

|   |  |                                  |   |                          |   |
|---|--|----------------------------------|---|--------------------------|---|
|  <b>WRAPAROUND<br/>MILWAUKEE<br/>POLICY &amp;<br/>PROCEDURE</b> | Date Issued:<br><b>9/1/98</b>  | Date Revised:<br><b>6/17/08</b>  | Section:<br><b>LIAISONS</b>                           | Policy No:<br><b>019</b> | Pages:<br><b>1 of 3</b><br>(12 Attachments) |
|   | <input checked="" type="checkbox"/> Wraparound<br><input type="checkbox"/> Wraparound/REACH<br><input type="checkbox"/> FISS | Effective Date:<br><b>1/1/09</b> | Subject:<br><b>FOSTER CARE PLACEMENT – NON-AGENCY</b> |                          |   |

## I. POLICY

It is the policy of Wraparound Milwaukee that anytime a youth is placed in a Foster Care setting, the following guidelines/criteria be followed.

## II. PROCEDURE

- A. **A Plan of Care (POC) Review must occur with the entire Child & Family Team to determine that the youth's and family's needs would best be met by a Foster Home placement. This review must include the BMCW Case Manager for all CHIPS youth to ensure that this placement and this payment rate is transferable to the BMCW and that it meets State of Wisconsin Foster Home Payment Rate Review requirements.**

**The BMCW Case Manager must make the referral for a youth for a regular foster home.**

1. The Care Coordinator in collaboration with the BMCW worker must explain to the Child & Family Team at this POC Review what a Foster Home will provide. This must include a description of the services the Foster Care Agency must provide.
2. The Care Coordinator must facilitate the inclusion of the Foster Care Parents and the Foster Care Consultation Worker into the Child and Family Team.
3. The Care Coordinator must arrange for the youth's pre-placement visit(s) at the identified home.
4. The Care Coordinator must ensure that the agreed upon payment rate meets the requirements of the State of Wisconsin, BMCW, Delinquency Management and the foster parents.

B. **When Placing a Youth in a Licensed Foster Home Setting:**

Placement of a youth in an unlicensed home is illegal unless a court has specifically ordered the placement, or the BMCW Case Manager has successfully completed the BMCW Pre-Placement Screening Plan (which includes a criminal and background clearance check), the Caregiver Child Placement Plan and the Plan to Support Permanency for Unlicensed Relative or Non-Relative Potential Caregivers.

1. **For a CHIPS Youth**, the Care Coordinator must secure a copy of the official BMCW legal Notice of Change in Placement before the youth is moved.

The Care Coordinator should then complete the forms below as appropriate to the youth's situation:

- NOTICE OF CHANGE IN PLACEMENT (*see Attachment 1*)
- FOSTER/KINSHIP CARE INVOICE (*see Attachment 2*)
- FOSTER/KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 3*)
- FINANCIAL ASSESSMENT REFERRAL (FAR) (*see Attachment 4*) along with a copy of the TEMPORARY PHYSICAL CUSTODY ORDER (TPC) (*see Attachment 5*).

**If this placement removes the youth from the home of the parent or guardian, then a court hearing MUST occur before the move can take place.**

**For a Delinquent or JIPS Youth**. Contact your WM Liaison immediately if the Delinquent or JIPS youth requires a regular foster home placement. Regular foster homes are established for use by CHIPS youth primarily and special arrangements will be required to place a Delinquent or JIPS youth in a regular foster home. The Care Coordinator should then complete the forms below as appropriate to the youth's situation:

- NOTICE OF CHANGE IN PLACEMENT (*see Attachment 1*)
- FOSTER/KINSHIP CARE INVOICE (*see Attachment 2*)
- FOSTER/KINSHIP CARE SERVICE AUTHORIZATION (*see Attachment 3*)
- FINANCIAL ASSESSMENT REFERRAL (FAR) (*see Attachment 4*) along with a copy of the TEMPORARY PHYSICAL CUSTODY ORDER (TPC) (*see Attachment 5*)

**If this placement removes the youth from the home of the parent or guardian, then a court hearing MUST occur before the move can take place.**

**\* Note: Care Coordinator should provide Foster Parent with the INVOICE form to be completed and explain to the Foster Parent how to complete the Invoice and submit it to the Wraparound Finance Office at the end of the month for every service month.**

2. All youth that are in substitute care placements for six months or more will be required to have their case reviewed by a Court official in a court review or by an Administrative Review Board (ARB). A typed SEMI-ANNUAL PERMANENCY PLAN CASE REVIEW must be presented at this review.

**For a CHIPS Youth**, the BMCW Case Manager will prepare this report. The WM Care Coordinator should assist by providing information about the youth and family to the Case Manager on a continuous, regular and ongoing basis. The Care Coordinator should also maintain contact with the BMCW Case Manager to remain aware of this scheduled review, and should appear with the BMCW Case Manager at the Annual Review Board or Permanency Planning Review, or the Court hearing, at which the youth's permanent plan will be reviewed.

**For a Delinquent or JIPS Youth**, the Care Coordinator will prepare this report called a DELINQUENCY DIVISION PERMANENCY PLAN (*see Attachment 6*). The WM Care Coordinator should, however, be providing this information about the youth and family to the Probation Officer on a continuous, regular and ongoing basis. The Care Coordinator should also maintain contact with the Probation Officer to remain aware of this scheduled review, and will appear with the Probation Officer at the Annual Review Board or Permanency Planning Review, or the Court hearing, at which the youth's permanent plan will be reviewed.

3. **For a CHIPS Youth**, the BMCW Ongoing Case Manager (OCM) must put in a referral to Children's Service Society of Wisconsin (CSSW) to secure a foster home placement.
4. When placing a youth in foster care, the Care Coordinator must complete the FOSTER PARENT CHECKLIST (*see Attachment 7*) prior to placing a youth or, if an emergency placement, within one (1) week of the placement. The Checklist must be signed by both the foster parent(s) and the Care Coordinator to indicate that it has been completed. A copy of the Checklist should be left with the foster parent(s), a copy should be kept by the Care Coordinator for their Agency file for the youth, and the original should be kept in the Wraparound file of the identified youth.
5. When placing a youth in a foster home, the Care Coordinator must provide a copy of the INFORMATION FOR FOSTER PARENTS form (*see Attachment 8*) as required by Wisconsin State Statute 895.485(4)(a) and Wisconsin State Administrative Code Chapter HSS37 to the foster parents. The foster parents must sign and date the last page. The Care Coordinator must then supply a copy of the signed form to the foster parents and place a copy in the Agency file for the youth. The original should be kept in the Wraparound file for the identified youth.

If the BMCW Worker for a CHIPS youth has already provided this form to the foster parent, the Care Coordinator must get a copy of the form signed by the foster parent and place a copy in the agency file.

6. **Prior to the actual placement of the youth in a foster home**, the BMCW Worker, in collaboration with the WM Care Coordinator for all CHIPS youth, must determine the foster care rate with the foster parent, using the UNIFORM FOSTER CARE RATE pamphlet (*see Attachments 9*) or the Foster Care Uniform Rate Setting Form (*see Attachment 10*) as a guideline.

For CHIPS youth, this mutually agreed upon rate must be reflective of communication and collaboration with the BMCW to ensure that the rate is transferrable to the BMCW, and that it meets State of Wisconsin Foster Home Payment Rate Review requirements. The Care Coordinator should clearly explain this to the foster parents. The Care Coordinator should then submit a SERVICE

AUTHORIZATION REQUEST (SAR) to Wraparound Milwaukee reflecting the indicated rate as well as the foster parents' complete address and phone number (service code is 5390). The Care Coordinator is also responsible for explaining the Invoice procedures done through the Wraparound Finance Office. For questions related to the SAR or Invoice Procedure, please contact the Wraparound Finance Office at 257-6176.

**C. Emergency Placement:**

1. In the event of an emergency situation after normal business hours:

**For a CHIPS Youth**, if the BMCW Case Manager or Supervisor are unavailable, the Care Coordinator must call the BMCW emergency phone line at 220-SAFE (220-7233). The BMCW emergency response system will then direct any further action. The Care Coordinator must then take all appropriate actions related to a Change in Placement and complete and submit all Change in Placement forms (as detailed in Policy 005), no later than 48 hours after the youth's placement has been achieved.

**For a Delinquent or JIPS Youth**, if the Probation Officer or their Supervisor are unavailable, the Care Coordinator can remove a youth from their current placement, if the safety of the youth, family or placement resource is threatened. In this event, the Care Coordinator is then responsible for informing the Probation Officer of the youth's current whereabouts and the reason for the removal by noon of the following business day. The Care Coordinator must also take all appropriate actions related to a Change in Placement and complete and submit all Change in Placement forms (as detailed in Policy 005) no later than 48 hours after the placement has been achieved.

If there are any objections by either the Judge, District Attorney, Public Defender, Guardian ad Litem, Parent, Child Guardian or Native American Tribe, Probation Officer to the placement change, a hearing must be held in Court for the objections to be presented and a determination made by the Judge regarding the youth's placement.

2. If the move is contested, the Care Coordinator must then ascertain the court date for the hearing on the matter by contacting the **Clerk of Courts at 257-7700**. At the time of the court hearing the Care Coordinator must be prepared to explain his or her involvement with the youth, how the decision for the change in placement was arrived at, who was consulted regarding the decision, and be able to speak to what is in the best interest of the youth. A CHILDREN'S COURT ORDER PROGRESS REPORT (*see Attachment 11*) is required. The child should NOT then be moved, except in an emergency, until the Court has heard the objection and made a ruling.
3. Placement of a youth in a foster or substitute care setting must be accomplished legally through the use of the legal NOTICE OF CHANGE IN PLACEMENT (*see Attachment 1 – refer to Policy #005*) being completed in Synthesis and submitted to your assigned Wraparound Liaison within the legally required time frames. For a CHIPS youth, the Care Coordinator must secure a copy of the official BMCW legal Notice of Change in Placement before the youth can be moved.
4. The Care Coordinator will need to submit a COURT LETTER - REQUEST FOR REVISION AND/OR EXTENSION OF DISPOSITIONAL ORDER (*see Attachment 12*) to the WM Liaison per Wraparound Court Extension Policy (#013), if it is determined by the Child and Family Team that the youth's out-of-home placement and/or Court involvement must be continued beyond the duration of the existing Order.

