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TERMINATION OF PARENTAL RIGHTS/FOSTER PARENT ADOPTION FORM

I. TPR INFORMATION TPR Date \_\_\_\_\_ County \_\_\_\_\_

Child

Birth Name \_\_\_\_\_
Date of Birth \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_
County of Residence \_\_\_\_\_ Ward Number (assigned by Office of Adoption) \_\_\_\_\_

Parents

Birth Mother Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Maiden Name \_\_\_\_\_

Birth Father Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Parents' Marital Status At Time Of Child's Birth \_\_\_\_\_

Legal Father (check one) [ ] Same as birth father or [ ] Other (enter name on next line)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Worker \_\_\_\_\_ Date Submitted \_\_\_\_\_

II. PLACEMENT/DISRUPTION INFORMATION Placement Date \_\_\_\_\_

A. Placement Type [ ] Foster Parent Adoption [ ] Non - Foster Parent Adoption

Child's Name After Adoption Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Child's T Number (to be assigned by the Office of Adoption) \_\_\_\_\_

Adoptive Mother Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Adoptive Father Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Adoptive Family Approval Date \_\_\_\_\_ County of Residence \_\_\_\_\_

Placement Worker \_\_\_\_\_ Date Submitted \_\_\_\_\_

B. Date Placement Disrupted \_\_\_\_\_ Worker \_\_\_\_\_ Date Submitted \_\_\_\_\_

III. SUBSIDY INFORMATION

Type [ ] Federal [ ] State Begin Date \_\_\_\_\_ Amount \$ \_\_\_\_\_

Adoptive Parent Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Subsidy Changes [ ] Change in Amount effective \_\_\_\_\_ to \$ \_\_\_\_\_

[ ] Address Change effective \_\_\_\_\_ to \_\_\_\_\_

Approved: \_\_\_\_\_ Date \_\_\_\_\_
County Director

## CHECKLIST FOR FOSTER CARE RECORDS SUBMITTED TO OFFICE OF ADOPTION

### Complete Record (Original)

- White narrative (up-to-date)
- All legal documents and court reports
- Blue narrative (if available) since court child has been in foster care
- Face Sheet (PSD 213)
- Last Individualized Service Plan

### Verifications

- Child's birth certificate
- All marriages and divorces of child's parents

### Information on Child

- Birth medicals (if born in Alabama or if can be obtained from other states)
- Developmental information
- School information (IQ tests, IEPs, report cards, behaviors, grade level, etc.)
- Current medical
- Previous medical reports from any physicians who have treated the child since entering foster care including records of hospitalizations, Crippled Children's reports, Medicaid screening
- Physical description
- Adjustment to foster care
- Narrative of child's understanding of adoption, attitude toward adoption etc.
- Narrative of child's relationship with siblings, biological parents, other relatives
- Psychological evaluations, D & E reports, counseling reports
- Narrative of child's behavior, habits, personality, experiences
- Immunization record
- Sickle cell test on all children of black heritage
- Recent color photograph

### Information on Biological Family

Unless otherwise specified below, the items must be covered on the child's mother, legal or alleged father, grandparents, siblings of the child, aunts and uncles, and other extended family members

- Physical Description
- Prenatal care received by mother
- Information about personalities, attitudes, experiences, talents
- Information on drug or alcohol usage, including type and extent of drug usage
- Educational levels, individual Special Education placements
- Marital history
- For involuntary placements, complete discussion with both parents on understanding of adoption
- Complete health histories on both parents, including mental illness, mental retardation
- Health history on other family members (illnesses, dates, causes of death, inheritable diseases)
- Criminal history (charges, convictions, time served, other punishment)
- Employment (history, type work)
- Parents' Social Security numbers
- Psychological, if indicated, and description of level of functioning
- Parents' dates of birth

**RELINQUISHMENT OF MINOR FOR ADOPTION**

THE STATE OF ALABAMA

\_\_\_\_\_ COUNTY

KNOW ALL MEN BY THESE PRESENT, that:

1. I, \_\_\_\_\_  
(name of person relinquishing)

the  parent /  legal guardian of the minor

\_\_\_\_\_

(state all names by which the minor has been known)

born \_\_\_\_\_, \_\_\_\_\_  
(month and day) (year) relinquish the said minor to

\_\_\_\_\_

(name and address of agency)

for the purpose of adoption in order that said minor may have all the privileges which may be accorded to (him) (her) by the laws of Alabama upon (his) (her) legal adoption.

- 2. I am executing this document voluntarily and unequivocally thereby relinquishing said minor.
- 3. I understand that by signing this document I will forfeit all rights and obligations and that I understand the relinquishment and execute it freely and voluntarily.
- 4. I understand that the relinquishment may be irrevocable, and I should not execute it if I need or desire psychological or legal advice, guidance or counseling;
- 5. I have received or been offered a copy of this document.
- 6. I waive the right to know the identity of each petitioner who petitions to adopt the said minor child.
- 7. I waive further notice of the adoption proceedings by the execution of this relinquishment to the named agency.
- 8. I understand that notice of withdrawal of relinquishment must be mailed to

\_\_\_\_\_

(name and address of agency with whom document is filed)

and that such withdrawal must be mailed within five days after the birth of said minor or the execution of this document whichever comes last.

- 9. I do hereby request that the Probate Judge make all such orders and decrees as may be necessary or proper to legally effectuate said adoption.

Given under my hand at \_\_\_\_\_ o'clock, \_\_\_\_\_ day of \_\_\_\_\_,  
(time) (month) (year)

at \_\_\_\_\_  
(address of filing)

(SEAL)  
Affiant's Signature

I, \_\_\_\_\_, sign my name to this instrument this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, and being first duly sworn, do hereby declare to the undersigned authority that I execute it as my free and voluntary act for the purposes therein expressed, and that I am \_\_\_\_\_ years of age or older, of sound mind, and under no constraint or undue influence.

\_\_\_\_\_ (SEAL)  
Affiant's Signature

STATE OF ALABAMA

\_\_\_\_\_ COUNTY

Subscribed, sworn to and acknowledged before me by \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

(Signed) \_\_\_\_\_

\_\_\_\_\_  
(Official Capacity of Officer)

I acknowledge receipt of two copies of this document.

\_\_\_\_\_(SEAL)

\_\_\_\_\_  
Date

\*\*\*\*\*

I \_\_\_\_\_, on this  
(affiant)

\_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.

in the presence of the two witnesses whose signatures and addresses are subscribed below, hereby withdraw the adoption  
relinquishment previously signed by me.

\_\_\_\_\_  
Affiant's Signature

Witness

\_\_\_\_\_

Address

\_\_\_\_\_

\_\_\_\_\_

Witness

\_\_\_\_\_

Address

\_\_\_\_\_

\_\_\_\_\_

**CONSENT TO RELEASE OF IDENTIFYING INFORMATION**

I, \_\_\_\_\_, hereby  
(Name)

consent to the disclosure of identifying information relating to me and my family contained in the adoption files of the Department of Human Resources including a copy of the birth certificate as it relates to me to be given to

\_\_\_\_\_  
(Birth Name of Adoptee)

at age 19 according to the Code of Alabama, 1975, Section 26-10A-31(h).

I, \_\_\_\_\_, sign my name to this instrument this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_, and being duly sworn, do hereby declare to the undersigned authority that I execute it as my free and voluntary act for the purposes therein expressed, and that I am \_\_\_\_\_ years of age or older, of sound mind, and under no constraint or undue influence.

\_\_\_\_\_  
Affiant's Signature

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Subscribed, sworn to and acknowledged before me by \_\_\_\_\_,

this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_.

(Signed) \_\_\_\_\_  
Notary Public

### FAMILY BACKGROUND INFORMATION

Names of Child's Maternal and Paternal Relatives and Siblings *(all relationships are to the child)*

Name of Child/Family: \_\_\_\_\_ County: \_\_\_\_\_

\_\_\_\_\_ DHR C.N. \_\_\_\_\_

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Female  Male  
Race:  Caucasian  African-American/Black  Hispanic  Other, Specify: \_\_\_\_\_

#### MATERNAL RELATIVES

Name:	Date of Birth:
<b>Child's Mother:</b> _____	_____
<b>Grandmother:</b> _____ <i>(Mother's Mother)</i>	_____
<b>Grandfather:</b> _____ <i>(Mother's Father)</i>	_____
<b>Aunts /Uncles:</b> _____ <i>(Mother's Sisters &amp; Brothers)</i>	_____
_____	_____
_____	_____
_____	_____

#### PATERNAL RELATIVES

Name:	Date of Birth:
<b>Child's Father:</b> _____	_____
<b>Grandmother:</b> _____ <i>(Father's Mother)</i>	_____
<b>Grandfather:</b> _____ <i>(Father's Father)</i>	_____
<b>Aunts /Uncles:</b> _____ <i>(Father's Sisters &amp; Brothers)</i>	_____
_____	_____
_____	_____
_____	_____

#### CHILD'S BROTHERS AND SISTERS

Name:	Sex:	Relationship:
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full-Sibling <input type="checkbox"/> Half-Sibling
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full-Sibling <input type="checkbox"/> Half-Sibling
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full-Sibling <input type="checkbox"/> Half-Sibling
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full-Sibling <input type="checkbox"/> Half-Sibling

FAMILY BACKGROUND INFORMATION

Name of Child/Family: \_\_\_\_\_ County: \_\_\_\_\_ DHR C.N. \_\_\_\_\_

Source(s) of Information (including name and relationship to child) : \_\_\_\_\_

Date Information Obtained: \_\_\_\_\_

THIS INFORMATION PERTAINS TO THE FOLLOWING RELATIVE OF CHILD:  MATERNAL  PATERNAL OR (if applicable)  CHILD'S GROWN SIBLING (Duplicate form, as needed, to list all relatives – 1 sheet per relative)

RELATIVE'S RELATIONSHIP TO CHILD (mother, maternal aunt, paternal grandfather, etc.): \_\_\_\_\_

Record background information on maternal and paternal relatives (i.e., child's mother, child's father, child's maternal/paternal grandparents, child's maternal/paternal aunts and uncles, etc.) If the person is deceased, complete information as it pertained during person's lifetime. If there is additional information in case record, make notation of the page/section of record where information is located.

