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|  | | **Provider Notification of Family Time/ Sibling Visit Transport Schedule**  **Initial Intake Screening Report**  **(Completed by Contracted Provider)** | | | | | |
| Provider will send this form back to the referring DCYF worker to provide details regarding the intake screening and scheduling of the ongoing Family Time/Sibling Visits.  **Any changes to the Family Time/Sibling Visits schedule must be approved in advance by the assigned DCYF worker.** | | | | | | | |
| **Agency Assignment** | | | | | | | |
| REFERRAL RECEIVED    Accepted  Denied | REFERRAL EXPIRATION DATE\* (SIX MONTHS FROM REFERRAL DATE)    \* After this date, Family Time/Sibling Visits are not authorized and may not be paid. A new referral must be submitted and must include an Area Administrator’s signature to authorize the extension of the Family Time/Sibling Visits and payment. | | | | | | FAMLINK CASE ID |
| ONGOING SERVICE START DATE | CASE NAME |
| AGENCY NAME / PHONE NUMBER (AND AREA CODE) / EMAIL ADDRESS | | | | | | | DATE FAMILY TIME/SIBLING VISIT SCHEDULE SENT ELECTRONICALLY TO DCYF STAFF |
| **Visitation** | | | | | | | |
| **Contractor shall notify assigned DCYF worker of any changes to the assigned Family Time/Sibling Visits supervisor.** | | | | | | | |
| ASSIGNED FAMILY TIME/SIBLING VISIT FACILITATOR | | | PHONE NUMBER (AREA CODE) | | | LANGUAGES SPOKEN BY FACILITATOR | |
| ADDRESS / LOCATION WHERE FAMILY TIME/SIBLING VISIT WILL OCCUR (I.E., PARENT HOME, CAREGIVER HOME, COMMUNITY) | | | | | | | |
| FAMILY TIME/SIBLING VISITS WILL BEGIN AT (ENTER TIME OF DAY)  1.  2.  3.  4.  5.  6.  7. | | | | DAY OF WEEK  1.  2.  3.  4.  5.  6.  7. | | | |
| **Transportation** | | | | | | | |
| ASSIGNED TRANSPORTATION FACILITATOR | | | PHONE NUMBER (AREA CODE) | | LANGUAGES SPOKEN BY FACILITATOR | | |
| TIME OF PICK-UP  1.  2.  3.  4.  5.  6.  7. | | | | TIME OF DROP-OFF  1.  2.  3.  4.  5.  6.  7. | | | |
| **Family Time/Sibling Visit Intake Screening** | | | | | | | |
| Review the Family Time/Sibling Visit Service Referral for the following information: Medical / dietary needs, communication needs and safety / behavioral concerns, sibling dynamics, or hygiene needs.  Documented contact with caregiver to discuss: relevant child specific information (include the child’s name), scheduling (availability) and barriers to participation:  Comments: | | | | | | | |
| Day and time of intake Family Time/Sibling Visit: | | | | | | | |
| **Notifications to/from assigned DCYF Staff** | | | | | | | |
| Document any changes to Family Time/Sibling Visits (days and times, location, date, length and duration, level of supervision, change in DCYF worker, etc.) and the date that the change was requested and/or authorized by DCYF staff. | | | | | | | |
| DATE OF CHANGE | | PARTY REQUESTING CHANGE | | | | | |
| CHANGE MADE | | | | | | | |
| DATE OF CHANGE | | PARTY REQUESTING CHANGE | | | | | |
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