G – Withdrawal of Approval Decision**

* Enter the applicant’s name and the RRRN.
* Enter the date the approval was withdrawn in the space provided.
* Indicate the reason(s) for withdrawing approval by checking the appropriate box(es). In the “Comments” section, write in the reason(s) when the pre-designated reasons are not applicable.
* The lead panel member enters their name, title, signature, telephone number and date signed. All other panel members’ sign and date in the space provided.

The Department of Children and Families is an equal opportunity employer and service provider. If you have a disability and need to access services, receive information in an alternate format, or need information translated to another language, please call the Rehabilitation Review Coordinator at 608-422-7041. Individuals who are deaf, hard of hearing, deaf-blind or speech disabled can use the free Wisconsin Relay Service (WRS) – 711to contact the Department. 4

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| DEPARTMENT OF CHILDREN AND FAMILIESOffice of Legal Counsel | | | | | | | | | | | | | |
| Rehabilitation Review Panel Decision Report | | | | | | | | | | | | | |
| Completion of this form is required under the provisions of sections 48.685 and 48.686 of the Wisconsin Statutes and Chapters DCF 12 and 13, Wisconsin Administrative Code. **Submit this form within 10 days of the decision to: Attn: Rehabilitation Review Coordinator, Department of Children and Families, Office of Legal Counsel, 201 West Washington Avenue, P.O. Box 8916, Madison, WI 53708-8916.** Questions concerning this form may be directed to 608-422-7041. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay. | | | | | | | | | | | | | |
| Rehabilitation Review Request Number | | |  | | | | | | | | | | |
| **Section A – Rehabilitation Review Applicant Information** | | | | | | | | | | | | | |
| Name – Applicant | | | | | | Telephone Number | | Social Security No. | | Gender  Male  Female Female | | | Birth Date |
| Street Address | | | | City | | | | County | | State | | Zip Code | |
| Approval Type Requested by Applicant | | | | | | | | | Entity Type Requested by Applicant | | | | |
| Current  Proposed | | Employment  Regulatory Approval  Non-Client Residency  Contracting | | | | | | |  | | | | |
| **Section B – Rehabilitation Review Panel Information** | | | | | | | | | | | | | |
| Name – Reviewing Agency | | | | | | | | | Agency Type  DCF  School Board  County  Child Placing  Tribe  Agency | | | | |
| Name – Contact Person | | | | | | | | | Telephone Number | | | | |
| Street Address | | | | City | | | | County | | | State | Zip Code | |
| Offense(s) Affecting Caregiver Eligibility | | | | | | | | | | | | | |
| Statute Number | Offense – Include Whether Felony or Misdemeanor | | | | Date Committed | | Date Convicted / **Date of Finding** | | Sentence \*See JOC for Court Orders and Withheld Sentence | | | | County |
| 1. |  | | | |  | |  | |  | | | |  |
| 2. |  | | | |  | |  | |  | | | |  |
| 3. |  | | | |  | |  | |  | | | |  |
| 4. |  | | | |  | |  | |  | | | |  |
| Barred Offense(s) – Summary | | | | | | | | | | | | | |
| Applicant has Non-Barred Offense(s)  Yes  No | | | | | | | Caregiver Background Check Run Date | | | | | | |
| If Rehabilitation Panel did not review the Application, indicate reason(s) below. Complete only if applicable. Foster Parent Permanent Bar  Reviewing Agency Does Not Have Jurisdiction  Foster Parent Barred for 5 Years  Applicant Does Not Require Rehabilitation Approval | | | | | | | | | | | | | |

DCF-F-418-E (R. 12/2020)

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| Date Application Initially Received | | | Date Application Complete | | Date of Panel Meeting | | |
| Applicant’s Appearance at Rehabilitation Review Meeting | | | | Is this a Panel Meeting After a Deferral? | | | |
| Personal Telephone  Did Not Appear | Tape Recording Cassette Number (Optional) | | | Yes  No Deferral Date: | | | |
| **Section C – Rehabilitation Review Deferral** | | | | | | | |
| Name – Rehabilitation Review Applicant | | Rehabilitation Request No. | | Date Approval Deferred | | Date to Which Deferred | |
| More time is needed for applicant to demonstrate sufficient evidence of rehabilitation.  More information is needed in the areas stated below. | | | | | | | |
| Comments – Specify Deferral Reasons | | | | | | | |
| **PANEL MEMBERS** | | | | | | | |
| 1. Review Panel Contact Person – Printed Name, Title and Signature | | | | Telephone Number | | | Date Signed |
| 2. Panel Member – Printed Name and Signature | | | | | | | Date Signed |