**If you need assistance, please contact your assigned Wraparound Liaison.**

Reviewed & Approved by: Bruce Kamradt  
Bruce Kamradt, Director

**WRAPAROUND MILWAUKEE  
Foster Care Placement Policy  
Attachment 1**

**STATE OF WISCONSIN, CIRCUIT COURT, MILWAUKEE COUNTY**

*For Official Use*

IN THE INTEREST OF

**Notice of  
Change in Placement**

Smith, John

Name

- Out of Home to Out of Home  
 Out of Home to In Home  
 In Home to In Home

12/11/90

Date of Birth

Case No. 99JV0000000

This placement  was  will be changed on (date) 6/25/08 as follows:

This change  was  was not authorized by the original dispositional order.

Give reason for new placement, why it is preferable and how it satisfied treatment plan:

Youth is transitioning home from Lad Lake. Wraparound Milwaukee will continue to provide ongoing case management services.

Name and address of new placement:

Mary Smith  
3035 W Wisconsin Ave #207

Milwaukee, WI 53208

If placement continues to be outside the home, the parents/guardian/legal custodian/trustee will be required to pay support for the placement.

**Hearing Rights**

If you object to the change in placement:

- A written request for a hearing must be filed with the court listed above within 10 days of your receipt of this notice. Copies of this request should be sent to all concerned parties.
- The change of placement is authorized in the current dispositional order. Therefore, your request for a hearing must allege new information which affects the advisability of that dispositional order.

Distribution:

1. Original - Court
2. Child/Juvenile
3. Parents/Guardian/Legal Custodian/Trustee
4. Social Worker/District Attorney/Corporation Counsel
5. Juvenile's Attorney

Signature of Case Worker/District Attorney/Corporation Counsel

Owen Felix for Skyla Roper

Name Printed or Typed

6/9/08

Date

**WRAPAROUND MILWAUKEE  
INTEGRATED PROVIDER NETWORK INVOICE**

FOSTER/KINSHIP NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PHONE #: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

CLIENT SS#: \_\_\_\_\_

SERVICE MONTH/YEAR: \_\_\_\_\_

SERVICE CODE: 5390/5392

SERVICE NAME: FOSTER/KINSHIP

PROVIDER NAME: \_\_\_\_\_

PLEASE ENTER THE NUMBER OF UNITS PROVIDED BY DATE IN THE APPROPRIATE BOX:

|    |    |    |    |    |    |    |
|----|----|----|----|----|----|----|
| 1  | 2  | 3  | 4  | 5  | 6  | 7  |
| 8  | 9  | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 |    |    |    |    |

TOTAL DAYS \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE CONTACT BONNIE LEWITZKE (414) 257-6176 WITH ANY QUESTIONS

PLEASE MAIL INVOICE TO:

MILWAUKEE COUNTY - BHD - WRAPAROUND  
9201 WATERTOWN PLANK ROAD  
MILWAUKEE, WI 53226

**WRAPAROUND MILWAUKEE  
 INTEGRATED PROVIDER NETWORK INVOICE**

FOSTER/KINSHIP NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

CLIENT SS#: \_\_\_\_\_

SERVICE MONTH/YEAR: \_\_\_\_\_

SERVICE CODE: 5390/5392

SERVICE NAME: FOSTER/KINSHIP

PROVIDER NAME: \_\_\_\_\_

SAMPLE

PLEASE ENTER THE NUMBER OF UNITS PROVIDED BY DATE IN THE APPROPRIATE BOX:

|    |   |    |   |    |   |    |   |    |   |    |   |    |   |
|----|---|----|---|----|---|----|---|----|---|----|---|----|---|
| 1  | I | 2  | I | 3  | I | 4  | I | 5  | I | 6  | I | 7  | I |
| 8  | I | 9  | I | 10 | I | 11 | I | 12 | I | 13 | I | 14 | I |
| 15 | I | 16 | I | 17 | I | 18 | I | 19 | I | 20 | I | 21 | I |
| 22 | I | 23 | I | 24 | I | 25 | I | 26 | I | 27 | I | 28 | I |
| 29 | I | 30 | I | 31 | I |    |   |    |   |    |   |    |   |

TOTAL DAYS 31

SIGNATURE: John Smith

DATE: 1/31/07

PLEASE CONTACT BONNIE LEWITZKE (414) 257-6176 WITH ANY QUESTIONS

PLEASE MAIL INVOICE TO:

MILWAUKEE COUNTY - BHD - WRAPAROUND  
 9201 WATERTOWN PLANK ROAD  
 MILWAUKEE, WI 53226





# Wraparound Milwaukee Foster / Kinship Care Initial Service Authorization

Youth's Name: Emily Meyer DOB: 5-7-1990

Type of Service Requested: Foster Care  Kinship Care   
(circle one)

### Foster/Kinship Provider Information

Name: Mary Smith

Address: 222 W. 2<sup>nd</sup> Street

City, State, Zip: Milwaukee, WI 53222

Phone Number(s): (home) (414) 555-1234  
(work) (414) 555-5678

Service Month: May 2008

Daily Rate Authorized: \$5,000

Number of Days Requested: 31

Jill Saren 4-22-08  
Care Coordinator Signature Date Signed

Phillip Jones 4-22-08  
Supervisor Signature Date Signed

### SUBMIT THIS SERVICE AUTHORIZATION REQUEST TO:

Wraparound Milwaukee Billing Department  
Milwaukee County Behavioral Health Division  
9201 Wauwatosa Plank Road  
Wauwatosa, WI 53226

If you have any questions on how to fill out the form, please feel free to call Bonnie Lewitke at (414) 257-6176.

SAMPLE



Financial Assessment Referral

Referral Date: \_\_\_\_\_

1. Enter the following information on the child for whom Title IV-E/Medicaid benefits are being requested:

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_
Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Petition: \_\_\_\_\_
F# \_\_\_\_\_ CC# \_\_\_\_\_ Next CT Date: \_\_\_\_\_
Child Placed At: \_\_\_\_\_ Address: \_\_\_\_\_
Date of Placement: \_\_\_\_\_ Voluntary [ ] Court Ordered [ ] VPA/Order Date: \_\_\_\_\_
Child Removed From the Home Of: Mother: [ ] Other: Name: \_\_\_\_\_
Father: [ ] Relationship to Child: \_\_\_\_\_
Mother: Phone: \_\_\_\_\_
Name: \_\_\_\_\_ Address or LKA: \_\_\_\_\_
Father: Phone: \_\_\_\_\_
Name: \_\_\_\_\_ Address or LKA: \_\_\_\_\_
Date of Removal: \_\_\_\_\_ Worker's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Complete all of the information for each person in the home from which the child was removed:

Table with 6 columns: Name, Relationship to Child, SSN, DOB, US Citizen, Source of Income

3. Did the child reside with any relative during the six months prior to the month the petition was filed, other than those listed in #2?

No [ ] Yes [ ] Name/Relationship to Child: \_\_\_\_\_

4. Is the child deprived of one or both parents due to one of the following reasons:

Continued Absence No [ ] Yes [ ] Mother [ ] Father [ ]
Death No [ ] Yes [ ] Mother [ ] Father [ ]
Disabled No [ ] Yes [ ] Mother [ ] Father [ ]
Unemployment No [ ] Yes [ ] Mother [ ] Father [ ]

Please enter the following information if known:

5. Was the child in receipt of AFDC-MA in the month the petition was filed or in one of the six months prior to the month the petition was filed, or was the child removed from an AFDC-MA household?

Yes  No

6. Complete the following chart on the parent(s) that are absent. If both, complete both charts.

|                   |       |            |       |            |       |
|-------------------|-------|------------|-------|------------|-------|
| Mother's Name:    | _____ | SSN:       | _____ | Telephone: | _____ |
| Address:          | _____ | DOB:       | _____ | Race:      | _____ |
|                   | _____ |            |       |            |       |
| Employer's Name:  | _____ | Telephone: | _____ |            |       |
| Address:          | _____ |            |       |            |       |
|                   | _____ |            |       |            |       |
| Health Insurance: | _____ |            |       |            |       |

|                   |       |            |       |            |       |
|-------------------|-------|------------|-------|------------|-------|
| Father's Name:    | _____ | SSN:       | _____ | Telephone: | _____ |
| Address:          | _____ | DOB:       | _____ | Race:      | _____ |
|                   | _____ |            |       |            |       |
| Employer's Name:  | _____ | Telephone: | _____ |            |       |
| Address:          | _____ |            |       |            |       |
|                   | _____ |            |       |            |       |
| Health Insurance: | _____ |            |       |            |       |

7. Family Court Support No./Paternity No.:

\_\_\_\_\_

\_\_\_\_\_  
Worker Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

MILWAUKEE COUNTY CHILDREN'S COURT CENTER

ORDER FOR TEMPORARY PHYSICAL CUSTODY

SECURE  NON-SECURE

IN THE INTEREST OF: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
JUVENILE ID: \_\_\_\_\_ CCAP CASE #: \_\_\_\_\_

A request for temporary physical custody has been filed with the court. A hearing for temporary physical custody was held on \_\_\_\_\_, which is the effective date of this order. The juvenile was represented by: \_\_\_\_\_

THE COURT FINDS the child/juvenile is in the jurisdiction of this court and probable cause exists to believe that the:

- 1. Juvenile will commit injury to person or property of others
- 2. Child/Juvenile will  Cause injury to self  Cause injury to others
- 3. Parent, guardian, legal custodian or other responsible adult is  Neglecting  Refusing  Unable  Unavailable to provide adequate supervision and care.
- 4. Child/Juvenile will run away or be taken away, making the child/juvenile unavailable for further court proceedings.
- 5. Child/juvenile is not subject to the federal Indian Child Welfare Act.
- 6. Parent has relinquished custody of the child.