Name of Child's Relative: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  F  M

Race:  Caucasian  African-American/Black  Hispanic  Other (Specify): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Build: \_\_\_\_\_ Skin Coloring: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Texture: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Social Sec. # \_\_\_\_\_

General Health:  Excellent  Good  Poor  Unknown

Existing Illnesses/Disabilities/Limitations/Mental Health Diagnosis:  Yes  No  Unknown If yes, provide information: \_\_\_\_\_

Glasses/Corrective Lenses:  Yes  No  Unknown

Past Surgery/Hospitalization:  Yes  No  Unknown If yes, provide information, including dates, if known: \_\_\_\_\_

If Deceased, Age at Time of Death: \_\_\_\_\_ Check box, if:  unknown or  not applicable

Cause of Death: \_\_\_\_\_ Check box, if:  unknown or  not applicable

Date of Death: \_\_\_\_\_ Check box, if:  unknown or  not applicable

Grade Completed in School: \_\_\_\_\_ Special Education:  Yes  No  Unknown

Academic Achievement:  Gifted  Above-Average  Average  Below Average  Special Education  Unknown

Favorite Subjects: \_\_\_\_\_

Interests/Hobbies/Talents: \_\_\_\_\_

Religious Affiliation/Preference: \_\_\_\_\_

Personality Traits, Strengths, Needs: \_\_\_\_\_

Employment (work history, occupation, special training): \_\_\_\_\_

Criminal History:  Yes  No  Unknown If yes, give information including charges, convictions, time served: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed  Unknown

If married, name of spouse: \_\_\_\_\_

Date and place of marriage: \_\_\_\_\_

Prior Marriage:  Yes  No  Unknown

If yes, name of former spouse: \_\_\_\_\_

Date and place of divorce: \_\_\_\_\_

Names of Person's Children (including age, if known, or approximate age): \_\_\_\_\_

Military Service:  Yes  No  Unknown If applicable, list branch, dates of service, type discharge: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

FAMILY BACKGROUND INFORMATION

Name of Child/Family: \_\_\_\_\_ County: \_\_\_\_\_ DHR C.N. \_\_\_\_\_

Source(s) of Information (including name and relationship to child) : \_\_\_\_\_

Date Information Obtained: \_\_\_\_\_

**CHILD’S SIBLINGS** Use this form to record background information on each of child’s sisters and brothers. If sibling is over age of eighteen (18), use “Relative” background information sheet. For additional information in the case record, note the page of narrative or section of record where information is located. (Duplicate form, as needed, to list all siblings – 1 sheet per child.)

Name of Child’s Sibling: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  F  M

Full Sibling  Half Sibling *If Half-Sibling, indicate:*  Maternal or  Paternal Half-Sibling

Race:  Caucasian  African-American/Black  Hispanic  Other (Specify): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Build: \_\_\_\_\_ Skin Coloring: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Texture: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Social Sec. # \_\_\_\_\_

General Health:  Excellent  Good  Poor  Unknown

Existing Illnesses/Disabilities/Limitations/Mental Health Diagnosis:  Yes  No  Unknown *If yes, provide information:*

Glasses/Corrective Lenses:  Yes  No  Unknown

Past Surgery/Hospitalization:  Yes  No  Unknown *If yes, provide information, including dates, if known:*

If Deceased, Age at Time of Death: \_\_\_\_\_ Check box, if:  unknown or  not applicable

Cause of Death: \_\_\_\_\_ Check box, if:  unknown or  not applicable

If Applicable, Date of Death: \_\_\_\_\_ Check box, if:  unknown or  not applicable

Childhood Development:  Normal  Delayed *If delayed, provide information:*

Current Grade in School (K through grade 12): \_\_\_\_\_ Special Education:  Yes  No  Unknown

Academic Achievement:  Gifted  Above-Average  Average  Below Average  Special Education  Unknown

Favorite Subjects: \_\_\_\_\_

Interests/Hobbies/Talents: \_\_\_\_\_

Religious Affiliation/Preference: \_\_\_\_\_

Personality Traits, Strengths, Needs: \_\_\_\_\_

**Information Regarding Sibling:**

Is Sibling in DHR Custody:  Yes  No *If yes, is Adoption the Plan for Sibling:*  Yes  No

*If no, provide information regarding plan:* \_\_\_\_\_

Is Sibling Currently in Foster Care Placement:  Yes  No *If yes, is Sibling Placed in Same Foster Home:*  Yes  No

*If child is not in foster care, where does child live (e.g., w/parents, relative):* \_\_\_\_\_

Additional Information: \_\_\_\_\_

FAMILY BACKGROUND INFORMATION

Name of Child/Family: \_\_\_\_\_ County: \_\_\_\_\_ DHR C.N. \_\_\_\_\_

Source(s) of Information (including name and relationship to child) : \_\_\_\_\_

Date Information Obtained: \_\_\_\_\_

**THIS INFORMATION PERTAINS TO THE FOLLOWING RELATIVE OF CHILD:**  MATERNAL  PATERNAL

Note: complete one form on the child’s mother’s family and one form on the child’s father’s family. Circle any diseases/ conditions which apply. \*For circled items, at bottom of sheet, name the family member and give brief description of the disease/condition, its effect, age of onset, and indicate if it resulted in person’s death. For additional case record information, note narrative page or section where information is located. (Complete 1 form for maternal & 1 form for paternal relatives.)

<b>1. Allergies</b> a) drugs b) foods c) asthma d) hay fever e) other f) if other	<b>8. Cardiovascular Disease</b> a) atherosclerosis b) congenital heart defect c) heart attack d) hyperlipidemia e) stroke f) other	<b>18. Visual Disorders</b> a) cataracts b) dyslexia c) glaucoma d) retinitis pigmentosa e) strabismus
<b>2. Alcoholism/Drug Addiction</b>	<b>9. Respiratory Diseases</b> a) emphysema b) bacterial pneumonia c) tuberculosis d) other	<b>19. Pregnancy Complications</b> a) premature birth b) still births c) incompetent cervix d) ectopic pregnancies e) eclamptogenic toxemia f) spontaneous abortion g) multiple births h) other
<b>3. Blood Diseases</b> a) hemophilia b) RH disease c) sickle cell disease/trait d) thalassemia (cooley’s anemia) e) other	<b>10. Mental Illness</b> a) manic-depressive b) schizophrenia c) other	<b>20. Migraine Headache</b> <b>21. Congenital Birth Abnormalities</b> <b>22. Cleft Lip</b> <b>23. Cleft Palate</b> <b>24. Cystic Fibrosis</b> <b>25. Diabetes</b> <b>26. Dwarfism</b> <b>27. Huntington’s Disease</b> <b>28. Sudden Infant Death</b> <b>29. Systemic Lupus Erythematosis</b> <b>30. Thyroid Disorders</b> <b>31. Tay-Sachs Disease</b> <b>32. Myasthenia Gravis</b> <b>33. Obesity</b> <b>34. Multiple Sclerosis</b> <b>35. Multiple Dystrophy</b> <b>36. Any other diseases which have occurred repeatedly in family (specify)</b>
<b>4. Bone Diseases</b> a) arthritis b) curvature of spine c) other structural malformation d) other	<b>11. Mental Retardation</b> a) Downs Syndrome b) PKU c) Lesch-Nyham Syndrome d) Hunters e) tuberous sclerosis f) other	
<b>5. Cancer</b> a) breast b) bowel c) colon d) ovarian	<b>12. Speech Disorders</b> a) stuttering b) tongue tie c) sound omissions/distortions	
e) skin f) stomach g) lungs h) leukemia i) other	d) delayed speech e) other	<b>37. Biological mother’s age at onset of menses</b> _____ *At bottom of page or on back, identify number and code (such as “5, g” for cancer of lungs) and identify name of relative, if known, who had this disease and relationship to child (such as maternal aunt). Provide known information such as age of onset, if
<b>6. Skin Disorders</b> a) psoriasis b) other	<b>13. Learning Disability (specify)</b> <b>14. Hearing Disorders</b> <b>15. Hyperactivity</b> <b>16. Epilepsy</b> <b>17. Liver Disease</b>	



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DHR-FCS – 2119 d

**STATE FILE ROOM CLEARANCE FOR POTENTIAL STATE WARDS**  
 (This section is to be completed by the county social worker for the child.)

\_\_\_\_\_  
Date

**COUNTY** \_\_\_\_\_ **WORKER** \_\_\_\_\_

**CHILDREN:**

	<u>Last Name</u>	<u>First Name</u>	<u>Middle Name</u>	<u>Date Of Birth</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

**PARENTS:**

	<u>Last Name</u>	<u>First Name</u>	<u>Middle Name</u>	<u>Maiden Name</u>
<b>Mother</b>	_____	_____	_____	_____
	<u>Race</u>	<u>Date Of Birth</u>	AKA	_____
	_____	_____	AKA	_____

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	<u>Last Name</u>	<u>First Name</u>	<u>Middle Name</u>	<u>Suffix</u>
<b>Father</b>	_____	_____	_____	_____
	<u>Race</u>	<u>Date Of Birth</u>	AKA	_____
	_____	_____	AKA	_____

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**STATE FILE ROOM**

(This section is to be completed by State Records Management personnel.)

- No other county record located.
- Other county record located.

County Name \_\_\_\_\_

Case Name \_\_\_\_\_

Case Number \_\_\_\_\_ Ward Number (if applicable) \_\_\_\_\_

Cleared by: \_\_\_\_\_ Date: \_\_\_\_\_

**ALABAMA DEPARTMENT OF HUMAN RESOURCES  
ASSESSMENT OF CHILDREN AT RISK**

Date Printed: ###/###/####

This Assessment contains allegations of Child Abuse/Neglect.

