**Public Adoptions Request  
for Specialized Services or Congregate Care Placements**

**Use of Form:** This form is required to be completed by a Public Adoption Professional when requesting approval for Specialized Services and/or a placement within a RCC or group home for a child. After completing the form, the Public Adoption Supervisor will submit the request to the Adoption and Post-Permanency Supports Section at [DCFDSPPublicAdoptionAgencyRequest@wisconsin.gov](mailto:DCFDSPPublicAdoptionAgencyRequest@wisconsin.gov) for approval or denial for the requested service(s). Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)m), Wisconsin Statutes.]

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Section I: Case Information** | | | | | | | |
| Public Adoption Professional’s Full Name | | | | | | | |
| Child’s Full Name | | | | | | | eWiSACWIS Case ID |
| **Section II: Specialized Services and/or RCC Placement Information** | | | | | | | |
| Date of Request (mm/dd/yyyy) | | | | | | | |
| Approval Request for (choose all that apply) | | | | | | | |
| Specialized Services | | RCC Placement | | Group Home Placement | | | |
| Summary of Issue (include all relevant information) | | | | | | | |
| Identify the specialized service that is being requested | | | | | | | |
| Proposed Provider for Requested Services | | | | | | | |
| Cost of Services  $ | Duration of Services | | | | | | |
| Professional’s Recommendation | | | | | | | |
| **Payment Options** | | | | | | | |
| Bill to Contract | | | Bill to DCF Adoption Accountant | | | | |
| **Section III: Public Adoption Supervisor Approval** | | | | | | | |
| By checking this box, I have reviewed and approve this request. | | | | | | | |
| Special considerations or expectations: | | | | | | | |
|  | | | | |  |  | |
| Public Adoption Supervisor’s Signature | | | | |  | Date Signed (mm/dd/yyyy) | |
| **Section IV: DCF Adoption and Post-Permanency Supports Section Approval** | | | | | | | |
| By checking this box, I approve this request as is for the following time period:       to | | | | | | | |
| By checking this box, I approve this request for the following time period:       to      and with the followingconditions: | | | | | | | |
| By checking this box, I deny this request.  Reason for denying request: | | | | | | | |
|  | | | | |  |  | |
| DCF APPS Representative’s Signature | | | | |  | Date Signed (mm/dd/yyyy) | |