For secure custody, the court further finds that probable cause exists to believe that:

- 1. The juvenile has committed a delinquent act and there is substantial risk of  Physical harm to another  Running away
- 2. The juvenile is a  Fugitive from another state  Runaway from a secure correctional facility and there has been no reasonable opportunity to return the juvenile.
- 3. A protective order has been issued and the child/juvenile consents in writing to the custody.
- 4. The child/juvenile has run away or committed a delinquent act while in non-secure custody.
- 5. The juvenile is alleged/adjudicated delinquent and is a runaway from another county and would run away from non-secure custody.
- 6. The juvenile is subject to adult criminal court jurisdiction and is under 15 years of age.

For secure custody in a jail, the court further finds that:

- 1. No other secure detention facility approved by DOC or the county is available.
- 2. The juvenile presents a substantial risk of physical harm to others in the secure detention facility.

For all custody outside of the home, the court further finds that:

- 1. Continuation of residence in the home at this time is contrary to the child's/juvenile's welfare because: \_\_\_\_\_
- 2. Reasonable efforts to prevent removal and return child/juvenile safely home were:
  - Made by the department or agency responsible for providing services while on/in:
    - Probation  Deferred Prosecution Agreement  JIPS Order  CHIPS Order
    - After Care OR  Alternative Programming Considered and Not Appropriate
  - Specifically: \_\_\_\_\_
  - Custody Intake screening process determined return home is inappropriate given seriousness of situation/offense  
Specifically: \_\_\_\_\_
  - Not required under 938.355(2d) because: \_\_\_\_\_
  - Required, but good cause has been shown why sufficient information is not available to enable the court to make the necessary findings. This hearing is continued until (date): \_\_\_\_\_ (Not to exceed 5 days)
  - Required, but the department or agency responsible for providing services failed to make reasonable efforts.

3. **As to the department or agency recommendation:**
- The placement location recommended by the department or agency is adopted. **OR**
  - After giving bona fide consideration to the recommendations of the department or agency and all parties, the placement location recommended is not adopted.

**THE COURT ORDERS:**

- 1a. The child/juvenile be
- held in temporary secure custody
  - remain in temporary secure custody awaiting non-secure placement at: (include name and address of placement)
    - Parental Home \_\_\_\_\_
    - Relative Home \_\_\_\_\_
    - Temporary Shelter \_\_\_\_\_
    - Other \_\_\_\_\_
- 1b. The child/juvenile be held in temporary non-secure custody at: (include name and address of placement)
- Parental Home \_\_\_\_\_
  - Relative Home \_\_\_\_\_
  - Temporary Shelter \_\_\_\_\_
  - Other \_\_\_\_\_

**Special Delinquency Programs:**

- In-House                       Level II

**Under the Following Conditions:**

- |  |  |
|--|--|
| <input type="checkbox"/> Daily School Attendance                                     | <input type="checkbox"/> Curfew - 24 Hours Except School               |
| <input type="checkbox"/> Cooperate with Counseling                                   | <input type="checkbox"/> Curfew: _____ Weekdays; _____ Weekends        |
| <input type="checkbox"/> No Passes   | <input type="checkbox"/> No Association with Accomplices(s)            |
| <input type="checkbox"/> Passes at Discretion of Intake Specialist/Probation Officer | <input type="checkbox"/> No Further Violations Reaching Probable Cause |
| <input type="checkbox"/> No Association with Victim(s)                               | <input type="checkbox"/> Voluntary Inpatient at CATC                   |
| <input type="checkbox"/> Obey Rules of the Home                                      | <input type="checkbox"/> Other: _____                                  |

**The Child is Released to:**

- |  |  |
|--|--|
| <input type="checkbox"/> Parent                              | <input type="checkbox"/> Relative      |
| <input type="checkbox"/> Child Welfare                       | <input type="checkbox"/> Sheriff       |
| <input type="checkbox"/> DJC                                 | <input type="checkbox"/> Self          |
| <input type="checkbox"/> Intake Specialist/Probation Officer | <input type="checkbox"/> Shelter Staff |
| <input type="checkbox"/> Other: _____                        |  |

**When:**

- Upon Request
- Immediately

**For:**

- Home
- EAS / LHS / SOGS
- Temporary Shelter
- Other: \_\_\_\_\_

2. Other conditions of custody: \_\_\_\_\_
3. The parent(s)/guardian shall contribute toward the expenses of custody/services in the amount of:
- \$ \_\_\_\_\_
  - to be determined by (agency): \_\_\_\_\_
4. The petition for temporary physical custody is denied.

**NEXT HEARING:**    **Branch:** \_\_\_\_\_    **Date:** \_\_\_\_\_    **Time:** \_\_\_\_\_ **AM / PM**

**Type:**  Initial    Status    Plea/Disp    Disp Placement    Sentence    Contest    Other : \_\_\_\_\_

Probation Officer's / Intake Specialist's Signature: \_\_\_\_\_

Name

Date

Judge's/Commissioner's Signature: \_\_\_\_\_

Name

Branch

Date

DELINQUENCY DIVISION PERMANENCY PLAN

A Permanency Plan is to be completed for all juveniles who are in or are about to be placed in Out-Of-Home Care (i.e. Foster Home, Group Home, RCCY, or Relative Placement). The plan must be filed with the court within 60 days of the juvenile first being removed from the home and being placed in shelter, with a relative or an out of home care facility. An updated plan must be submitted to the Court and/or be reviewed through our Administrative Review Panel Process after the juvenile has been in placement 6 months, 12 months, and annually thereafter as long as the juvenile remains in an out of home care placement.

This is an:  Initial Permanency Plan  6 Month Permanency Plan  12 Month Permanency Plan  Ongoing Permanency Plan

Honorable Judge \_\_\_\_\_ CCAP Number: \_\_\_\_\_

Hearing Date (if applicable): \_\_\_\_\_

Juvenile's Name: \_\_\_\_\_ D. O. B.: \_\_\_\_\_

Juvenile's ID Number: \_\_\_\_\_ Probation Number: \_\_\_\_\_

Juvenile's Pending / Adjudicated Offense (s): \_\_\_\_\_

Is there a concurrent CHIPS order or a pending CHIPS action?  Yes  No

If so, what is the CHIPS CCAP Number: \_\_\_\_\_

Assigned Intake Specialist / Probation Officer / Care Coordinator: \_\_\_\_\_

Date of Permanent Plan: \_\_\_\_\_

The Permanent Plan goal for this Juvenile is (check one):

- Return Home  Relative Placement  Independent Living  Long Term Out of Home Care  Other (specify): \_\_\_\_\_

The target date for achieving this plan is: \_\_\_\_\_

FAMILY / GUARDIAN INFORMATION

Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Who is Guardian? (Mother? Father? Both?) \_\_\_\_\_

If the parent(s) is/are not the guardian, who is:

Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

If the juvenile has been out of the home for 15 months or more of the last 22 months, has a referral been made to the District Attorney's office regarding possible TPR proceedings?  Yes  No

If "Yes", on what date? \_\_\_\_\_

If "No", please indicate why no referral was made.

- Child is placed with a relative and the relative will provide permanency. *(Provide supporting information.)*

\_\_\_\_\_  
\_\_\_\_\_

- Termination of Parental Rights is not in the juvenile's best interest. *(Provide supporting information.)*

\_\_\_\_\_  
\_\_\_\_\_

- Reasonable efforts to reunify the family have not been made. *(Provide supporting information.)*

\_\_\_\_\_  
\_\_\_\_\_

- Other \_\_\_\_\_

\_\_\_\_\_

JUVENILE EDUCATION AND MEDICAL INFORMATION

Name and location of most recently enrolled school: \_\_\_\_\_

\_\_\_\_\_

Is/was the juvenile in any special programs? *(describe)* \_\_\_\_\_

\_\_\_\_\_

Current grade: \_\_\_\_\_

Summarize any information from school records. *(Include such things as assessments, current and past academic performance, behavior issues, progress records, and current and past educational difficulties.)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was consideration given in making the current/proposed placement to continuing the school program juvenile was enrolled in before placement. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the most recent grade report attached?  Yes  No



LIST ALL CURRENT MEDICATIONS:

| Name of Medication | Dosage | Date First Prescribed | Purpose |
|--------------------|--------|-----------------------|---------|
|                    |        |                       |         |
|                    |        |                       |         |
|                    |        |                       |         |
|                    |        |                       |         |

Is juvenile cooperating with taking their current medications?  Yes  No

If known, has the juvenile been on other medications in the past? (*List and indicated what these were for, and when and why the juvenile stopped taking them.*)

| Name of Medication | Purpose | When Terminated | Why Terminated |
|--------------------|---------|-----------------|----------------|
|                    |         |                 |                |
|                    |         |                 |                |
|                    |         |                 |                |
|                    |         |                 |                |

If know, list any allergies or negative reactions to any medications.

| Allergies / Reactions | Name of Medication ( <i>if any</i> ) |
|-----------------------|--------------------------------------|
|                       |                                      |
|                       |                                      |
|                       |                                      |
|                       |                                      |

PLACEMENT INFORMATION

CURRENT PLACEMENT:

Lives With: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address (unless not to be disclosed): \_\_\_\_\_  
 Type of Home / Institution: \_\_\_\_\_  
 Date of Current Placement: \_\_\_\_\_

List Placements (*Name, Address, Dates, Types*) prior to current placement since the last referral to Children's Court Center:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date Placed: \_\_\_\_\_ Type of Placement: \_\_\_\_\_





RELATIVE PLACEMENT POSSIBILITY:

Is a safe and appropriate placement with a relative available?  Yes  No

If there was a decision made to not place the juvenile with an available relative, why was the placement perceived as not safe or appropriate? \_\_\_\_\_

If a Native American juvenile:

Tribal authority to place:  Yes Date: \_\_\_\_\_  
 No Reason: \_\_\_\_\_

Name of Tribe: \_\_\_\_\_

Address: \_\_\_\_\_

SERVICES CONSIDERED, OFFERED, PROVIDED TO JUVENILE/FAMILY TO PREVENT REMOVAL OR RETURN HOME  
 (Check all that apply and write date next to service):

|   | Offered/Refused | Referred | Provided | Unavailable | Not Appropriate |
|---|-----------------|----------|----------|-------------|-----------------|
| Deferred Prosecution                          |                 |          |          |             |                 |
| Consent Decree                                |                 |          |          |             |                 |
| Parenting Education                           |                 |          |          |             |                 |
| Probation Services                            |                 |          |          |             |                 |
| Day Treatment                                 |                 |          |          |             |                 |
| First Time Offender Program                   |                 |          |          |             |                 |
| Education/Vocational Services                 |                 |          |          |             |                 |
| Emergency Out of Home Care ( <i>Respite</i> ) |                 |          |          |             |                 |
| Temporary Shelter ( <i>Short Term</i> )       |                 |          |          |             |                 |
| Health Services Referral                      |                 |          |          |             |                 |
| Financial Assistance                          |                 |          |          |             |                 |
| Diversion Programs                            |                 |          |          |             |                 |
| Anger Management                              |                 |          |          |             |                 |
| Recreation Program                            |                 |          |          |             |                 |
| Monitoring                                    |                 |          |          |             |                 |
| Mentoring                                     |                 |          |          |             |                 |
| Family Counseling/Therapy/Evaluation          |                 |          |          |             |                 |
| Individual Counseling/Therapy/Evaluation      |                 |          |          |             |                 |
| Placement with Relative ( <i>Short Term</i> ) |                 |          |          |             |                 |
| AODA Counseling/Evaluation                    |                 |          |          |             |                 |
| Visitation - Supervised                       |                 |          |          |             |                 |
| Visitation - Unsupervised                     |                 |          |          |             |                 |
| Transportation Coordination/Funding           |                 |          |          |             |                 |
| Other ( <i>Explain</i> ):                     |                 |          |          |             |                 |

Must discuss services considered, offered, and provided to prevent removal of to return juvenile home and their appropriateness on meeting child and family needs.

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SERVICES TO BE PROVIDED DURING THE DURATION OF THE ORDER

(If a service is needed, but not available, please indicate by checking the text describing that particular service):

To insure proper care and treatment of the juvenile including social, emotional and physical needs:

- Placement with relative
- Placement in licensed foster home
- Placement in licensed group home
- Supervision of placement by probation and services through Wraparound
- Probation Services
- Day Treatment
- Counseling / Therapy for the juvenile (may include foster parents)
- Anger Management
- Referral to appropriate medical care providers
- Family planning
- Independent living skills
- Day Care
- Respite Care
- AODA counseling / evaluation
- Recreational program
- Mentoring
- Monitoring
- Other: \_\_\_\_\_

Services to meet the juvenile's educational and vocational needs:

- Enrollment in public education system
- Special education plan within public school system - IEP
- Educational / vocational plan funded / coordinated by Wraparound
- Enrolled in special vocational programming
- Day Treatment
- Alternative school program
- Other: \_\_\_\_\_

Independent living services (age 15 and over -- check at least one):

- Not appropriate - returning to parents
- Not appropriate - DD child
- Not appropriate - under 15
- Job readiness
- Referral to school social worker
- Educational planning
- Living arrangement
- Financial planning / assistance
- Other: \_\_\_\_\_



CONDITIONS TO BE MET FOR THE JUVENILE TO RETURN HOME

(Mark all that apply, using M for Mother, F for Father, and B for Both)

Parent to:

- Comply with court orders, including any items in the court order which do not appear in this document
- Attend psychological evaluation / therapy
- Participate in parent education program
- Participate in therapy
- Abstain from alcohol and other drug use / abuse
- Participate in AODA counseling / support groups
- Locate housing acceptable to social worker / court
- Improve / maintain health and sanitation standards
- Participate in education / vocational skills programming
- Maintain stable living arrangement (*adequate furniture and appliances*)
- Terminate associations deemed not in a juvenile's / family's best interest
- Maintain adequate food supply
- Make / keep medical appointments and other appointments
- Cooperate with juvenile visitation plan (*regular and successful visits*)
- Be available to social worker and other service providers, including notifying of change in address and / or phone number
- Abstain from law violations
- Complete and sign necessary papers, such as consent forms, program referrals, etc.
- Cooperate in plan for rehabilitation of the child
- Other: \_\_\_\_\_

Juvenile to:

- Comply with all conditions of court orders
- Attend psychological evaluation / therapy
- Comply with rules of probation as set forth in the court order
- Comply with rules of treatment center / group home or foster home
- Attend school regularly
- Participate in AODA counseling / support groups
- Abstain from alcohol or other drug use / abuse
- Abstain from law violations
- Show evidence of improvement in special need area as a result of therapy / treatment
- Other: \_\_\_\_\_

Agency to:

- Provide services as specified
- Make referral to provider of necessary services
- Facilitate client utilization of identified services

\_\_\_\_\_  
Intake Specialist / Probation Officer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

## FOSTER PARENT CHECKLIST

**When placing a child in foster care, please provide the following information to the foster parent(s):**

- Child's name / nicknames.
  - Child's date of birth.
  - Reason for placement outside of the home (i.e., CHIPS / delinquency).
  - Child's strengths/needs.
  - Child's interests.
  - Biological family's strengths and expected level of involvement.
  - Significant behavioral challenges presented in the home, school and community.
  - Medical history of child:
    - Physical health (including dental, eye exam information and family specific health problems).
    - Emotional health.
    - Mental health diagnosis.
    - Medications taken both past and present.
    - Allergies (food / medication).
    - Immunization record.
    - Hospitalizations (within the last 12 months and reasons for admission).
    - Physician's name and telephone number, if known.
    - Mental health providers.
  - Expected length of placement of child in foster home.
  - Identify the Permanency Plan for the child.
  - Provide foster parents with the names of the parent(s) and / or siblings.
  - Provide foster parents with the Care Coordinator's name, agency name and phone numbers.
  - Provide foster parents with the Plan of Care highlighting the details of the Crisis Plan, including necessary contacts.
  - Provide expectations for involvement in Child and Family Team and further Plan of Care meetings.
  - Provide foster parents with Safety Plan including MUTT pamphlet.
  - Explain the Wraparound T19 medical card to be issued.
  - Provide Wraparound Milwaukee Family Handbook.
  - Provide information on Wraparound philosophy and process.
- 

### **Responsibilities of Care Coordinator and Foster Parent:**

- Foster parents should schedule a routine medical exam within the next 30 days for the child.
- Foster parents should keep a record of the foster child's school, medical, dental and immunization information.
- Care Coordinator should negotiate the monthly foster care rate with the foster parent and Wraparound Liaison and explain:
  - Payment timeline, SAR, and Invoice process.
  - Prorated payment if child is in CCI.
- Care Coordinator should explain that the monthly foster care rate includes:
  - Food, clothing, furniture, housing, personal care and other expenses related to the care of child.
- Care Coordinator should determine an allowable initial clothing allowance, not to exceed \$250 without special permission from Wraparound Administration.
- Care Coordinator will usually arrange parental visitation, but the foster parent can also schedule parental visitation with the Care Coordinator's approval, if not prohibited by the Court Order.
- Care Coordinator should explain that travel with the foster child is permissible, but requires written parental/guardian permission if traveling outside the state.
- Foster parents must carry liability/homeowner's insurance.

**I have reviewed the above information with my Care Coordinator prior to having a foster child placed in my home.**

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Signature of Foster Parent

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Signature of Care Coordinator / Witness

DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
Division of Community Services  
DCS-872 (3/95)

WISCONSIN

## INFORMATION FOR FOSTER PARENTS

TO: Foster Parent

The attached forms and information are provided to you according to s. 895.485(4)(a), Wis. Stats., and ch. HSS 37, Adm. Code. We have tried to give you all of the information indicated on the forms, but we often do not have complete information at the time of placement.

Together we are partners in the provision of services to this child. Therefore, we must both try to gather and share information on this child. Please add information to this form whenever you gather it (for example, from the child or his/her family or from a physician). We shall also continue to provide you with information.

During our later visits, we shall share with each other any new information that becomes available.

All of the information regarding this foster child provided to you on these forms and in any other manner is done so with the expectation that you will maintain the information in confidence. State and federal statutes require that this information be kept confidential. If you have any questions regarding what information you may share with any party (e.g., health care providers, schools), please contact the child's social worker.

Note: If the space provided on the form is not adequate, please make a note that information is continued on the back or on a separate sheet. On the back or on a separate sheet, please clearly indicate to which section or item number this information applies.