INITIAL INFORMATION			
<b>Case Name:</b>	Wisteria Elizabeth Lancelott	<b>Provider Name:</b>	
<b>County Name:</b>	Montgomery County DHR	<b>County Case #:</b>	45,893
<b>Received Date/Time:</b>	03/22/2005	<b>Intake Type:</b>	Family
<b>Contact Method:</b>	Phone	<b>Intake Description:</b>	Single Female
<b>Completion Date:</b>		<b>Overall Disposition:</b>	
<b>Restricted Reason:</b>	Unrestricted	<b>Designated Response Time:</b>	5 Days
FACTORS IDENTIFIED AT INTAKE			
<b>Vulnerable Child</b> – Disability (e.g. physical, mental, developmental) <b>Case Currently Opened To</b> – TANF <b>Case Currently Opened To</b> – Food Stamps			
REPORTER/REFERRAL SOURCE			
<b>Reporter/Referral Source Name:</b>	Lieutenant Dick Tracey Jr.		
<b>Found Out How:</b>	Statement by Person Identified at Risk		
<b>Description of</b>	Legal, Law Enforcement, Criminal Justice Reporter/Referral		
<b>Source:</b>			
<b>Employee or Relationship:</b>	Montgomery Police Department		
PARTICIPANTS WITH ROLE OF PERSON IDENTIFIED AT RISK			
<b>Name:</b>	Angel a Lancelott	<b>Gender:</b>	Female
<b>DOB:</b>	09/19/2001		
<b>Verified:</b>			
<b>Roles:</b>	Person Identified at Risk		
<b>Race:</b>	Native Hawaiian or Other Pacific Islander White Black or African American		
<b>SSN:</b>			
<b>AKA:</b>	Nickname: Baby Lancelott		
<b>Address:</b>	Primary Residence: Apt. 34 Willow Terrace, 7100 Court Street, Montgomery, AL, 36106		
<b>Phone:</b>			
PARTICIPANTS WITH ROLE OF PERSON ALLEGEDLY RESPONSIBLE			
<b>Name:</b>	Mrs. Wisteria Elizabeth Lancelott	<b>Gender:</b>	Female
<b>DOB:</b>	09/12/1968		
<b>Verified:</b>			
<b>Roles:</b>	Person Allegedly Responsible, Witness		
<b>Race:</b>	Native Hawaiian or Other Pacific Islander White		
<b>SSN:</b>	223-434-6677, 677-76-8899		
<b>AKA:</b>	Nickname: Violet Lancelott Maiden : Wisteria Churchill Also Known As: Lizzie Lancelott, Wisty Lancelott		
<b>Address:</b>	Primary Residence: Apt. 34 Willow Terrace, 7100 Court Street, Montgomery, AL, 36106-3400 Work: C/O McDonalds, 3500 Atlanta Highway, Montgomery, AL, 36116-3500		

<b>Phone:</b>	Home: 334-224-8596 Call before 7:00 pm Work: 334-221-8763 Only for emergencies Cellular: 334-443-2191			
OTHER PARTICIPANTS				
<b>Name:</b>	Lieutenant Dick Tracey Jr			
<b>Gender:</b>	Male			
<b>DOB:</b>				
<b>Verified:</b>				
<b>Roles:</b>	Reporter/Referral Source			
<b>Race:</b>	Unable to Determine			
<b>SSN:</b>				
<b>AKA:</b>				
<b>Address:</b>	Work: C/O Montgomery Police Department, 2500 Upper Wetumpka Road, Montgomery, AL 36106-2500			
<b>Phone:</b>	Work: 334-222-2525			
UNVERIFIED PARTICIPANTS				
<b>Participant</b>	<b>Type</b>	<b>Role:</b>		
Mrs. Joyce Williamson	Collateral			
HOUSEHOLD MEMBERS				
<b>Head of Household:</b>	Mrs. Wisteria Elizabeth Lancelott			
<b>Household Members</b>		<b>Relationship To Head of Household</b>		
Angela Lancelott	Daughter			
Adam Lancelott	Son			
OTHER RELATIONSHIPS				
<b>Participant</b>	<b>Relationship</b>	<b>To Whom</b>		
Angela Lancelott	Niece	Lieutenant Dick Tracey Jr		
Adam Lancelott	Nephew	Lieutenant Dick Tracey Jr		
CONTRIBUTING FACTORS IDENTIFIED DURING ASSESSMENT				
Child: Angela Lancelott	Health Problems			
Family Circumstances	Financial Problems Inadequate Housing			
Parent/Primary Caregiver Circumstances	Alcohol Abuse Inadequate or Inappropriate Parenting Skills			
Other Risk Factors				
SAFETY THREATS IDENTIFIED DURING ASSESSMENT				
Basic parental duties not being performed Child safety affected by lack of parental skill				
SAFETY PLAN AND ACTION TAKEN				
<b>Safety plan Type:</b>	In-Home	<b>Date Completed:</b> 03/31/2005		
<b>Action Taken:</b>	Open for On-going CPS Services			
ALLEGATIONS				
<b>Allegation:</b>	Physical Abuse: Cuts & Bruises	<b>Incident Date:</b> 03/21/2005		
<b>Date/Time Received:</b>	03/22/2005 10:00 am	<b>Incident Location:</b> Home		
<b>Person at Risk</b>	<b>Disposition</b>	<b>Person Responsible</b>	<b>Disposition</b>	<b>Relationship to PIR</b>
Angela Lancelott	Not Indicated	Mrs. Wisteria Elizabeth Lancelott	Not Indicated	Birth Mother
Adam Lancelott	Indicated	Mrs. Wisteria Elizabeth Lancelott	Indicated	Birth Mother



**DECISION**

<b>Date Administrative Hearing Requested:</b>		<b>Upheld:</b>
<b>Date Administrative Record Review Requested:</b>	04/04/2005	<b>Upheld:</b> Yes
<b>Agency Responsible for Investigation:</b>	DHR	<b>Referral Date If Other Than DHR:</b>

**NOTIFICATIONS**

<b>Initial Notification to District Attorney:</b>	03/22/2005	<b>Method:</b>	Fax	<b>Name:</b>	Gary Nelson
<b>Initial Notification to Law Enforcement:</b>		<b>Method:</b>	Not Applicable	<b>Name:</b>	

**APPROVAL HISTORY**

<b>Worker Name</b>	<b>Decision</b>	<b>Date</b>
Jill Manly	Pending	

**INTAKE ASSIGNMENTS**

<b>Start Date/Time</b>	<b>End Date/Time</b>	<b>Type</b>	<b>Worker Name</b>	<b>Office</b>
03/24/2005 03:35 PM		Primary	Jill Manly	Montgomery
03/24/2005 03:35:PM		Supervisor	Russell Beard	Montgomery

**ASSESSMENT ASSIGNMENTS**

<b>Start Date/Time</b>	<b>End Date/Time</b>	<b>Type</b>	<b>Worker Name</b>	<b>Office</b>
03/24/2005 09:25 AM		Primary	Tim Preskitt	Montgomery
03/24/2005 09:25 AM		Supervisor	Russell Beard	Montgomery

**ALABAMA DEPARTMENT OF HUMAN RESOURCES**  
**REPORT OF SUSPECTED CASE OF CHILD ABUSE/NEGLECT**

Co. \_\_\_\_\_ Case # \_\_\_\_\_ Date Report Received: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Wkr. \_\_\_\_\_

Case Name: \_\_\_\_\_  P. Abuse  E. Abuse  S. Abuse  Neglect

**SECTION G - DESCRIPTION OF ALLEGATION(S)**

Description of Allegations: (Include date of incident, if known, and effects of abuse/neglect upon child(ren).)

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

**SECTION H - ADDRESSES**

Child's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If different from child, other addresses and phone numbers:

Legal Mother: \_\_\_\_\_ Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_

Legal Father: \_\_\_\_\_ Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_

Alleged Perpetrator: \_\_\_\_\_ Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_

Other Address: (specify) \_\_\_\_\_ Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_

**SECTION I - HOUSEHOLD COMPOSITION**

Other Adults in Home	Relationship	Other Children in Home	Age/Sex
_____	_____	_____	____/____
_____	_____	_____	____/____
_____	_____	_____	____/____

**SECTION J - REPORTER**

Reporter Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_

Did reporter observe the victim? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, how was the reporter aware of the abuse/neglect? \_\_\_\_\_

Other people with information:

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

Address: \_\_\_\_\_ Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_

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

Address: \_\_\_\_\_ Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_

Parental or mandatory reporter requested notification of disposition Yes \_\_\_\_\_ No \_\_\_\_\_

**SECTION K - OTHER**

Is the family known to Child Protective Service outside the county? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give any identifying data (dates, places, dispositions, AKA's, etc.)

Other Pertinent Information: \_\_\_\_\_

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

Report referred to D.A. \_\_\_\_\_ Date \_\_\_\_\_

Law Enf. \_\_\_\_\_ Date \_\_\_\_\_

Method of Intake: Phone \_\_\_\_\_ In-Person \_\_\_\_\_ Letter \_\_\_\_\_

Intake Worker's Signature \_\_\_\_\_

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

# WRITTEN REPORT OF SUSPECTED CHILD ABUSE/NEGLECT

STATE OF ALABAMA  
DEPARTMENT OF HUMAN RESOURCES  
Date Rec'd by Co. DHR \_\_\_\_\_

County Name \_\_\_\_\_  
DHR Case No \_\_\_\_\_

**COMPLETED BY DHR**

According to Code of Alabama 1975, Section 26-14-1 through 26-14-13, a written report is required. Persons reporting are requested to fill out as much information as is known to them. An explanation of the Child Abuse and Neglect Reporting Law and instructions for completion of this form are listed below.

## SECTION I - CHILD VICTIMS

FIRST NAME	MI	LAST	SEX	ETHNICITY	DATE OF BIRTH/AGE
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____

## SECTION II - PARENT(S)/CUSTODIANS (Household)

[Father] First Name	[Step-father] MI	[Custodian] MI	[Unknown] Last	[NA]	Ethnicity	Date of Birth/Age	If Custodian, Give Relationship to Victim
_____	_____	_____	_____	_____	_____	_____	_____
[Mother] First Name	[Step-mother] MI	[custodian] MI	[Unknown] Last	[NA]	Ethnicity	Date of Birth/Age	If Custodian, Give Relationship to Victim
_____	_____	_____	_____	_____	_____	_____	_____
Street Address	City	State	Zip Code	Telephone No.			
_____	_____	_____	_____	_____			

Location of child if different from parent's or custodian's address \_\_\_\_\_

## SECTION III - ALLEGED PERPETRATOR(S)

(1) First Name	MI	Last	Sex	Ethnicity	Date of Birth/Age
_____	_____	_____	_____	_____	_____
Address	City	State	Zip Code	Relationship to Victim	
_____	_____	_____	_____	_____	
(2) First Name	MI	Last	Sex	Ethnicity	Date of Birth/Age
_____	_____	_____	_____	_____	_____
Address	City	State	Zip Code	Relationship to Victim	
_____	_____	_____	_____	_____	

## SECTION IV - ABUSE/NEGLECT ALLEGATIONS

Description of Allegation(s) of abuse/neglect (Include date of incident, if known, and effects of abuse/neglect upon child(ren)) \_\_\_\_\_

Did reporter observe the victim(s)? [ ] Yes [ ] No

If No, how was reporter made aware of the abuse/neglect? \_\_\_\_\_

Other person(s) who may have knowledge of the abuse/neglect or family situation

Name	Address	Telephone No.	Relationship to Victim
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____

## SECTION V - OTHER PERTINENT INFORMATION

## SECTION VI - REPORTER

Did you make a verbal report of these allegations? ( ) Yes ( ) No If yes, specify to whom in the space below.

