



DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)
Unlicensed Caregiver Placement Checklist
 (RCW 74.15.020(2)(I-IV))

NAME OF FAMILY	DATE OF PLACEMENT		
NAME OF CHILD			
The placing worker is responsible for completion of all the following requirements within 72 hours of original placement date. (OPD).			
<u>DATE COMPLETED</u>	<u>PRIOR TO PLACEMENT</u>		
	Criminal history checks (WSP, local LE and/or Tribal law enforcement) on all adults living in the home.		
	Child abuse and neglect history review and clearance.		
	Home visit and check for obvious safety hazards. NOTE: Use the Basic Household Safety Assessment Tip Sheet.		
	Review of the reason for placement and known information about the medical status, allergies and special needs of the child.		
	Provide a copy of "Relative Guide to CPS" (DCYF 22-492).		
	NCIC name and date of birth check completed (emergent placements only)		
	<u>WITHIN 72 HOURS OF PLACEMENT</u> NOTE: Use Basic Household Assessment Tip Sheet		
	Child abuse and neglect check in other states when applicable.		
	Fingerprint check on all adults residing in the home.		
	Review of protection issues with the relative caregiver including whether contact is allowed with the birth family.		
	<u>AT PLACEMENT</u>		
	Fingerprint checks completed within 10 days of criminal background check, when applicable.		
	Advise relative of the availability of financial support and services:		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> Foster care licensing TANF Benefits – (In applying for these benefits, caregiver must report child has been placed by DCYF). </td> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> Medical coverage Training opportunities Right to be heard at court hearings </td> </tr> </table>	<ul style="list-style-type: none"> Foster care licensing TANF Benefits – (In applying for these benefits, caregiver must report child has been placed by DCYF). 	<ul style="list-style-type: none"> Medical coverage Training opportunities Right to be heard at court hearings
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	Review the Placement Agreement with the family and sign the agreement. (DSHS 15-281)		
	Advise caregiver of the Child Health and Education Tracking (CHET)		
	<ul style="list-style-type: none"> Schedule an Early & Periodic Screening, Diagnosis & Treatment (EPSDT) exam. Schedule a dental exam (if child has not had one in the previous 6 months) 		
	Two verbal reference checks.		
Comments			
NAME OF PLACING WORKER	DATE COMPLETED		



DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)

Caregiver Intake

RCW 74.15.020 (2) (I-IV)

NAME OF CHILD					DATE OF PLACEMENT	
LAST NAME	FIRST NAME	GENDER M/F	DATE OF BIRTH	RELATIONSHIP TO CHILD	BACKGROUND CHECK*	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
*Attach Documentation: Background Check includes completed NCIC, Fingerprint, BCCU, and CA/N						
WHO IS THE PRIMARY CAREGIVER				TRIBAL AFFILIATION		
ADDRESS				E-MAIL ADDRESS		TELEPHONE NUMBER
Have you resided in Washington State consecutively for the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the city, state and years you lived in another state.						
The relationship of caregiver to the child: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Other:				Limited English Proficient: <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language:		
Reasons child requires placement:						
Does the caregiver, or anyone residing in the home, have any behaviors, conditions, or limitations, which would affect the health and safety of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:						
Comments/Concerns which might affect suitability of placement:						
WHO PROVIDED THIS INFORMATION: <input type="checkbox"/> Birth Mother <input type="checkbox"/> Birth Father <input type="checkbox"/> Other Relative: <input type="checkbox"/> Other Suitable Person:				CASE WORKER'S SIGNATURE		

EMERGENCY CONTACT INFORMATION				
In State:	CONTACT NAME		NAME OF COUNTY	
ADDRESS		CITY		STATE ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL PHONE NUMBER	E-MAIL ADDRESS	
Out of State:	CONTACT NAME		NAME OF COUNTY	
ADDRESS		CITY		STATE ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL PHONE NUMBER	E-MAIL ADDRESS	

TO BE COMPLETED BY THE CASE WORKER FOR ALL PERSONS STAYING IN THE HOME.