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| 3. Panel Member – Printed Name and Signature | | | | | Date Signed | |
| 4. Panel Member – Printed Name and Signature | | | | | Date Signed | |
| 5. Panel Member – Printed Name and Signature | | | | | Date Signed | |
| **Section D – Rehabilitation Approval Decision** | | | | | | |
| Name – Rehabilitation Review Applicant | Rehabilitation Review Request Number | | | Date Approval Granted | | |
| Applicant Approved For (Check ALL that apply)  Employment  Regulatory Approval  Contracting  Non-Client Residency | | | | | | |
| Entity Type (Check ALL that apply)  DCF-56 Family Foster Homes  DCF-50/51 Foster Home-Adoption  DCF-57 Group Homes for Children  DCF-59 Shelter Care Facilities for Children  DCF-54 Child Placing Agencies  DCF-52 Residential Care Centers for Children & Youth | | DCF-250 State Licensed Family Child Care Centers  DCF-251 County Certified Child Care Centers  DCF-251 State Licensed Group Child Care Centers  DCF-252 Child Day Care Contracted by School Boards  DCF-252 Day Camps for Children | | | | |
| Conditions (Check ALL that apply) | | | | | | |
| No further criminal law violations. No further threats or acts of violence towards others.  No use of illegal drugs (and alcohol).  No contact (direct or indirect) with **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**  Continue / participate in counseling as recommended.  Do not commit any offenses that lead to arrest or conviction or findings by a government agency of misconduct (abuse or neglect of another or misappropriation of a client’s property). | | | | | | |
| Comments – Include Any Other Approval Conditions | | | | | | |
| **PANEL MEMBERS** | | | | | | |
| 1. Review Panel Contact Person – Printed Name, Title and Signature | | | Telephone Number | | | Date Signed |
| 2. Panel Member – Printed Name and Signature | | | | | | Date Signed |
| 3. Panel Member – Printed Name and Signature | | | | | | Date Signed |
| 4. Panel Member – Printed Name and Signature | | | | | | Date Signed |
| 5. Panel Member – Printed Name and Signature | | | | | | Date Signed |

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| **Section E – Rehabilitation Denial Decision** | | | | |
| Name – Rehabilitation Review Applicant | Rehabilitation Review Request Number | | Date Approval Denied | |
| The applicant did not demonstrate sufficient evidence of rehabilitation in one or both of the following areas considered by the Rehabilitation Review Panel.  Position related offense factors.  The applicant’s personal development and progress. | | | | |
| Comments – Specify Denial Reasons | | | | |
| **PANEL MEMBERS** | | | | |
| 1. Review Panel Contact Person – Printed Name, Title and Signature | | Telephone Number | | Date Signed |
| 2. Panel Member – Printed Name and Signature | | | | Date Signed |
| 3. Panel Member – Printed Name and Signature | | | | Date Signed |
| 4. Panel Member – Printed Name and Signature | | | | Date Signed |
| 5. Panel Member – Printed Name and Signature | | | | Date Signed |

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| **Section F – Transfer Approval Decision** | | | | | |
| Name – Rehabilitation Review Applicant | | Rehabilitation Review Request Number | | Date Transfer Authorized | |
| **Transfer Approved**  The receiving agency, entity or tribe determined that the offense that initially required applicant to seek rehabilitation approval is not substantially related to client care.  Limitations and / or conditions imposed with the rehabilitation approval continue to be able to be met.  **Transfer Denied** –Specify reasons transfer approval denied: | | | | | |
| Name – Receiving ENTITY or AGENCY | Address | | | | Telephone Number |
| Comments | | | | | |
| **PANEL MEMBERS** | | | | | |
| 1. Review Panel Contact Person – Printed Name, Title and Signature | | | Telephone Number | | Date Signed |
| 2. Panel Member – Printed Name and Signature | | | | | Date Signed |
| 3. Panel Member – Printed Name and Signature | | | | | Date Signed |
| 4. Panel Member – Printed Name and Signature | | | | | Date Signed |
| 5. Panel Member – Printed Name and Signature | | | | | Date Signed |

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| **Section G – Withdrawal of Approval Decision** | | | | |
| Name – Rehabilitation Review Applicant | Rehabilitation Review Request Number | | Date Approval Withdrawn | |
| Check ALL that apply  Applicant failed to comply with the limitations or conditions imposed with the rehabilitation approval.  Subsequent to rehabilitation approval, the applicant was convicted of a new offense and is no longer eligible.  The applicant knowingly withheld pertinent information that could or would have affected the Review Panel’s decision to grant rehabilitation approval.  The applicant knowingly submitted false information relevant to the rehabilitation request that could or would have affected the Review Panel’s decision to grant rehabilitation approval. | | | | |
| Comments | | | | |
| **PANEL MEMBERS** | | | | |
| 1. Review Panel Contact Person – Printed Name, Title and Signature | | Telephone Number | | Date Signed |
| 2. Panel Member – Printed Name and Signature | | | | Date Signed |
| 3. Panel Member – Printed Name and Signature | | | | Date Signed |
| 4. Panel Member – Printed Name and Signature | | | | Date Signed |
| 5. Panel Member – Printed Name and Signature | | | | Date Signed |

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