Name	County DHR Police/Sheriff	Date
_____	_____	_____

Signature of Person Reporting \_\_\_\_\_ Title/Agency/Relationship to Victim \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone No. \_\_\_\_\_

State of Alabama Department of Human Resources  
**Child Abuse and Neglect Risk Assessment Summary**

Case Name \_\_\_\_\_ County Name \_\_\_\_\_  
 Date of Report \_\_\_\_\_ Case Number \_\_\_\_\_

Instructions: Complete on all in-home reports (except "Unable to Complete" and High Risk). Refer to the Risk assessment Index Chart to clarify risk levels. Code each factor to the higher assessed level of risk. This form should reflect the risk assessment at the time a decision is made during the course of the investigation to either leave the child(ren) in his/her present living situation or to take steps for removal.

Assessment Codes: L = Low Risk M = Moderate Risk H = High Risk NA = Not Applicable

1. CHILD ASSESSMENT FACTORS (I-IV) Code for each child victim (when applicable)

Child Sequence #	1	2	3	4	5	6
Child's First Name	_____	_____	_____	_____	_____	_____
I. Child's Age, Physical and/or Mental Abilities Comments: _____	I. _____	_____	_____	_____	_____	_____
II. Severity and/or frequency of Abuse Comments: _____	II. _____	_____	_____	_____	_____	_____
III. Severity and/or frequency of Neglect Comments: _____	III. _____	_____	_____	_____	_____	_____
IV. Location of Injury Comments: _____	IV. _____	_____	_____	_____	_____	_____

2. FAMILY ASSESSMENT FACTORS (V-XIII)

V. Parent's/Caretaker's Physical, Intellectual, or Emotional Abilities/Control Comments: _____	V. _____
VI. Parent's/Caretaker's Level of Cooperation Comments: _____	VI. _____
VII. Parent's/Caretaker's Parenting Skills and/or Knowledge Comments: _____	VII. _____
VIII. Perpetrator's Access to Child Comments: _____	VIII. _____
IX. Presence of Paramour/Step-Parent/or Parent Substitute in the Home Comments: _____	IX. _____
X. Previous History of Abuse/Neglect Comments: _____	X. _____
XI. Physical Condition of the Home Comments: _____	XI. _____
XII. Strength of Family/Non-Family Support System Comments: _____	XII. _____
XIII. Stresses Comments: _____	XIII. _____

3. WORKER'S OVERALL ASSESSMENT OF RISK OF HARM: (Code each child victim to highest assessed level)

Child Sequence #	1	2	3	4	5	6
Code:	_____	_____	_____	_____	_____	_____
Comments:	_____					
	_____					

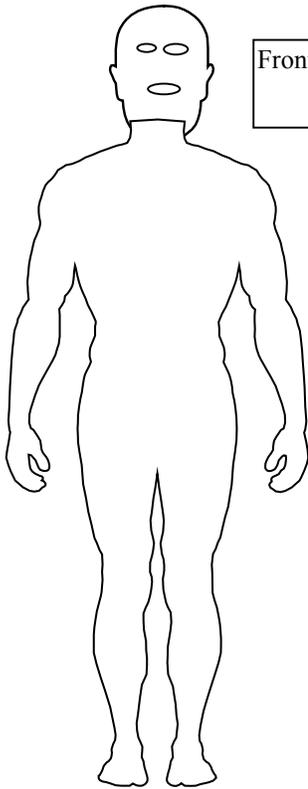
Worker's Signature \_\_\_\_\_ Date \_\_\_\_\_

# OBSERVED SUSPECTED ABUSE INJURY NOTESHEET

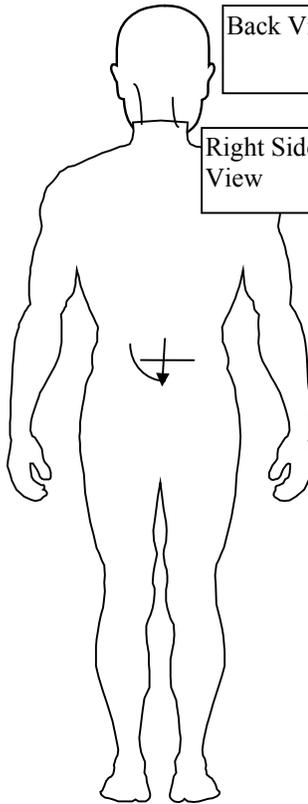
Child's Name: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
County Name: \_\_\_\_\_

Worker: \_\_\_\_\_  
Date of Observation: \_\_\_\_\_  
Date of Report: \_\_\_\_\_

**DIRECTIONS:** To be completed on all physical abuse reports when a suspected injury is observed. Be descriptive in noting your observations. Exception: If pictures are taken of the suspected injury, completion of this form is not necessary.

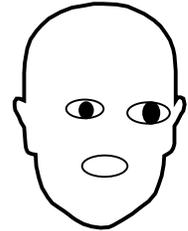


Front View



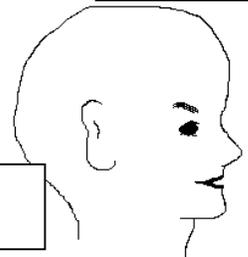
Back View

Right Side View

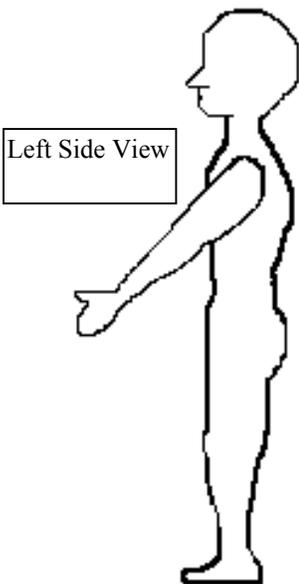
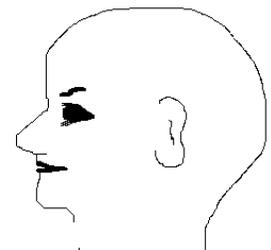


Front View

Left View



Right View



Left Side View



# CHILD PROTECTIVE SERVICE ALERT

## MEMORANDUM

TO: (Other State or County Department)  
FROM: , Supervisor  
Office of Child Protection and ICPC  
SUBJECT: Child Protective Service Alert

Children: (Name)	DOB	Sex	Race	SSN
Parent/Caretaker				

- Attached is a Protective Service Alert. Please conduct a Public Assistance records and agency records check and distribute this Protective Service Alert to the child services agencies in your state.
- Please share this information with your master file room personnel. Make a tickler card on this Protective Service Alert in the event that the subjects of this report come to the attention of your County Department through different means, e.g., ADC intake, service intake, food stamps, etc.
- Cancel the Protective Service Alert. The above named family has been located.
- Comments: \_\_\_\_\_

Attachment

cc:

DHR-DFC-1597

ALABAMA DEPARTMENT OF HUMAN RESOURCES  
**REQUEST FOR CLEARANCE OF STATE CENTRAL REGISTRY ON CHILD ABUSE/NEGLECT**

INSTRUCTIONS: Please print or type the information. Refer to the back of this form (hard copy) for information on the laws of confidentiality and on how to interpret the information released from the State Central Registry on Child Abuse/Neglect.

TO: Department of Human Resources  
 Division of Family and Children's  
 Services  
 State Central CAN Registry  
 50 Ripley Street  
 Montgomery, AL 36130-4000

FROM: ORGANIZATION: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 TELEPHONE: \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_  
 WITNESS: \_\_\_\_\_

Signature of Requestor                      Date  
 Signature of Witness                      Date

I am requesting that the following person be cleared through the Central Registry on Child Abuse/Neglect as a perpetrator or alleged perpetrator. This information will be used for \_\_\_\_\_

Name: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Last)                      (First)                      (Middle)

\* Alias, Maiden, or Prior Married Names: \_\_\_\_\_

\* Names of Spouse or Ex-spouse(s) (DOB for each) : \_\_\_\_\_

\* Name of Children/Step-children (DOB for each): \_\_\_\_\_

\* Alabama Counties where person(s) have lived: \_\_\_\_\_

\* Additional Pages May be Attached if Needed.

Below To Be Completed by the Employee/Potential Employee/Adoptive or Foster Parent Applicant.

I authorize the Department of Human Resources to release information regarding me contained in the State Central Registry on Child Abuse/Neglect to the above-named person/agency/organization. I hereby waive any right to review or hearing to which I may otherwise be entitled. I further release the Department of Human Resources and its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Below to Be Completed by DHR

Note: Only those perpetrator records which are determined as needed to discover or prevent child abuse/neglect will be released by DHR.

\_\_\_\_\_ Request denied: \_\_\_\_\_ Reason : \_\_\_\_\_

In clearing the State Central Registry regarding the above request, the following information was obtained:

\_\_\_\_\_ No Perpetrator Record Located.

\_\_\_\_\_ Substantiated Report Located:

	Type of Report	
_____	physical abuse	_____ emotional abuse
_____	sexual abuse	_____ neglect

\_\_\_\_\_ Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CHECKLIST FOR SETTING OF PRIORITIES AT INTAKE**

**INSTRUCTIONS: THIS FORM IS TO BE COMPLETED BY THE SERVICE INTAKE WORKER (OR ANY OTHER WORKER RECEIVING A REPORT) ON ALL REPORTS OF CHILD ABUSE/NEGLECT. IF IT IS DETERMINED THAT THE REPORT IS NOT HIGH RISK, THE REPORT IS PROCESSED AS INSTRUCTED IN CHAPTER VII OF THE FAMILY AND CHILDREN’S SERVICES MANUAL.**

---

**I. Intake**

Date and Time Report Received \_\_\_\_\_ Report Received By \_\_\_\_\_

**YES NO**

Has identifying information been documented on PSD-1591 and PSD-1592?

Has the Central Registry for Child Abuse/Neglect been cleared?

---

**II. Do any of the following high risk situations exist in this report? (Taken from Chapter VII; V-B)**

1. Child abuse/or neglect report received from an emergency room/medical facility.

2. Child abuse or neglect report from a physician and/or hospital, indicating the child is in need of immediate services.

3. Child left alone at home, in public place, in parked car, or in streets without adult supervision.

4. Child left with someone unable to provide safe supervision: i.e., intoxicated, under the influence of drugs, psychotic, fighting, extremely young (child caring for younger children), or too old or handicapped.