**INFORMATION FOR FOSTER PARENTS  
FACE SHEET**

Date of Placement:     /     /    

|  |  |
|--|--|
| Child's Name: _____  | Nickname(s): _____   |
| DOB: <u>   </u> / <u>   </u> / <u>   </u>  | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female    SS#: _____ |
| Cultural Identification (as indicated by child if old enough): _____               |  |
| Height: _____  | Weight: _____ lbs.   |
| Religious Preference (of child or family): _____                                   |  |
| Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations): _____ |  |
| _____  |  |

|  |                        |
|--|------------------------|
| Child's Social Worker With Whom Foster Parent Will Have Contact: |                        |
| Name: _____  | Title: _____           |
| Agency: _____  |                        |
| Agency Secondary Contact (if social worker not available): _____ |                        |
| Telephone: Regular Hours: ( ) _____                              | After Hours: ( ) _____ |

| Reason(s) for Placement   |  |
|---|--|
| <input type="checkbox"/> Delinquent Act(s)<br><input type="checkbox"/> Assaultive<br><input type="checkbox"/> Non-Assaultive  | Nature of Offense(s):  |
| <input type="checkbox"/> CHIPS, other than CAN  | Type of CHIPS:   |
| <input type="checkbox"/> CAN<br><input type="checkbox"/> Physical Abuse<br><input type="checkbox"/> Sexual Abuse<br><input type="checkbox"/> Emotional Abuse<br><input type="checkbox"/> Neglect  | Relationship of Alleged Perpetrator(s)<br><br>Does the child exhibit any inappropriate sexual behaviors? |
| <input type="checkbox"/> Developmental Disability<br><input type="checkbox"/> Physical Handicap<br><input type="checkbox"/> AODA<br><input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter)<br><input type="checkbox"/> Learning Disability |  |

This is a:

Voluntary Placement

Court-ordered Placement

Medical Assistance #: \_\_\_\_\_

Insurance Company (if any): Name \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Physician: \_\_\_\_\_

Type: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Other Health Specialists/Therapists

Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Specialty: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Specialty: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

(Note: Use of hospital may be dictated by insurance company/plan)

Is foster parent expected to participate in therapy with the child?  Yes  No

Name of

Child's

(Check most appropriate one)

Birth Mother:

Stepmother: \_\_\_\_\_

Adoptive Mother:

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Name of

Child's

(Check most appropriate one)

Birth Father:

Stepfather: \_\_\_\_\_

Adoptive Father:

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Child's

Siblings:

Name: \_\_\_\_\_ DOB: / / Phone: ( ) \_\_\_\_\_

At home  Out of home (where: \_\_\_\_\_)

Name: \_\_\_\_\_ DOB: / / Phone: ( ) \_\_\_\_\_

At home  Out of home (where: \_\_\_\_\_)

Name: \_\_\_\_\_ DOB: / / Phone: ( ) \_\_\_\_\_

At home  Out of home (where: \_\_\_\_\_)

Significant Extended Family Members (Name, Phone and Relationship):

Legal Custodian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

GAL\*/Legal Counsel: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

\*Guardian ad litem

Significant individuals who may be having contact with the child:

| Name  | Phone | Relationship |
|-------|-------|--------------|
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |

Individuals whose contact with the child is forbidden or restricted  
(e.g., supervised visitation)

| Name  | Relationship | Type of Restriction | Rationale (e.g., court order, parents' wishes) |
|-------|--------------|---------------------|--|
| _____ | _____        | _____               | _____  |
| _____ | _____        | _____               | _____  |
| _____ | _____        | _____               | _____  |
| _____ | _____        | _____               | _____  |

(Should you have any questions about contacts, please call the child's social worker.)

Previous Placements (If no court order prohibiting release of name of previous foster home placement(s))

Type (FH, GH,  
BCC/CCL hospital, etc.)

Name

Dates

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

School Attending or Will Attend: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

Grade: \_\_\_\_\_

Is child enrolled in a special education program? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what type: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Day Care or Respite Provider(s)

\_\_\_\_\_

Phone: ( ) \_\_\_\_\_

\_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Does the child have specific hobbies or interests? Does the child have special abilities/talents (e.g., music, art, athletics)? Does the child prefer group or solitary activities?

Does the child have preferences that the foster parent may want to know about (e.g., favorite foods, clothing, toys, music)?

Placing agency has given the foster parent:

- Birth certificate (copy), if available
- Medical records/summary
- Social history/summary
- Court order
- Permission to operate hazardous machines
- Social Security Card
- Court report/summary
- Placement Agreement
- Summary of social/psychiatric evaluations
- Dental records/summary
- School academic records/summary
- Information on child's specific diagnosis and/or disability
- School and community activity permissions
- Summary of mental health treatment
- MA card
- Signed medical release for emergency health care

\* Summary is requested to ensure that materials (e.g., psychological assessments) can be interpreted by foster parents. Primary source documents can be provided if useful for clarification.

**INFORMATION FOR FOSTER PARENTS  
CHECKLIST**

|  | Yes | No | NK | If "Yes", please comment |
|--|-----|----|----|--------------------------|
| Previous hospitalizations  |     |    |    |                          |
| a. Was anesthesia used?  |     |    |    |                          |
| b. Problems with anesthesia?   |     |    |    |                          |
| 2. Previous serious illnesses or injuries  |     |    |    |                          |
| 3. Has child had any other medical tests (e.g., CAT Scan, EEG, MRI)?   |     |    |    |                          |
| 4. Taking any medication including birth control pills or the use of birth control devices which require a prescription or other involvement of a physician? (If "Yes", name of medication, dosage, reason, prescription or over the counter, how given, by whom, who prescribed): |     |    |    |                          |
| 5. Immunizations (Indicate date(s))  |     |    |    | Date(s)                  |
| DPT (infants)(Diphtheria, Pertussis, Tetanus)  |     |    |    |                          |
| Polio (type: TOPV-Oral or IPV-Injectable)  |     |    |    |                          |
| MMR (Measles, Mumps, Rubella)  |     |    |    |                          |
| Flu  |     |    |    |                          |
| Pneumonia  |     |    |    |                          |
| Hepatitis B  |     |    |    |                          |
| Significant biological family medical history: (e.g., cancer, heart problems)  |     |    |    |                          |
| 7. Medical needs   |     |    |    |                          |
| Apnea monitor  |     |    |    |                          |
| Gastrostomy  |     |    |    |                          |
| Tracheotomy  |     |    |    |                          |
| Ventilator   |     |    |    |                          |
| Heart monitor  |     |    |    |                          |
| Other (specify)  |     |    |    |                          |
| 8. Degenerative disorder   |     |    |    |                          |
| 9. Allergies, including animals, insect bites/stings, soap, wool, food, drugs, milk. (If "Yes", to what, symptoms, treatment)  |     |    |    |                          |
| 10. Child has or ever had the following:<br>(If yes, date child had it)  |     |    |    | Date(s)                  |
| 7-day Measles  |     |    |    |                          |
| 3-day German Measles   |     |    |    |                          |
| Chicken Pox  |     |    |    |                          |
| Rubella  |     |    |    |                          |
| Mumps  |     |    |    |                          |

|     |   | Yes | No | NK | If "Yes", please comment |
|-----|---|-----|----|----|--------------------------|
|     | Whooping Cough  |     |    |    |                          |
|     | Scarlet Fever   |     |    |    |                          |
|     | Strep-Throat  |     |    |    |                          |
|     | Impetigo  |     |    |    |                          |
|     | Lice  |     |    |    |                          |
|     | Worms   |     |    |    |                          |
|     | Sexually Transmitted Disease  |     |    |    |                          |
|     | Hepatitis B   |     |    |    |                          |
|     | Polio   |     |    |    |                          |
|     | Pneumonia   |     |    |    |                          |
|     | Mononucleosis   |     |    |    |                          |
|     | Scabies   |     |    |    |                          |
|     | Other   |     |    |    |                          |
| 11. | Current dental problems   |     |    |    |                          |
|     | Braces or retainers?  |     |    |    |                          |
|     | Bridges or dentures?  |     |    |    |                          |
|     | Last dental exam date? _____  |     |    |    |                          |
| 12. | Appetite above or below normal  |     |    |    |                          |
|     | Balanced diet   |     |    |    |                          |
|     | Unusual eating patterns/habits (e.g., large sugar intake, no vegetables)                  |     |    |    |                          |
| 13. | Abdominal Concerns  |     |    |    |                          |
|     | Has had an ulcer or heartburn   |     |    |    |                          |
|     | Child regularly uses Tums or other antacid  |     |    |    |                          |
|     | Frequent nausea or vomiting   |     |    |    |                          |
|     | Child drinks caffeinated coffee or cola. How much per day?                                |     |    |    |                          |
|     | Has had "yellow jaundice" or liver disease  |     |    |    |                          |
|     | Gets abdominal pain   |     |    |    |                          |
|     | Child uses laxatives. How often?  |     |    |    |                          |
|     | Becomes constipated or gets diarrhea  |     |    |    |                          |
|     | Has had blood in stool recently   |     |    |    |                          |
|     | Special diet needs (religious, medical, philosophical, vitamin/mineral supplements, etc.) |     |    |    |                          |
| 14. | Anorexia/bulimia/other eating disorders. Ever had treatment?                              |     |    |    |                          |

|     |  | Yes | No | NK | If "Yes", please comment |
|-----|--|-----|----|----|--------------------------|
| 15. | Headaches<br>Migraine  |     |    |    |                          |
| 16. | Coordination or balance problems/dizziness<br>Has had serious head injury or loss of consciousness<br>Numbness or loss of strength in hand, arm or leg<br>Any trouble with swallowing or speaking      |     |    |    |                          |
| 17. | Has had a seizure<br>Has had epilepsy<br>Type and frequency of seizures<br><del>How to respond</del><br>Controlled or uncontrolled<br>Ever hospitalized for seizures<br>Ongoing medicines for seizures |     |    |    |                          |
| 18. | Does child wear glasses? If yes, for how long?<br>Last eye exam (date, Dr.'s name)<br>Blurred or double vision<br>Contact lenses   |     |    |    |                          |
| 19. | Has hearing problem<br>Ringing in ears<br>Discharge or infection in ears<br>Tubes(s) in ears   |     |    |    |                          |
| 20. | Blocking of nose, discharge, post-nasal drip<br>Nose bleeds<br>Persistent hoarseness   |     |    |    |                          |
| 21. | Treatment for skin trouble, rashes, hives, acne, or breaking out   |     |    |    |                          |
| 22. | Has had bursitis, sprain or dislocation of bone or joint<br>Cramps or pain in legs<br>Backaches<br>Arthritis   |     |    |    |                          |
| 23. | Thyroid problems   |     |    |    |                          |
| 24. | Child has had test for AIDS/HIV (If yes, date: _____)  |     |    |    | Results:                 |
| 25. | Child has had test for Hepatitis (If yes, (date: _____)  |     |    |    | Results:                 |

