

## DCF 12 NEGATIVE ACTION NOTICE

**Use of form:** Use of this form is voluntary. However, the information requested on this form must be provided pursuant to s. DCF 12.07, Wis. Adm. Code. Information collected on this form will be entered into the Department of Children and Families' Children's License Denial database which lists individuals whose application for a license, or adoption is denied or whose license is revoked or not renewed (negative actions) for reasons specified in the list of offenses affecting caregiver eligibility, DCF 12, Adm. Code, Appendix A. 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.

**Instructions:** Complete a separate form for each person subject to the negative action taken. Send the completed form to the address listed at the bottom of the form.

**Action Requested:**

- Add New Record**       **Modify Previously Created Record**       **Delete Previously Created Record**  
 Appeal Has Overturned Finding  
 Other: \_\_\_\_\_

**I. Individual Against Whom the Negative Action Was Taken**

Name (Last, First, Middle)	Social Security Number	Birthdate (mm/dd/yyyy)
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**II. License / Certification Type (Check one)**

- Adoption       Foster Home

**III. Negative Action Taken**

Check appropriate box below. <input type="checkbox"/> Denial <input type="checkbox"/> Revocation <input type="checkbox"/> Non-Renewal	Date Negative Action Taken (mm/dd/yyyy)
Reason Negative Action Taken <input type="checkbox"/> Substantiated finding of child abuse or neglect <input type="checkbox"/> Criminal conviction <input type="checkbox"/> Misappropriation of client's property	If criminal conviction, cite statute indicating specific crime(s) from Offenses List (DCF 12-Appendix A). For example: 940.01.

**IV. Agency Taking the Negative Action**

Agency Type (Check one) <input type="checkbox"/> Child Placing Agency (CPA) <input type="checkbox"/> County <input type="checkbox"/> Tribe	
Name – CPA	Facility ID Number
Name – County / Tribe	County / Tribe Number

**V. Person Completing Form**

Name	Title
Telephone Number	Email Address <input type="checkbox"/> Check if no email address.

\_\_\_\_\_  
**SIGNATURE** – Person Completing Form

\_\_\_\_\_  
Date Signed

Immediately send completed form to the address below:

Out-of-Home Care Section  
DCF/DSP – Room E200  
P.O. Box 8916  
Madison, WI 53708-8916  
FAX (608) 422-7157