5. Child suffering from illness or injury, in need of medical attention that is not being provided.

6. Child who is the object of a report of suspected medical neglect of a handicapped child (Newborn infant who is having food withheld, infant who is not receiving medical treatment due to handicap, etc.) (Refer to Chapter VII-IX, “Reports of Medical Neglect of Handicapped Infants Under One Year of Age.”)

7. Child currently has a physical injury which is reported as suspected abuse/neglect, particularly for children under age six (6) and the alleged perpetrator has access to the child or has not been identified.

8. Child is currently being sexually abused by a parent/caregiver who has access to the child or the child is being sexually abused and the parent/caregiver is not protective.

9. Child whose parents are being incarcerated, hospitalized, etc., and there is no one to care for him.

10. Child who has been left with a child care person beyond the agreement to give care and the person is no longer willing to provide care.

11. Domestic violence.

- YES NO
12. An isolated single parent/caretaker who is mentally ill.
13. An isolated parent/caretaker who is mentally retarded.
14. A parent/caretaker using a controlled substance such as crack cocaine, heroin, or alcohol to the excess.
15. Child whose parent is a child (C.H.I.N.S. especially) and there is a dispute in the home over the care of the younger child.
16. Self referral from parent/custodian who states they are unable to cope, feel they may hurt or kill their children, or desire their children's removal and placement away from home.
17. Report alleging that the child(ren) is/are suicidal. (as relates to maltreatment)
18. Are there previous reports of abuse/neglect? If so, print the 1591 TAD for each report and attach to this form. Review previous reports for intake assessment and send prior CA/N reports to the investigative worker/supervisor for their review. (Do not mail TADs on prior reports to the State Office.)
19. Is the child at high risk of harm due to the above factors or some other reason?  
Explain: \_\_\_\_\_
- \_\_\_\_\_

**III. If any of the yes boxes (1-19) are checked, worker consults with the supervisor to determine if immediate response is needed. IF NOT, THE SUPERVISOR GIVES EXPLANATION BELOW. IF YES, CASE IS ASSIGNED AND AGENCY RESPONSE IS INITIATED IMMEDIATELY.**

- YES NO
- Is immediate response to the report required? If NO, explain \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
Signature of Reviewing Supervisor  
Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Signature of Intake Worker  
Date \_\_\_\_\_ Time \_\_\_\_\_

**IF IMMEDIATE RESPONSE IS REQUIRED:**

\_\_\_\_\_  
Date/Time Assigned to Investigative Worker

\_\_\_\_\_  
Name of Worker Assigned

\_\_\_\_\_  
Date/Time Investigation Initiated

- Law Enforcement/District Attorney Notified of Report.

**IV. If all of the boxes (1-19) are checked no it is not necessary to secure supervisory concurrence. Assessment for low or moderate risk proceeds as instructed in chapter vii of the family and children's services manual. Sign below.**

Intake Worker's Signature \_\_\_\_\_ Date \_\_\_\_\_



**CHECKLIST FOR HIGH RISK INDICATORS FOR CAN INVESTIGATIONS**

**INSTRUCTIONS:** Check **YES** or **NO** for each factor listed below. For each factor checked YES, a brief explanation MUST be written in the space provided. Identify children and adults by name. This form must be completed by the investigative worker on every CAN investigation. Complete one form per family.

**I. MALTREATMENT**

**YES NO**

- 1. Child is being physically or sexually abused. Explain \_\_\_\_\_
- 2. Child requires immediate medical attention \_\_\_\_\_
- 3. Child requires immediate supervision or child abandoned \_\_\_\_\_
- 4. Child lacks basic needs, (food, shelter, water) \_\_\_\_\_
- 5. Patterns of abuse/neglect escalating in severity and/or frequency \_\_\_\_\_
- 6. Chronic stress or crisis resulting from bizarre behavior, acute psychiatric episodes, alcohol, drugs, family violence and or financial stress \_\_\_\_\_
- 7. Previous incidents serious in nature resulting in serious harm or death of a child \_\_\_\_\_
- 8. Offender has unlimited access to the child \_\_\_\_\_
- 9. Previous incident on child or sibling serious in nature that did not result in serious harm \_\_\_\_\_

**II. CHILD(REN)**

- 1. Child under the age of six (6) \_\_\_\_\_
- 2. Child has severe/chronic physical or mental disability \_\_\_\_\_
- 3. Child lacks any emotional attachments \_\_\_\_\_
- 4. Child presents severe emotional or behavioral problems \_\_\_\_\_
- 5. Child is difficult (e.g., has severe colic, poor eating or sleeping patterns, hard to toilet train) \_\_\_\_\_
- 6. Child expresses extreme fear of parent/caretaker or the home environment \_\_\_\_\_
- 7. Child fears further abuse or retaliation \_\_\_\_\_
- 8. Child threatening suicide \_\_\_\_\_

## II. ADULT/PARENT/CARETAKER

- 1. Single parent household \_\_\_\_\_
- 2. Physical illness or disability prevents child's basic needs to be met \_\_\_\_\_
- 3. Mental illness/retardation or extreme immaturity results in inadequate judgment \_\_\_\_\_
- 4. Substance abuse (crack cocaine, alcohol or other controlled substance) \_\_\_\_\_
- 5. Poor impulse control, anger control, resulting in violent behavior \_\_\_\_\_
- 6. Lack of support from family and/or significant others \_\_\_\_\_
- 7. Adult/parent or caretaker abused or neglected as a child \_\_\_\_\_
- 8. Previous history of violent actions against another individual \_\_\_\_\_
- 9. Previous history of serious or chronic abuse/neglect in the family \_\_\_\_\_
- 10. Domestic violence in current or previous relationship \_\_\_\_\_
- 11. Injury inconsistent with adult/parent/caretaker's explanation \_\_\_\_\_
- 12. Parent/caretaker vehemently denies allegations even when confronted with actions \_\_\_\_\_
- 13. Adult/Parent/Caretaker shows no remorse/empathy toward the child or his/her condition \_\_\_\_\_
- 14. Parent/caretaker has a negative perception of child resulting in scapegoating, blaming, ignoring \_\_\_\_\_

---

## IV. FAMILY INTERACTION

- 1. Parent/primary caretaker has multiple short lived relationships involving violence negative interactions and instability \_\_\_\_\_
- 2. Parent/primary caretaker frequently leaves child with relatives or unrelated persons \_\_\_\_\_
- 3. Lack of positive attachments, affection or interaction among family members, apathetic \_\_\_\_\_
- 4. Family is isolated from other extended family/community/resources \_\_\_\_\_
- 5. Constant marital or family conflict resulting in aggression or violence or intimidation \_\_\_\_\_
- 6. Family unwilling or unable to cooperate or accept assistance \_\_\_\_\_
- 7. Role reversals between the child and adults or unrealistic expectations of child \_\_\_\_\_

**V. HOME ENVIRONMENT**

- 1. Hazardous, dilapidated, extreme deterioration of home resulting in immediate threat to child \_\_\_\_\_
- 2. Lack of functional utilities (i.e., water, gas, electricity, heat) or plan for reinstating them \_\_\_\_\_
- 3. Family will imminently lose its residence or is homeless \_\_\_\_\_
- 4. Seriously overcrowded conditions \_\_\_\_\_
- 5. Adults and children of various ages and opposite sex occupying same bedroom space \_\_\_\_\_
- 6. Home is considered a dangerous environment due to drugs, violence, high crime, etc. \_\_\_\_\_
- 7. People who pose a danger to children in and out of home \_\_\_\_\_
- 8. Family relocates frequently which results in instability \_\_\_\_\_
- 9. Family has no financial resources \_\_\_\_\_

**VI. PERSONS INTERVIEWED**

YES	NO	Date/Time
<input type="checkbox"/>	<input type="checkbox"/> Child interviewed/observed	_____
<input type="checkbox"/>	<input type="checkbox"/> Parent/Caretaker interviewed	_____
<input type="checkbox"/>	<input type="checkbox"/> Person responsible for maltreatment interviewed	_____

**VII. DETERMINING RISK TO CHILD(REN)**

When the worker has assessed risk factors in the home, she/he and the supervisor will determine the level of risk of harm to the child(ren) by evaluating the severity and/or interrelationship of each factor checked yes.

**Level of Risk**            High Risk \_\_\_\_\_    Not A High Risk \_\_\_\_\_  
An explanation of this determination is required.

\_\_\_\_\_

\_\_\_\_\_

Both the worker's and supervisor's signatures are required on this form to show that they have examined the risk factors and concur on level of risk and the explanation.

_____	_____
Worker's Signature	Supervisor's Signature
Date _____	Date _____

**THIS DOES NOT TAKE THE PLACE OF A FORMAL DETERMINATION OF LOWER LEVELS OF RISK.**

**SAFETY PLAN**

COUNTY: \_\_\_\_\_  
NAME: \_\_\_\_\_  
CASE #: \_\_\_\_\_  
WORKER: \_\_\_\_\_

**WHEN IS A SAFETY PLAN NEEDED?**

**A SAFETY PLAN MUST BE MADE IF A LEVEL OF HIGH RISK HAS BEEN DETERMINED ON PART B, SECTION VII OF THE HIGH RISK PROTOCOL. A SAFETY PLAN MAY ALSO BE USED FOR OTHER LEVELS OF RISK.**

**ACTION TO PROVIDE SAFETY FOR A CHILD MUST BEGIN IMMEDIATELY IF A DETERMINATION OF HIGH LEVEL OF RISK WAS MADE AFTER ASSESSING THE HIGH RISK INDICATORS FOR CAN INVESTIGATIONS.**

**I. DETERMINATION OF RESPONSIBLE PERSON TO PROTECT CHILD**

YES NO

There is a responsible, non-maltreating parent/caretaker who is willing and able to protect the child or you can obtain supervision from a safe source. In determining parent/caretaker's ability and willingness to protect the child the following must be considered.

1. Parent/caretaker's willingness to cooperate with DHR and service providers.
2. Parent/caretaker's ability to be independent of emotional or financial support from the person responsible for maltreatment of child.
3. Parent/caretaker is able to provide a safe home environment.

IF THE ABOVE BOX IS CHECKED YES GO TO IN HOME SAFETY PLAN.

IF THE ABOVE BOX IS CHECKED NO GO TO OUT OF HOME SAFETY PLAN.

