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|  |  DEPARTMENT OF CHILDREN, YOUTH, FAMILIES **Placement Entry Tool** |
| placemententryR1@dshs.wa.gov; placemententryR2@dshs.wa.gov; placemententryR3@dshs.wa.gov**All emails should have a subject line with: office name, child name, and case number.** |
| 1. CHECK ONE[ ]  Initial placement [ ]  Change of placement [ ]  Placement ending [ ]  Temporary situation [ ]  BRS |
| 2. PLACEMENTBEGIN DATE | 3. PLACEMENTEND DATE | 3A. REASON[ ]  On the run [ ]  Aged out [ ]  Adoption [ ]  Guardianship[ ]  Trial return home [ ]  Return home [ ]  Dependency Dismissed - RH |
| 4. PLACEMENT CHANGE REASON[ ]  Changed caregiver [ ]  Caregiver chose to terminate service [ ]  Detention[ ]  Hospital>15 days on the run [ ]  Trial return home – Father [ ]  Trial return home – Mother[ ]  Trial return home – Guardian [ ]  On the run ended [ ]  Other:  |
| 5. CASE NAME | 5A. CASE ID | 5B. CHILD’S NAME | 5C. CHILD’S ID |
| 5D. SIBLINGS THIS PLACEMENT APPLIES TO (IF DIFFERENT INFORMATION, ADDITIONAL FORM NEEDED) CHILD NAME CHILD ID |
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| **Please complete for Initial Placement Only** |
| 6. DATE LEGAL CUSTODY OBTAINED (PCA) | 6A. COUNTY / TYPE / TRIBE |
| 7. REMOVAL REASONS[ ]  Physical abuse [ ]  Sexual abuse [ ]  Neglect [ ]  Caregiver’s alcohol use[ ]  Caregiver’s drug abuse [ ]  Child’s alcohol use [ ]  Child’s drug use [ ]  Extended foster care[ ]  Inadequate housing [ ]  Child’s behavior problem [ ]  Child’s disability [ ]  Incarceration of caregiver(s)[ ]  Death of caregiver(s) [ ]  Caregiver’s inability to cope [ ]  Abandonment[ ]  Relinquishment (Safety of Newborn Child Act) |
| 8. REMOVAL MANNER[ ]  Court ordered [ ]  Temporary physical custody [ ]  Voluntary |
| 9. CAREGIVER / FAMILY STRUCTURE[ ]  Married couple [ ]  Single female [ ]  Single male [ ]  Unable to determine [ ]  Unmarried couple |
| 10. PRIMARY CARETAKER (PARENT)’S NAME | 10A. SECONDARY CARETAKER (PARENT)’S NAME |
| **Provider Information Only** |
| 11. CHECK ONE[ ]  Licensed Home [ ]  Licensed CPA Home [ ]  Relative placement [ ]  Suitable other [ ]  Court ordered placement [ ]  Other:  |
| 12. PROVIDER’S NAME (LAST NAME, FIRST NAME / LAST NAME, FIRST NAME | 12A. PROVIDER ID |
| 13. SPECIAL NOTES TO CLARIFY PLACEMENT TYPE (HOSPITAL, PICC, CRC, LICENSED RELATIVE, TEMPORARY SITUATION, ETC.) |
| 13A. CPA Case Management needed: [ ]  Yes [ ]  No | 13B. Contracted Receiving Care Rate: [ ]  Yes [ ]  No |
| 14. ANY OTHER PERTINENT NOTES: KNOWN CHANGE N PLACEMENT DATES, PLACEMENT NEEDS (VOUCHERS, DAYCARE, ETC.  SERVICE REFERRAL WILL BE MADE BY SOCIAL WORKER (AA APPROVAL NEEDED FOR ECP AND PLEASE ATTACH ECP), OTHER: |
| 15. **UNLICENSED PLACEMENTS ONLY.**  IF BACKGROUND CHECK IS ATTACHED, ONLY ANSWER **BOLDED\*** QUESTIONS, **IF NOT, ANSWER ALL.** |
| PRIMARY PROVIDER INFORMATION | SECONDARY PROVIDER INFORMATION | OTHERS IN HOME (ADD ADDITIONAL PAGES IF NECESSASRY) |
| FULL NAME | FULL NAME | FULL NAME |
| **GENDER \*** | **GENDER \*** | **GENDER \*** |
| DATE OF BIRTH | DATE OF BIRTH | DATE OF BIRTH |
| SOCIAL SECURITY NUMBER | SOCIAL SECURITY NUMBER | SOCIAL SECURITY NUMBER |
| **RACE \*** | **RACE \*** | **RACE \*** |
| **ETHNICITY \*** | **ETHNICITY \*** | **ETHNICITY \*** |
| **MARITAL STATUS \*** | **MARITAL STATUS \*** | **MARITAL STATUS \*** |
| [ ]  Background Check complete | [ ]  Background Check complete | [ ]  Background Check complete |
| 15A. PLACEMENT PHYSICAL ADDRESS PHONE NUMBER (WITH AREA CODE) |
|  |  |
| 15B. IN CASE OF EMERGENCY CONTACT (ICE) NAME PHONE NUMBER (WITH AREA CODE) |
|  |  |
| ADDRESS |