|   | Yes | No | NK | If "Yes", please comment |
|---|-----|----|----|--------------------------|
| 26. Chest pain or discomfort/heart concerns                 |     |    |    |                          |
| Asthma or wheezing  |     |    |    |                          |
| Cough, phlegm, bronchitis                                   |     |    |    |                          |
| Has coughed up blood  |     |    |    |                          |
| Smoke? If yes, how long? How much?                          |     |    |    |                          |
| TB skin test. If yes, when? Results?                        |     |    |    |                          |
| Heart trouble   |     |    |    |                          |
| Rheumatic Fever   |     |    |    |                          |
| Has had electrocardiogram (EKG)                             |     |    |    |                          |
| Has had chest X-ray. If yes, when was last one?             |     |    |    |                          |
| Heart murmur  |     |    |    |                          |
| High or low blood pressure. Last check up?                  |     |    |    |                          |
| Irregular heart beat  |     |    |    |                          |
| Shortage of breath  |     |    |    |                          |
| Swollen ankles  |     |    |    |                          |
| How many pillows does child sleep on?                       |     |    |    |                          |
| 27. Urinary or prostate problems/Gall bladder               |     |    |    |                          |
| Incontinence, urine or fecal                                |     |    |    |                          |
| Bleeding or burning when urinating                          |     |    |    |                          |
| Abnormally frequent urination                               |     |    |    |                          |
| Has had kidney or gall bladder stone                        |     |    |    |                          |
| 28. Anemia  |     |    |    |                          |
| 29. Blood problems  |     |    |    |                          |
| 30. Cancer, leukemia, or other malignancy                   |     |    |    |                          |
| 31. History of abusing or not taking prescribed medications |     |    |    |                          |
| 32. Alcohol use or abuse                                    |     |    |    |                          |
| 33. Other drug use or abuse                                 |     |    |    |                          |
| AODA treatment  |     |    |    |                          |
| 34. Is child menstruating?                                  |     |    |    |                          |
| Child understands menstruation                              |     |    |    |                          |
| Child's periods are normal                                  |     |    |    |                          |
| Excessive cramping or pain                                  |     |    |    |                          |
| PMS symptoms  |     |    |    |                          |
| Medication for cramps. If yes, what medication?             |     |    |    |                          |

|   |  | Yes | No | NK | If "Yes", please comment |
|---|--|-----|----|----|--------------------------|
| Bleeding or discharge other than when menstruating            |  |     |    |    |                          |
| Has had a "yeast" infection                                   |  |     |    |    |                          |
| Has had a "Pap" test. If yes, when? Why?<br>Abnormal results? |  |     |    |    |                          |
| 35.   | Child has physical or developmental disabilities                             |     |    |    |                          |
|   | If yes, what type of disability?   |     |    |    |                          |
|   | Autism   |     |    |    |                          |
|   | Blindness  |     |    |    |                          |
|   | Cerebral Palsy   |     |    |    |                          |
|   | Deafness   |     |    |    |                          |
|   | Dyslexia   |     |    |    |                          |
|   | Emotional Disturbance  |     |    |    |                          |
|   | Epilepsy   |     |    |    |                          |
|   | Fetal Alcohol Effect   |     |    |    |                          |
|   | Fetal Alcohol Syndrome   |     |    |    |                          |
|   | Mental Retardation   |     |    |    |                          |
|   | Muscular Dystrophy   |     |    |    |                          |
|   | Neurological Impairment  |     |    |    |                          |
|   | Physical Impairment  |     |    |    |                          |
|   | Other (specify):   |     |    |    |                          |
|   | Restrictions on Activities<br>(e.g., lifting, driving, riding bikes)         |     |    |    |                          |
|   | Special equipment (e.g., cane, walker, wheelchair)                           |     |    |    |                          |
| 36.   | Considering the age of the child, his/her abilities are not appropriate for: |     |    |    |                          |
|   | Bathing  |     |    |    |                          |
|   | Feeding  |     |    |    |                          |
|   | Toileting  |     |    |    |                          |
|   | Dressing   |     |    |    |                          |
|   | Learning   |     |    |    |                          |
|   | Receptive Language   |     |    |    |                          |
|   | Mobility   |     |    |    |                          |
|   | Danger Awareness   |     |    |    |                          |

|     |  | Yes | No | NK | If "Yes", please comment |
|-----|--|-----|----|----|--------------------------|
|     | Social/Emotional Functioning   |     |    |    |                          |
|     | Capacity for Independent Living  |     |    |    |                          |
|     | Other (specify):   |     |    |    |                          |
| 37. | Limitations in verbal skills. (If yes, also check a or b below)  |     |    |    |                          |
|     | a. Child is non-verbal   |     |    |    |                          |
|     | b. Child has very limited verbal skills  |     |    |    |                          |
| 38. | History of behavioral or emotional problems  |     |    |    |                          |
| 39. | History of treatment for behavioral or emotional problems at a clinic or hospital  |     |    |    |                          |
| 40. | Someone in child's immediate family has been treated or hospitalized for emotional or mental health problems. (If yes, also check below) |     |    |    |                          |
|     | Depression   |     |    |    |                          |
|     | Anxiety  |     |    |    |                          |
|     | Mood swings  |     |    |    |                          |
|     | Suicide attempts   |     |    |    |                          |
|     | AODA   |     |    |    |                          |
|     | Mental Health  |     |    |    |                          |
| 41. | Has the child ever:  |     |    |    |                          |
|     | Felt hopeless or depressed   |     |    |    |                          |
|     | Had unexplained crying spells  |     |    |    |                          |
|     | Planned or attempted suicide   |     |    |    |                          |
|     | Had peculiar or bizarre thoughts   |     |    |    |                          |
|     | Had trouble eating or sleeping (either too much or too little)   |     |    |    |                          |
|     | Had an excess of energy or activity  |     |    |    |                          |
|     | Felt like hurting him/her self   |     |    |    |                          |
|     | Displayed reckless or dangerous behavior   |     |    |    |                          |
|     | Heard things no one else around him/her heard  |     |    |    |                          |
|     | Shown inappropriate emotions (reactions that didn't make sense in the situation).  |     |    |    |                          |
|     | Assaulted anyone physically (if yes, who, how recently, and how severely).   |     |    |    |                          |
|     | Assaulted anyone sexually (if yes, who, how recently, and how severely).   |     |    |    |                          |
|     | Assaulted or abused animals  |     |    |    |                          |

\* NK = Not Known At This Time

|     |   | Yes | No | NK | If "Yes", please comment |
|-----|---|-----|----|----|--------------------------|
| 42. | Child has had any of the following problems at home or in the community.  |     |    |    |                          |
|     | Withdrawing socially (doesn't want to be around other people)   |     |    |    |                          |
|     | Lying or stealing   |     |    |    |                          |
|     | Arguing or fighting with peers or siblings  |     |    |    |                          |
|     | Clinging excessively to a parent, teacher or other person   |     |    |    |                          |
|     | Problems with police  |     |    |    |                          |
|     | Setting fires   |     |    |    |                          |
|     | Refusing to follow instructions from parents or obey house rules, etc.  |     |    |    |                          |
| 43. | Child ran away in past. (If yes, answer below).   |     |    |    |                          |
|     | For how long?   |     |    |    |                          |
|     | From where did child run?   |     |    |    |                          |
|     | Where did child go?   |     |    |    |                          |
|     | How was child returned? (Voluntarily, law enforcement, social worker?)  |     |    |    |                          |
|     | Why did child run?  |     |    |    |                          |
|     | Did/does child run alone or with others?  |     |    |    |                          |
| 44. | Child has had any of the following problems at school   |     |    |    |                          |
|     | Poor grades   |     |    |    |                          |
|     | Difficulty making friends   |     |    |    |                          |
|     | Suspensions from school   |     |    |    |                          |
|     | Fighting or arguing with peers or teachers  |     |    |    |                          |
|     | Frequent lying or stealing  |     |    |    |                          |
|     | Frequent truancy (including cutting classes)  |     |    |    |                          |
| 45. | Child has trouble sleeping. If yes, answer below:   |     |    |    |                          |
|     | Child takes sleeping pills. If yes, how often?  |     |    |    |                          |
|     | General sleeping pattern (sleep alone, cold or warm room, lights on or off, door open or closed, usual hours of sleep, naps, sleep with toy, pajamas, sleep walk, wake during night, etc.) (Circle appropriate description or describe: |     |    |    |                          |

| 46. | Child has fears/phobias. If yes, answer below:                         | Yes | No | NK | If "Yes", please comment |
|-----|--|-----|----|----|--------------------------|
|     | Darkness   |     |    |    |                          |
|     | Animals  |     |    |    |                          |
|     | Cars   |     |    |    |                          |
|     | Loud noises  |     |    |    |                          |
|     | Heights  |     |    |    |                          |
|     | Water (e.g., swimming pools, baths, lakes)                             |     |    |    |                          |
|     | Weather (e.g., wind, thunder, storms)                                  |     |    |    |                          |
|     | Other (specify)  |     |    |    |                          |
| 47. | Child has a history of making abuse allegations against care providers |     |    |    |                          |

The information included herein and the form have been shared with the foster parent. The foster parents have been made aware of the laws regarding confidentiality and the limitations on sharing any of this information with individuals or agencies not involved in the case of this child and/or his/her parents.\*

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Signature of Staff Person Providing Information

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Date

---

Signature of Foster Parent

---

Date

---

Signature of Foster Parent

---

Date

(Two copies should be made and signed. Foster parents should keep one copy in the child's file, and the placing agency should keep one copy in the child's case record.)

\* In accordance with ss. 48.396, 48.78, 48.981(7) and other relevant sections of Wisconsin Statutes.