**II. IN-HOME SAFETY PLAN**

Name of Person Responsible for Protecting the Child in the Home

Relationship To The Child \_\_\_\_\_

Address \_\_\_\_\_

State the basis for your professional judgement that this person/supervision can and will protect the child. Provide information and an illustration that demonstrates he/she protected the child(ren) in the past. Identify strengths of the caretaker and family.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HIGH RISK PROTOCOL PART C

**Risk Factors/Safety Interventions**

List each risk factor or combination of risk factors identified in the assessment. Match risk to safety intervention/service. List date service begins.

Identified Risk Factors	Safety Intervention	Date Initiated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

From the above, identify how the safety intervention matches the risk factor and how the intervention will control the level of risk.

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

If In-Home Safety plan has been justified, proceed to Safety Plan Conclusion.

---

**III. OUT-OF HOME SAFETY PLAN**

Risk assessment indicates that the child’s safety can only be controlled through out-of-home placement. Identify factors necessitating this decision.

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

Plan is being made with: (least restrictive to most restrictive)

	Name	Relationship
**Family/Relationship	_____	_____
**Friend, Neighbor	_____	_____
Related Foster Care	_____	_____
Unrelated Foster Care	_____	_____
Group Home	_____	_____
Shelter Care	_____	_____
Residential Treatment	_____	_____
Institution	_____	_____



**DHR-DFC-1924C (3-97)**



**MULTI-DISCIPLINARY TEAM REFERRAL FORM**

County: \_\_\_\_\_  
Date of Initial Team Referral: \_\_\_\_\_  
DHR Worker: \_\_\_\_\_  
DHR Case No.: \_\_\_\_\_

I. Purpose For Referral To Team: (Check All That Apply)

- \_\_\_\_\_ Coordinate Resources \_\_\_\_\_ Adoption, Foster Care Crisis  
\_\_\_\_\_ Treatment Needs Unclear \_\_\_\_\_ Arbitrate Difference in Treatment Plan  
\_\_\_\_\_ Child's Safety \_\_\_\_\_ Other (Identify)

Case Identifier: \_\_\_\_\_

Child(ren) To Be Presented: (Age & Sex) \_\_\_\_\_

Family Profile: (Members of Child's Household) \_\_\_\_\_

Family Situation: (Problems and Crisis, Living Conditions, Extended Family, etc.) \_\_\_\_\_

Medical, School, And/Or Psychological Problems and Results Of Any Tests Or Evaluation: \_\_\_\_\_

Summary of DHR Work With Family: (Include Assessment of Child's Safety In -Home): \_\_\_\_\_

Other Agencies Directly Involved With Family: \_\_\_\_\_

II. Team's Assessment and Recommendation: \_\_\_\_\_

Disposition: \_\_\_\_\_

Team To Review: \_\_\_\_\_ Date: \_\_\_\_\_

Team To Close: \_\_\_\_\_ Recommendation Given/Sent To DHR Worker: \_\_\_\_\_ Yes

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Team Coordinator

**MULTI-DISCIPLINARY TEAM FOLLOW-UP REPORT**

County: \_\_\_\_\_  
Date of Initial Team Presentation: \_\_\_\_\_  
Current Team Review Date: \_\_\_\_\_  
DHR Worker: \_\_\_\_\_  
DHR Case No.: \_\_\_\_\_

Case Identifier: \_\_\_\_\_

I. Identify and comment on each portion of the Team’s recommendation. Include, as appropriate, action taken or not taken and any known results. Indicate any significant changes since last report to the Team. (Worker To Complete):

II. State any new or unresolved concerns and/or recommendations. (Team To Complete):

III. Disposition of Team

Team To Review: \_\_\_\_\_ Date: \_\_\_\_\_  
Team To Close: \_\_\_\_\_

Copy Of This Report Given/Sent To DHR Worker \_\_\_\_\_ Yes

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Team Coordinator

**AGREEMENT ON CONFIDENTIALITY OF REPORTS AND RECORDS  
OF CHILD ABUSE/NEGLECT AND COMMITMENT OF \_\_\_\_\_  
COUNTY MULTI-DISCIPLINARY CHILD PROTECTION TEAM MEMBER**

In an effort to better serve families and children, I recognize the benefits of associated agencies cooperating and collaborating on child protection cases. Hence, I will voluntarily serve as a consultant and share my professional expertise by agreement to serve as a member of the \_\_\_\_\_ County Multi-Disciplinary Child Protection Team.

I have read the Code of Alabama, 1975, Section 26-14-8 (copy attached) which provides that reports and records of child abuse/neglect are confidential. I understand that I am bound by the provisions of this law, and I agree to keep confidential all case information discussed during Multi-Disciplinary Team meetings.

Signature: \_\_\_\_\_

Agency: \_\_\_\_\_

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

County DHR Director's Signature: \_\_\_\_\_

County: \_\_\_\_\_

### CHILD ABUSE/NEGLECT ANNUAL MULTI-DISCIPLINARY TEAM REPORT

Part I - Annual Report - Submit to Adult, Child and Family Services, Office of Protective Services by September 30, annually

1. There is a functioning Multi-Disciplinary Team present in my county.  
 \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, give date of organization. \_\_\_\_\_ Month \_\_\_\_\_ Year  
 If no, give reasons why \_\_\_\_\_
  
2. Membership on the team is represented by the following professional: (Check and give the number of persons represented by this profession if a current Team member.)  
 \_\_\_\_\_ law enforcement \_\_\_\_\_ DHR  
 \_\_\_\_\_ District Attorney \_\_\_\_\_ medical  
 \_\_\_\_\_ education \_\_\_\_\_ other (Identify by Profession)  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. Team coordinator is represented by what profession? \_\_\_\_\_
4. How often does the Team meet? \_\_\_\_\_
5. Number of cases presented first time since 10/1/\_\_\_\_: \_\_\_\_\_
6. Number of cases reviewed for follow-up since 10/1/\_\_\_\_: \_\_\_\_\_
7. Function of the Team includes: (Check all those that apply.) Briefly describe your Team's activities in each of these functions.  
 \_\_\_\_\_ advisory case consultant \_\_\_\_\_ education \_\_\_\_\_  
 \_\_\_\_\_ treatment \_\_\_\_\_ referral \_\_\_\_\_  
 \_\_\_\_\_ resource development \_\_\_\_\_ other \_\_\_\_\_
8. Percentage of service staff and core Team members view the Team as:  

	<u>State DHR Staff</u>	<u>Team Core Members</u>
(1.) Waste of Time - No Value	_____	_____
(2.) Time Consuming but Serves a Need	_____	_____
(3.) Very Helpful and Productive - Well Worth the Time Invested	_____	_____
9. Identify any problems noted with the Team; e.g., lack or lagging commitment of Team members, high Team turnover, resentment of the Team by DHR staff, etc.,: \_\_\_\_\_
10. Other Accomplishment or Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ (Team Coordinator)  
 Date: \_\_\_\_\_ Signed: \_\_\_\_\_ (DHR County Director)



COUNTY _____
CASE NAME _____ CASE# _____

**SAMPLE**

**MEMORANDUM**

mm/dd/yyyy

TO: \_\_\_\_\_ Supervisor  
Office of Child Protection and ICPC

FROM: \_\_\_\_\_ Worker/Supervisor  
\_\_\_\_\_ County Department of Human Resources

SUBJECT: Child Protective Service Alert

Children: (Name)	DOB	Sex	Race	SSN
Parent(s)/Caretaker(s)				

Nature of Alert/Reason For Concern: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Relevant Information Regarding Child(ren) and Family: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Description of Child(ren): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Description of Parent/Caretaker: \_\_\_\_\_  
 \_\_\_\_\_

Name/Address/Telephone Number of Contact Person: \_\_\_\_\_

**LETTER TO DISTRICT ATTORNEY**  
SAMPLE

Honorable John Doe  
District Attorney  
Eight Judicial Circuit  
PO Box 1111  
Everywhere, AL 36111

Dear Mr. District Attorney:

Attached are the child abuse and neglect reports (you have requested) (we have agreed to send you) (that policy mandates we will send to your office) for (month) (date) (week).

These reports are being furnished to you in accordance with Code of Alabama 1975, Section 26-14-7, which provides for the sharing of child abuse/neglect reports with district attorneys. As you know, the statute allows for the disclosure of these reports for the purpose of preventing or discovering child abuse and neglect. Code of Alabama 1975, Section 38-2-6(8) provides in part that “the use of such records, papers, files, and communications by any other agency or department of government shall be limited to the purposes for which they may be furnished.”

Our Department protects these records and reports from disclosure to persons who are not strictly authorized to have access to them. We have taken the position that attorneys representing parents or other perpetrators in civil or criminal cases are not entitled to these reports without a Court Order.

Our procedure is to have in camera inspections of our reports by the appropriate judge and to be ordered to disclose those portions of the record adjudged to be necessary for release.

Our position and procedures for the release of these records is in keeping with the U.S. Supreme Court decision in the case of Pennsylvania vs. Ritchie. The Supreme court held that the defendant is entitled to the disclosure of information material to his defense after review of the records by the Trial Court.

The Department of Human Resources takes very seriously the confidentiality statute governing child abuse and neglect records. It is always very important that these records be kept confidential in order to assure citizens of this State who report Child Abuse and Neglect that their identity will be kept confidential.

We are asking, therefore, that written or verbal information from these reports not be furnished by you to defense attorneys or anyone else outside your office. It is with this stipulation that we are disclosing these reports to you and your staff. If you have questions about these policies, you may wish to call Legal Services, State Department of Human Resources, at 334-242-9330.

Sincerely,

County Director



## **REPORT TO COURT SUGGESTED OUTLINE**

When child abuse/neglect cases involve the juvenile court, it is necessary for workers to send reports to the court describing activities of the case and making recommendations. It is often difficult to separate out, from the multitude of details and bits of information, those facts that are most descriptive and persuasive and that will support the social worker's recommendations. The following outline covers the major areas that are usually included in response to the court:

1. Name, address, age of all family members;
2. Brief chronology of significant past events, such as:
  - (a) child's prior foster care history;
  - (b) dates and dispositions of prior custody hearings; and,
  - (c) dates, types, and dispositions of prior abuse/neglect reports.
3. Concise description of the current situation;
4. Summary of efforts made and services offered by the agency to prevent or eliminate the need for removal of the child from his/her home;
5. Conditions in the child's own home that need to be improved and those services which can be provided by the Department to improve those conditions;
6. All court reports prepared for any purpose after the Judicial Decision to remove a child from his/her home should include:
  - (a) Summary of efforts made and services provided (or to be provided) to reunify the child with his/her family;
  - (b) Summary of visitation, including number of visits, quality of visits;
  - (c) Summary of support, including the amount of support offered and whether it has been paid.
7. Recommendation for court disposition with concise statements supporting the recommendation.