## Understanding the

# UNIFORM FOSTER CARE RATE

Effective January 1, 2005 -  
December 31, 2006



Wisconsin Department of Health and Family Services  
Division of Children and Family Services  
Bureau of Programs and Policies

|                              |                        |  |  |  |  |  |
|------------------------------|------------------------|--|--|--|--|--|
| MY FOSTER CHILDREN'S RECORDS | CHILD'S NAME           |  |  |  |  |  |
|                              | BASIC MAINTENANCE RATE |  |  |  |  |  |
|                              | SUPPLEMENTAL RATE      |  |  |  |  |  |
|                              | EXCEPTIONAL RATE       |  |  |  |  |  |
|                              | MONTHLY RATE           |  |  |  |  |  |
|                              | LAST REVIEW RATE       |  |  |  |  |  |

PLACEMENT DATE

### What if a child, to my home with few or no clothes?

You may be provided an INITIAL CLOTHING ALLOWANCE (see table below) if:

- it is your foster child's first placement; or
- it has been at least four months since the child was last in out-of-home care.

| Age Group | Initial Clothing Allowance |
|-----------|----------------------------|
| 0 - 4     | up to \$150.00             |
| 5 - 11    | up to 175.00               |
| 12 - 14   | up to 200.00               |
| 15 - 18   | up to 200.00               |

Periodic clothing allowances, such as for seasonal clothing, are not allowed. An amount is included in the basic maintenance rate for this purpose each month.

### What if I don't agree with the rate?

You may request that the rate be redetermined. You may discuss your concerns with the rate setter and the agency director. If you still disagree with the rate, you should consider appealing through the fair hearing process. Your agency director or foster care coordinator will tell you how to request a fair hearing.

### Is there liability insurance for foster parents?

A statewide fund provides some protection when your own insurance policies do not. The state fund covers some property damage and personal injury caused by the foster child. The extent of coverage and exclusions is subject to change. The agency that licensed your foster home can give you up-to-date information.

### More questions?

Contact your case worker or Foster Care Coordinator for further explanations. See also our Foster Care website at <http://dhfs.wisconsin.gov/children/foster>

## What is the Uniform Foster Care Rate?

The Uniform Foster Care Rate (UFCR) is a standard scale of monthly payments to foster parents for the cost of caring for a foster child. Because the rate is based on the needs of each child, it may also include extra payments (called supplemental and exceptional payments) in addition to a BASIC MAINTENANCE RATE.

## What does the basic maintenance rate include?

The basic rate is intended to cover food, clothing, housing, basic transportation, personal care, and other expenses on a monthly basis.

The current basic rate for each child is listed below by age group. There will be a 5 percent increase to all levels for the basic rate effective January 1, 2006. The new rate amounts are also included below.

| Age of Child | Effective Date |           |
|--------------|----------------|-----------|
|              | Jan. 2005      | Jan. 2006 |
| 0 - 4        | \$302.00       | \$317.00  |
| 5 - 11       | \$329.00       | \$346.00  |
| 12 - 14      | \$375.00       | \$394.00  |
| 15 - 18      | \$391.00       | \$411.00  |

When a foster child in your care turns 5, 12, or 15 years of age, you will receive the next highest rate effective on the child's birthday.

You will receive payment for your foster child for the day the child enters your home but not for the day the child leaves your home.

On the next page is a breakdown of the percentages typically spent on the basic necessities for children at various ages. This is intended as a guide. It is understood that your family will use the monthly uniform foster care rates in the manner which best meets your foster child's needs.

## Guidelines for use of the Basic Rate

These specific breakdowns by food, clothing, housing, and personal care and other expenses are based on the cost of raising a child as calculated by the U.S. Department of Agriculture. Because the cost of raising a child is more than the amount provided through the Basic

Maintenance Rate, these percentages provide only a guide for foster parents. The figures presented are percentages of the basic maintenance rate received for a child in the designated age group.

### FOOD

|               |             |
|---------------|-------------|
| Age 0 to 4:   | 17 to 30%   |
| Age 5 to 11:  | 26 to 33%   |
| Age 12 to 14: | Approx. 33% |
| Age 15+       | Approx. 33% |

### CLOTHING

|               |             |
|---------------|-------------|
| Age 0 to 4:   | Approx. 6%  |
| Age 5 to 11:  | Approx. 8%  |
| Age 12 to 14: | Approx. 11% |
| Age 15+       | Approx. 13% |

### HOUSING

|               |             |
|---------------|-------------|
| Age 0 to 4:   | 48 to 58%   |
| Age 5 to 11:  | Approx. 43% |
| Age 12 to 14: | Approx. 39% |
| Age 15+       | Approx. 36% |

### PERSONAL CARE AND OTHER EXPENSES\*

|               |             |
|---------------|-------------|
| Age 0 to 4:   | Approx. 18% |
| Age 5 to 11:  | Approx. 19% |
| Age 12 to 14: | Approx. 17% |
| Age 15+       | Approx. 17% |

\* Other expenses include but are not limited to haircuts, soap, shampoo, toothpaste, and school supplies.

## Is there an additional payment for children who have special needs?

Yes. If your foster child has emotional, behavioral, or medical problems, you may request an additional monthly payment to cover the costs of caring for the child's special needs. When approved, this payment is called a SUPPLEMENTAL RATE.

## How is the supplemental rate determined?

Within the first 30 days after a foster child is placed in your home, you and your case worker will discuss whether the child may qualify for a

supplemental payment. If your foster child has needs that require special care or supervision, the case worker will submit a description of the child's problems or characteristics.

Evaluations from doctors, psychiatrists, therapists, or other specialists may be included with the case worker's report.

Using a point scale and all of the information regarding the child's emotional, behavioral, and medical problems, the placing agency determines the level of care the child requires.

This level of care establishes the supplemental payment.

## Can supplemental rates be changed?

You and your case worker will review your foster child's progress at least every six months. At those reviews, the supplemental rate may be changed if the child's condition is changed. Inform your case worker of significant changes when they occur.

## What if a child needs constant care or supervision?

If a child has extraordinary needs, you may receive an additional payment called an EXCEPTIONAL RATE. This payment may be provided if the child's placement in your home allows the child to be released from a more restrictive setting or prevents the child's placement in such a setting.

You may receive an exceptional rate if, for example:

- the child requires 24-hour medical care supervised by a doctor or nurse.
- the child has severe behavior problems.
- the child is diagnosed as having a severe mental illness such as schizophrenia, severe mental retardation, brain damage, or autism.
- the child chronically abuses alcohol or other drugs and needs close supervision.

No monthly payment for the combined basic maintenance, supplemental, and exceptional rates may exceed \$2,000.

DEPARTMENT OF HEALTH AND FAMILY SERVICES  
 Division of Children and Family Services  
 GF5-834 (Rev. 11/2005)

STATE OF WISCONSIN

**FOSTER CARE UNIFORM RATE SETTING**

|  |  |  |                            |
|--|--|--|----------------------------|
| Name - Child (Last, First, MI)                             |  | Birthdate - Child (mm/dd/yyyy)           | Age - Child                |
| Name - Foster Parent(s)                                    |  |  |                            |
| Address - Foster Parent(s) (Street, City, State, Zip Code) |  |  | Telephone Number - Daytime |
| Date - Child Placed in This Foster Home (mm/dd/yyyy)       |  | Date - Supplemental Request (mm/dd/yyyy) |                            |
| Type of Rate Evaluation                                    |  |  | County                     |

**DIFFICULTY OF CARE LEVELS**

Check "Yes" or "No" to indicate whether each of the following minimal, moderate or intensive characteristics apply to the foster child now. Check "No" if the behavior or feeling is generally age appropriate for the child. Add a description of other similar characteristics that apply to the foster child at the appropriate locations.

**EMOTIONAL CARE NEEDS**

Not Applicable (0 points) - Child does not exhibit unusual emotional characteristics for a foster child in this age group.

Minimal (4 points) - Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Demands excessive attention   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Nervous   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. High-strung   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Impulsive   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Displays temper tantrums  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Restless  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Hyperactive   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Short attention span  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Occasionally wets during the night  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Low self-esteem and confidence   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Periodically withdrawn and unresponsive; avoids feelings                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Occasionally whines, argues, swears, manipulates, etc.                         |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Exhibits other characteristics which correspond in extent or degree - specify: |

**Moderate (8 points)** - Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Frequently requires close supervision  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Habitually resistive   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Frequent difficulty in communicating with others; avoids feelings                |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Frequent failure to do what is expected  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Responds with apathy to situations   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Difficulty establishing / maintaining relationships; serious attachment problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Displays cultural / social conflicts   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Frequent night bed wetter; occasionally soiled or both                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Displays over-activity and over-excitedness                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Exhibits other characteristics which correspond in extent or degree - specify:  |

---

**Intensive (12 points)** - Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Requires constant and intensive supervision; daily structure                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Infantile / immature personality  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Wets or soils during daytime hours, several times per week                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Severe hyperactivity to the point of frequent destructiveness or sleeplessness  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Chronically withdrawn / depressed / anxious                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Self-injurious; extremely accident prone  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Needs behavioral program(s) requiring parent training                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Bizarre or severely disturbed behavior, destructive                             |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has anorexia nervosa or other eating disorders                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Exhibits other characteristics which correspond in extent or degree - specify: |
-

**BEHAVIORAL CARE NEEDS**

Not Applicable (0 points) - Child does not exhibit unusual behavioral characteristics for a child of this age.