**SAMPLE**

State of \_\_\_\_\_ )  
County of \_\_\_\_\_ )

**Limited Power of Attorney**

I, \_\_\_\_\_ the \_\_\_\_\_  
(custodial parent/legal guardian) (relationship)

\_\_\_\_\_ a ( ) minor, ( ) incapacitated person,  
(child/incapacitated person)

pursuant to Code of Alabama 1975, # 26-2A-7, do hereby delegate to \_\_\_\_\_, of  
(person being given authority)

\_\_\_\_\_  
(address)  
\_\_\_\_\_, authority to make any decision relating to the  
physical custody, health, education, or maintenance of \_\_\_\_\_  
(child/incapacitated person)

including power to consent to medical treatment. This authority expires:

- ( ) one year from the date of execution below; or,
- ( ) \_\_\_\_\_, 19\_\_  
(specified date within one year)

unless revoked sooner.

I recognized that this delegation of authority does not relieve me of any primary responsibility that I may have for  
\_\_\_\_\_  
( child/incapacitated person)

Date: \_\_\_\_\_, 19\_\_\_\_\_

\_\_\_\_\_  
(Signed - Custodial Parent/Legal Guardian)  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sworn to and subscribed before me on this date:

\_\_\_\_\_  
(Notary Public)

<b>State of Alabama Unified Judicial System</b>  <b>Form JU-2 Rev. 10/86</b>	<b>COMPLAINT (INFORMATION)</b>	<b>Case Number</b>
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IN THE JUVENILE COURT \_\_\_\_\_ COUNTY

In the Matter Of \_\_\_\_\_ AKA \_\_\_\_\_

Address \_\_\_\_\_

Lives With \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ DOB \_\_\_\_\_ POB \_\_\_\_\_ Verified By \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Eyes \_\_\_\_\_ Hair \_\_\_\_\_ SSAN \_\_\_\_\_ Religion \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Employer \_\_\_\_\_

Father \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Custodian \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Employer (F/M/C) \_\_\_\_\_ Address \_\_\_\_\_ (Bus.) Phone \_\_\_\_\_

Alleged Violation/Incident \_\_\_\_\_

Date of Violation/Incident \_\_\_\_\_ Category: Delinquent Dependent CHINS

Arresting Officer \_\_\_\_\_ Date of Arrest \_\_\_\_\_ Dept. \_\_\_\_\_

I agree to sign a formal petition and testify in court if necessary to substantiate the complaint.

Said child is also in immediate or threatened danger of physical and/or emotional harm in that \_\_\_\_\_

\_\_\_\_\_ and should be removed immediately.

Complainant's Name \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_

FACTS OF VIOLATION/INCIDENT (Use back of sheet or additional pages if necessary) (See attached report if applicable)

Include time, place, co-defendants and ages, victim, approximate value of property taken/damaged/recovered, and description of alleged delinquent behavior. In neglect/abuse cases include perpetrator and relation to victim, results of incident (extent of injury, etc.) previous abuse/neglect of child or perpetrator.

\_\_\_\_\_ Date

\_\_\_\_\_ Time of Filing

\_\_\_\_\_ Intake Officer

ACTION TAKEN:

<b>State of Alabama Unified Judicial System</b>  <b>Form RM 24 4/79</b>	<b>SUBJECT:</b>  <b>Complaint (Information)</b>	<b>Page No. JU-2</b> <hr/> <b>Date:</b>
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Jurisdiction: All juvenile cases.

Note: A complaint against an adult within juvenile court jurisdiction is made on an affidavit from criminal court.

Authority: Rule 12, ARJP.

Purpose: To orderly record the information given to the intake officer by the complainant. The complaint form is filed with the intake officer and with the court.

Note: This form and the Information Sheet of the Social History Serial (JU-12A) were combined since most of the data elements were identical.



WHEREFORE, the Petitioner prays that the court appoint a Guardian ad Litem, who is an attorney, to represent the said child; and that summons issue pursuant to law and rules of court to the said child and to the said parents, guardian, or other custodian, and such other persons as appear to the court to be proper or necessary parties to the proceedings, requiring them to appear personally before the court at the time fixed to answer or testify as to the allegations herein.

The Petitioner prays that the court grant temporary custody of the said child to the \_\_\_\_\_  
County Department of Human Resources and that the court grant such additional relief as the needs of justice may require for the best interests of the said child.

Dated this \_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_ as \_\_\_\_\_  
Petitioner Title

\_\_\_\_\_ County Department of Human Resources

I swear that I am informed and believe and state upon such information, knowledge, and belief,  
that the above allegations and facts are true.

\_\_\_\_\_  
Petitioner

Sworn to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
Intake Officer

WHEREFORE, the Petitioner prays that the court appoint a Guardian ad Litem, who is an attorney, to represent the said child; and that summons issue pursuant to law and rules of court to the said child and to the said parents, guardian, or other custodian, and such other persons as appear to the court to be proper or necessary parties to the proceedings, requiring them to appear personally before the court at the time fixed to answer or testify as to the allegations herein.

The Petitioner prays that after the final hearing in this cause the court will terminate permanently any and all rights of the parents of the said child in and to his custody and grant permanent custody of the said child to the Department of Human Resources of the State of Alabama, and that the Department of Human Resources of the State of Alabama be authorized to place the said child for adoption or make other permanent plans for said child. The Petitioner further prays that the court grant such additional relief as the needs of justice may require for the best interests of said child.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_.

\_\_\_\_\_ as \_\_\_\_\_  
Petitioner Title

\_\_\_\_\_ County Department of Human Resources

I swear that I am informed and believe and state upon such information, knowledge, and belief, that the above allegations and facts are true.

\_\_\_\_\_  
Petitioner

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_.

\_\_\_\_\_  
Intake Officer

<b>State of Alabama Unified Judicial System</b>  <b>Form JU-7 Rev. 2/79</b>	<b>JUVENILE PICK-UP ORDER</b>	<b>Case Number</b>  <b>JU</b> <hr style="width: 100%;"/> <b>ID          YR          Number</b>
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IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY  
 In the Matter Of \_\_\_\_\_

**Part I**          To Any Law Enforcement Officer of the State of Alabama or Any Authorized Official:

It appearing to the court that the best interest of the child or public requires that the custody of the above-named child be immediately assumed by the State in that:

It is ordered that the child be taken into immediate custody and delivered to \_\_\_\_\_

Date \_\_\_\_\_ Judge \_\_\_\_\_

**Part II**          **PARENT/GUARDIAN**

To question this order of removal, you must appear at the hearing to be held at \_\_\_\_\_  
 \_\_\_\_\_  on (date) \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.  
 time and date to be determined later. (You will be notified).

**Part III**          **DESCRIPTION**

Sex \_\_\_\_\_ Height \_\_\_\_\_ DOB \_\_\_\_\_ Eyes \_\_\_\_\_  
 Race \_\_\_\_\_ Weight \_\_\_\_\_ Hair \_\_\_\_\_ Marks \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_

**Part IV**          **OFFICER**

I certify that I have executed this order by placing the above-named child in custody as ordered, and that I have delivered a copy of this order to \_\_\_\_\_

Date \_\_\_\_\_ Officer \_\_\_\_\_

**Part V**          **CUSTODY RECEIPT**

I certify that I have received custody of the above-named.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**JUVENILE COURT SUMMONS**

IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_

**NOTICE TO:**

Name \_\_\_\_\_ Address \_\_\_\_\_

**YOU ARE TO APPEAR IN COURT**

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

Time: \_\_\_\_\_ AM/PM

Room: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Issued By

**Endorsements (Orders To Parents or for Pick-Up 12-15-33, Code of Alabama, 1975.**

**TO ANY LAW ENFORCEMENT OFFICER OR OTHER AUTHORIZED PERSON:**

You are ordered to serve the above-summons and a copy of the petition as directed to each person named above.

\_\_\_\_\_  
Clerk

I certify that I personally served a copy of this summons and petition on \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Server

<b>State of Alabama Unified Judicial System</b>  <b>Form JU-12B Rev. 2/79</b>	<b>LEGAL INFORMATION (SOCIAL HISTORY SERIAL)</b>	<b>Case Number</b> <b>JU</b> <hr/> <b>ID</b> <b>YR</b> <b>Number</b>
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IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_

**Part I PRIOR COURT RECORD:**

Date	Offense/Matter	Disposition
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**Part II** CHILD'S ATTITUDES TOWARD OFFENSE AND HIS STATEMENT

**Part III** COMPLAINANT'S (victim's) STATEMENT AND ATTITUDE TOWARD OFFENSE

**Part IV** PARENT'S PRIOR POLICE RECORD.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Probation Officer

<b>State of Alabama</b> <b>Unified Judicial System</b>  <b>Form JU-12C Rev. 2/79</b>	<b>SCHOOL INFORMATION</b> <b>(SOCIAL HISTORY SERIAL)</b>	<b>Case Number</b> <b>JU</b> <hr style="border: 0; border-top: 1px solid black; margin: 2px 0;"/> <b>ID      YR      Number</b>
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IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_ Nickname \_\_\_\_\_

School:

Schools Previously Attended:

Grades Repeated:

Present Grade: \_\_\_\_\_ Test Given: \_\_\_\_\_ Date \_\_\_\_\_  
 Results: \_\_\_\_\_ Given: \_\_\_\_\_

Functional Grade Level:

**Academic Record:**  Record Attached, Report card, etc.

Subject	Current Year							Last Year						
	1	2	3	4	5	6	Yr.	1	2	3	4	5	6	Yr
1.								1.						
2.								2.						
3.								3.						
4.								4.						
5.								5.						
6.								6.						

**Attendance:** Required Days: \_\_\_\_\_  
 Days Present: \_\_\_\_\_  
 Excused Absences: \_\_\_\_\_  
 Unexcused Absences: \_\_\_\_\_

Conduct Reports  
 Behavior, Attitude  
 Towards School &  
 Persons in Authority

Extracurricular Activities:

School Officials Contacted:

Phone: \_\_\_\_\_ Date: \_\_\_\_\_ School Official (Signature) \_\_\_\_\_  
 Probation Officer \_\_\_\_\_

<b>State of Alabama Unified Judicial System</b>  <b>Form JU-12D Rev. 2/79</b>	<b>PROFILE OF YOUTH (SOCIAL HISTORY SERIAL)</b>	<b>Case Number</b> <b>JU</b> <hr/> <b>ID      YR      Number</b>
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IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_

A profile of youth should include comments about physical appearance: self-image (how the child sees himself); general attitude towards authority, parents, school and police; peer relationships; strengths and weaknesses and attributes the child has that could help him through problems; employment history (full and part-time); interests, hobbies and activities; special placements (i.e., special education, foster homes, vocational rehabilitation, etc. Describe programs and adjustment, length of stay, reasons for removal); other pertinent comments or analysis.