Minimal (4 points) - Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Disappears or runs away occasionally for short periods of time with the intention of returning  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Occasionally skips classes or exhibits behavior affecting class achievement, requiring make-up and occasional parent / school contact, extra help with homework |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Occasionally uses sexual acting out, masturbation; inappropriate sexual language  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Occasionally experiments with alcohol and drugs or both   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Infrequent hostile conflicts with parents, community, authority figures   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Occasional problems with stealing, petty theft, vandalism, destroying property  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Occasional inappropriate behavior with peers; infrequent conflicts with friends   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Occasional aggressive behavior toward people; i.e., biting, scratching, throwing objects at another, sexual aggressiveness                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Exhibits other characteristics which correspond in extent or degree - specify:  |

---

Moderate (8 points) - Child must exhibit at least two characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Frequently runs away or disappears for longer periods of time requiring encouragement to return   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Frequently truant or exhibits behavior affecting class achievement; creates disturbance in the classroom, requires extra help with schoolwork from parents, frequent contact between parents and school |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Frequently exhibits sexual activity harmful to others; disruptive to family and community   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Frequently uses alcohol or drugs or both  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Occasionally involved in non-violent crimes / property which may bring contact with police / authorities; i.e., burglary  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Frequent aggressive behavior toward people; i.e., biting, scratching, throwing objects at another, sexual aggression  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Frequent self-abusive behavior; i.e., head banging, eye poking, kicking self, biting self   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Exhibits other characteristics which correspond in extent or degree - specify:  |
-

**Intensive (12 points)** - Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Runs away for long periods of time (8 or more times per year and 5 or more days at a time), returning only as a result of initiative of others |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Habitually creates disturbance in the classroom or on the school bus, habitually truant; requires daily parent / school contact                |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Exhibits sexual deviancy; i.e., that of a violent or unconsenting nature with others   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Habitually uses alcohol or drugs or both   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Repeated and uncontrollable social behavior resulting in delinquency status; i.e., property offenses, assault, arson                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Daily aggressive behavior; i.e., biting, scratching, throwing objects  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Constant self-abusive behavior; i.e., head banging, eye poking, kicking self, biting self  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Severe eating disorders, eats inappropriate items  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Child exhibits other characteristics which correspond in extent or degree - specify:   |

---

### PHYSICAL AND PERSONAL CARE NEEDS

**Not Applicable (0 points)** - Child does not exhibit unusual physical or personal characteristics for a child of this age.

**Minimal (4 points)** - Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Needs some help putting on braces or prosthetic devices and help with buttons or laces, but is basically self-caring and able to maintain own physical assisting devices |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Seizures, motor dysfunctions, controlled by medication   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Requires therapy for gross or fine motor skills  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Requires special diet preparation / supervision  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Child exhibits other characteristics which correspond in extent or degree - specify:   |
-

**Moderate (8 points)** - Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Requires help with dressing, bathing and general toilet needs, including maintenance procedures; i.e., diapering and applying catheters; requires help of a person or a device to walk or get around |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Needs assistance to care and maintain physical assistance devices  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Exhibits eating, feeding problems; i.e., excessive intake, extreme messiness, extremely slow eating - requires help, supervision or both   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Requires tube or gavage feeding  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Requires frequent special care to prevent or remedy serious skin conditions; i.e., bedsores, severe eczema   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Requires daily administration of medication, preparation of special diets, prescribed physical therapies; i.e., for vision, hearing, speech, gross or fine motor skills, 1 or 2 hours per day        |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Child exhibits other characteristics which correspond in extent or degree - specify:   |

---

**Intensive (12 points)** - Child must exhibit one or more characteristics which include or correspond in extent or degree with the following:

- | <u>Yes</u>               | <u>No</u>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Non-ambulatory   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Uncontrollable seizures  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Need appliances for drainage, colostomy, aspiration, suctioning, mist tent, etc.                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Impaired vision, speech, or hearing functions requiring parent training  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Requires home administration of daily prescribed exercise routines to improve or maintain gross or fine motor skills |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Requires prevention procedures; i.e., daily irrigation   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Requires excessive cleaning / laundry and control of body waste  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Orthotics care at this level demands excessive amount of time, care, and responsibility                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Requires intensive prescribed physical therapy up to 2-3 hours per day   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Child exhibits other characteristics which correspond in extent or degree - specify:                                |
-

**Basic Rate**

| <u>Age Group</u> | <u>Effective January 2006</u> |
|------------------|-------------------------------|
| 0 - 4 years      | \$317.00                      |
| 5 - 11 years     | \$346.00                      |
| 12 - 14 years    | \$394.00                      |
| 15 - 18 years    | \$411.00                      |

**Supplemental Payment Summary of Points**

Emotional \_\_\_\_\_  
 Behavioral \_\_\_\_\_  
 Physical and Personal Care \_\_\_\_\_  
**TOTAL Points** \_\_\_\_\_

| <u>Number of Points</u> | <u>Dollars / Month</u> | <u>Number of Points</u> | <u>Dollars / Month</u> |
|-------------------------|------------------------|-------------------------|------------------------|
| 0                       | \$ 00.00               | 20                      | \$180.00               |
| 4                       | \$ 36.00               | 24                      | \$216.00               |
| 8                       | \$ 72.00               | 28                      | \$252.00               |
| 12                      | \$108.00               | 32                      | \$288.00               |
| 16                      | \$144.00               | 36                      | \$324.00               |

**Exceptional Payment**

Document here or refer to attached documentation which justifies an exceptions payment under HFS 56.11 (4) (a) Enable the child to be placed in a foster home or treatment foster home instead of being placed or remaining in a more restrictive setting, or HFS 56.11 (4) (b) Replace a child's basic wardrobe that has been lost or destroyed through other than normal wear and tear.

**Recommended UFCR Rate**

Basic \$ \_\_\_\_\_  
 +  
 Supplemental \$ \_\_\_\_\_  
 +  
 Exceptional \$ \_\_\_\_\_  
 =  
 Total \$ \_\_\_\_\_

Effective Date: \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE - Worker

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

\_\_\_\_\_  
 SIGNATURE - Rate Setter

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Children and Family Services

CFS-834 (Rev. 11/2005)

STATE OF WISCONSIN

7

Six Month Review - If a review indicates no change in Basic, Supplemental or Exceptional payments, indicate that the above rate continues by signing below. Complete a new form if any rate factors have changed.

\_\_\_\_\_  
SIGNATURE - Worker

\_\_\_\_\_  
SIGNATURE - Rate Setter

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

\_\_\_\_\_  
SIGNATURE - Worker

\_\_\_\_\_  
SIGNATURE - Rate Setter

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

\_\_\_\_\_  
SIGNATURE - Worker

\_\_\_\_\_  
SIGNATURE - Rate Setter

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

(Date)

The Honorable (Judge's full name here)  
Milwaukee County Children's Court Center  
10201 W. Watertown Plank Road  
Wauwatosa, WI 53226

Dear Judge (name):

**RE: Request for Revision (and/or) Extension of Dispositional Order**

**Court No:** Case Type: (CHIPS or Delinquent or JIPS)

**Order Expires:**

**Child's Name:**

**Birthdate:**

**Age:**

**Caretaker (name & relationship):**

**Address:**

**Phone:**

**Mother:**

**Address:**

**Phone:**

**Father:**

**Address:**

**Phone:**

**In the interest of (Child's Name), a person under the age of 18:**

**A Petition for (Revision/Extension, whatever is appropriate) is being filed in Milwaukee County Children's Court. Wraparound Milwaukee, under contract with (Delinquency Management Services and/or the Bureau of Milwaukee Child Welfare) is providing this report to the Court for its consideration in this matter.**

- I. Public Safety:** This should include (but is not limited to) summary (with detail as needed) of Wraparound Milwaukee's Safety Plan. State the risk of the action you are requesting. Explain how we will provide control for that risk. Define how Community/Public Safety is provided (how we will meet the community's safety needs). Address issues of the Child & Family Team regarding the placement, the school, the police and the community.

**II. Accountability:** Define the child's reintegration plan. What actions are the child (specifically), any members of the child's family that are specifically addressed in the court order, and the Child & Family Team planning and executing to satisfy court-ordered conditions. What progress has been achieved toward this satisfaction? State how we will meet the victim's (if applicable) safety and service needs. What actions/activities are prepared for the child to perform in the home, school and community? What has occurred that now enables this child to do what is acceptable in the community?

**III. Current Situation/Competencies:** *(This should contain 2 to 3 paragraphs).*  
Description of current situation should include the competencies and skills gained by the child and family. It should include progress toward meeting treatment needs, fulfillment of court-ordered conditions, the supports and services Wraparound Milwaukee has provided and the outcomes of those services.

**Based upon the information contained in this report, Wraparound Milwaukee is recommending** *(state your recommendation).* **Wraparound Milwaukee requests that the Court consider this information in the process of its judicial determination of the** *(Revision/Extension)* **of the current** *(Delinquent/JIPS/CHIPS)* **order.**

**Signatures:**

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Care Coordinator

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Care Coordinator Supervisor

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Wraparound Milwaukee Liaison

(Date)

The Honorable (Judge's full name here)  
Milwaukee County Children's Court Center  
10201 W. Watertown Plank Road  
Wauwatosa, WI 53226

Dear Judge (name):

RE: **Children's Court Order Progress Report**

Court No: Case Type: (CHIPS or Delinquent or JIPS)

Order Expires:

Child's Name:

Birthdate:

Age:

Caretaker (name & relationship):

Address:

Phone:

Mother:

Address:

Phone:

Father:

Address:

Phone:

Wraparound Milwaukee, under contract with (Delinquency Management Services and/or the Bureau of Milwaukee Child Welfare) is providing this report to the court for its consideration in the matter currently in front of this court.

- I. **Public Safety**: This should include (*but is not limited to*) summary (*with detail as needed*) of Wraparound Milwaukee's Safety Plan. State the risk of the action you are requesting, or the plan you are describing. Explain how we will provide control for that risk. Define how Community/Public Safety is provided (*how we will meet the community's safety needs*). Address issues of the Child & Family Team regarding the placement, the school, the police and the community.

**II. Accountability:** Define the child’s reintegration plan. What actions are the child (*specifically*), any members of the child’s family that are specifically addressed in the court order, and the Child & Family Team planning and executing to satisfy court-ordered conditions. What progress has been achieved toward this satisfaction? State how we will meet the victim’s (*if applicable*) safety and service needs. What actions/activities are prepared for the child to perform in the home, school and community? What has occurred that now enables this child to do what is acceptable in the community?

**III. Current Situation/Competencies:** (*This should contain 2 to 3 paragraphs*). Description of current situation should include the competencies and skills gained by the child and family. It should include progress toward meeting treatment needs, fulfillment of court-ordered conditions, the supports and services Wraparound Milwaukee has provided and the outcomes of those services.

**Wraparound Milwaukee respectfully requests that the Court consider this information in the process of the current judicial review.**

**Signatures:**

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Care Coordinator

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Care Coordinator Supervisor

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Wraparound Milwaukee Liaison