\_\_\_\_\_ Date

\_\_\_\_\_ Probation Officer

<b>State of Alabama Unified Judicial System</b>  <b>Form JU-12E Rev. 2/79</b>	<b>FAMILY-HOME INFORMATION (SOCIAL HISTORY SERIAL)</b>	<b>Case Number</b>  <b>JU</b> <hr/> <b>ID          YR          Number</b>
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IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_ Age: \_\_\_\_\_ Sibling Rank By Birth: \_\_\_\_\_

Description of Home:

Family Information: Comment on all pertinent information about the child's family; income; parents marital status and marital history; medical problems; recurring illnesses, mental or physical; family activities, general relationships among parents, child, child's siblings, attitude of parents toward child's offense; etc.

Other agencies working with family or individual member: (Past or present)

\_\_\_\_\_ Date

\_\_\_\_\_ Probation Officer

<b>State of Alabama Unified Judicial System</b>  <b>Form JU-12F Rev. 2/79</b>	<b>MEDICAL INFORMATION (SOCIAL HISTORY SERIAL)</b>	<b>Case Number</b>  <b>JU</b> <hr/> <b>ID      YR      Number</b>
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IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_

**HEALTH HISTORY:**

Physical (List diseases/physical handicaps, surgical history)

Last Physical Exam: (Date, doctor, results)

Name of Family Doctor:

Hospital Plan:

Office Address:

Medicaid No.:

Phone:

Psychiatric History:

Immunizations - Childhood diseases:

Other Comments: (Immediate problems, current treatment, habits, diet and other factors detrimental to health, medical complaints and problems)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Probation Officer

<b>State of Alabama Unified Judicial System</b>  <b>Form JU-12G Rev. 2/79</b>	<b>SUMMARY--RECOMMENDATIONS (SOCIAL HISTORY SERIAL)</b>	<b>Case Number</b>  <b>JU</b> <hr/> <b>ID      YR      Number</b>
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IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_

Needs Assessment and Treatment Priorities: (Specific areas or target behavior: i.e., cursing, constant fighting)

Recommendations:

Referral resources that are indicated:

Other Comments:

\_\_\_\_\_ Date

\_\_\_\_\_ Probation Officer

<b>State of Alabama</b> <b>Unified Judicial System</b>  <b>Form JU-17 Rev. 2/79</b>	<b>ORDER OF DENTENTION/SHELTER CARE</b>	<b>Case Number</b>  <b>JU</b> <hr/> <b>ID</b> <b>YR</b> <b>Number</b>
--	---	--

IN THE JUVENILE COURT OF \_\_\_\_\_ COUNTY

In The Matter Of \_\_\_\_\_ DOB \_\_\_\_\_

The above named child, appearing with (parent) \_\_\_\_\_ and

(Attorney) \_\_\_\_\_, this date for a detention/shelter care hearing in response to a petition alleging that the child is:

- A child in need of supervision.
- A dependent child.
- A delinquent child.

And the Court, having considered the pleadings, evidence, and arguments of all parties, finds that said child should remain in detention/shelter care by reason of the following:

- There is no suitable person able and willing to provide for the care and supervision of the child.
- Release of the child would present a real and serious threat of substantial harm to the person or property of another.
- Release of the child would present a real and substantial threat of serious harm to the child.
- The child has a history of failing to appear before the Court for hearings.

It is, therefore, the order of the Court, that the child be, and hereby is, placed in the care and custody of the Juvenile Court at the \_\_\_\_\_ detention/shelter care facility where said child is to remain until further orders of this Court.

Date \_\_\_\_\_

\_\_\_\_\_  
 Judge/Referee

ORDER OF RELEASE

It is hereby ordered by the Court that the child be released from detention to \_\_\_\_\_

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Judge/Referee

State of Alabama  
Unified Judicial System  
Form C-18 Rev. 2/79

**ORDER**

Case Number

\_\_\_\_\_  
**ID**

\_\_\_\_\_  
**YR**

\_\_\_\_\_  
**Number**

IN THE \_\_\_\_\_ COURT OF \_\_\_\_\_ COUNTY

Plaintiff

vs. Defendant

In The Matter Of: \_\_\_\_\_

\_\_\_\_\_  
Judge

Certified As A True Copy

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clerk Registrar By: \_\_\_\_\_

**LETTER TO LAW ENFORCEMENT REGARDING REPORT – INVOLVING CORPORAL PUNISHMENT/DISCIPLINE  
IN SCHOOLS**

County DHR Letterhead

Date

**RE:** Case File Name & Number

Dear

Pursuant to Code of Alabama, Section 26-14-3 (c) the attached report of corporal punishment/discipline in the school is being submitted to you for your investigation or disposition. If this report is to be handled as an investigation of child abuse, please return a copy of this letter along with any information on the investigation to us. This information will then be entered into the State Central Registry on Child Abuse and Neglect, as required by law.

If your investigation of child abuse determines that the report is substantiated, an administrative hearing must be offered by this Department before the substantiated disposition may be entered into the Central Registry. If a hearing is held, you will be called upon, as the investigating agency, to participate in the hearing.

No action on this report will be taken by this Department unless we receive notification from you that the situation will be or has been investigated as a report of child abuse.

Sincerely,

(Worker's Name)

## LETTER TO ALLEGED PERPETRATOR WITH INDICATED DISPOSITION

{Date}

{Person Allegedly Responsible's Name}  
{Address line 1}  
{Address line 2}  
{Address line 3}

Dear: {Title} {Person Allegedly Responsible's Last Name}

The {county name} County Department of Human Resources (DHR) has completed the initial assessment on the suspected child abuse/neglect report that named you as being responsible for the abuse or neglect. Our preliminary decision is we have reasonable cause to believe the report is "Indicated" (true). An "Indicated" finding is used when there is more credible evidence than not, based on the professional judgement of the social worker, that child abuse or neglect has occurred. The initial assessment revealed that:

*(User entered text – describe the incident, timeframe, children involved and basis for the disposition)*

**You have the right to an administrative record review. This means that the county's written report will be reviewed by an independent panel of DHR employees who are not involved in the case. The panel members will review the written report and make a final decision about whether the written report supports the finding. The panel has the authority to overturn the county's decision if the documentation does not support the findings.**

**If you want the decision reviewed by the panel, you must submit your written request to me at the {county name} County Department of Human Resources (address is above) within ten (10) working days from the date of receipt of this letter. You may include any written information that, in your opinion, proves the findings are not true.**

**If we do not receive a written request within the 10 working days, we will consider that you have given up your opportunity for a review. At that time, the preliminary decision will become a final decision, and it will be entered into the Department's Central Registry for Child Abuse/Neglect. This information is for the Department's records only and does NOT refer to any criminal charges. Our records are confidential and may only be released according to State law.**

**If you have questions, please call me at {worker's phone number}.**

Sincerely,

{Name}  
Protective Services Worker

APPROVED:

{Name}  
Protective Services Supervisor

PSAS0

An

## SAFETY PLAN

Case Name \_\_\_\_\_

Date Plan Developed \_\_\_\_\_ Page \_\_\_\_ of \_\_\_\_

County \_\_\_\_\_

Type Plan:     In-Home         Out-Of-Home (Non-Foster Care)

### STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES WRITTEN REPORT OF SUSPECTED CHILD ABUSE/NEGLECT

**Please print or type** all known information. The Child Abuse/Neglect Reporting Law and instructions are explained on the back of this form.

#### SECTION I – CHILDREN ALLEGEDLY ABUSED OR NEGLECTED

	NAME (First, Middle Initial, Last)	SEX	ETHNICITY	DATE OF BIRTH/AGE
1.	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
2.	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
3.	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
4.	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
5.	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
6.	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____

**ADDRESS**

Street Address	City	State	Zip	Telephone
Number _____	_____	_____	_____	_____

#### SECTION II – OTHER PERSONS LIVING WITH THE CHILDREN (Include parents/custodians and other children in the home)

	NAME (First, Middle Initial, Last)	DATE OF BIRTH / AGE	ETHNICITY	RELATIONSHIP TO THE CHILDREN
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

5. \_\_\_\_\_

6. \_\_\_\_\_

**SECTION III – PERSON(S) ALLEGEDLY RESPONSIBLE FOR THE ABUSE OR NEGLECT**

NAME (First, Middle Initial, Last)	SEX	ETHNICITY	DATE OF BIRTH / AGE
1. _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
Street Address _____ City _____ State _____ Zip _____ Telephone Number _____	Relationship To Children Allegedly Abused/Neglected		
2. _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
Street Address _____ City _____ State _____ Zip _____ Telephone Number _____	Relationship To Children Allegedly Abused/Neglected		

**SECTION IV – ABUSE OR NEGLECT ALLEGATIONS (Describe what happened, how it affected the children, and the date(s) occurred, if known.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you see the abuse or neglect when it occurred?  Yes  No If no, how did you find out about it

Please identify other people who witnessed the abuse/neglect or who may have information about the child's or family's situation.

Name	Address	Telephone #	Relationship to Children
1. _____	_____	_____	_____
2. _____	_____	_____	_____

**SECTION V - OTHER PERTINENT INFORMATION**

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**SECTION VI - REPORTER**

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Name	Address	Telephone Number	Title/Agency/Relationship To Children
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Did you verbally report the allegations to the Department of Human Resources or law enforcement?  Yes (specify to whom in section below)  
 No

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Signature	Name	Name of County DHR, Police Department, or Sheriff's Department	Date Reported
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<b>For DHR Use Only</b>	County	Case #	Date Report Received
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**I. PURPOSE** This safety plan is developed to control identified safety threats. (select one)

- at initial child contact to allow time to complete the initial assessment
- during the initial assessment as additional information became available
- at completion of the initial assessment and prior to developing the initial ISP
- between ISPs when safety threats emerge

**II. INDIVIDUALS PARTICIPATING IN THE PLAN'S DEVELOPMENT AND IMPLEMENTATION**  
(Names and relationship to children)

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**III. SAFETY PLAN DETAILS**

Safety Need \_\_\_\_\_

**1. Service (Formal/informal; frequency; time needed (e.g., 3 hours per day, 2 times per week))**

**2. Person(s) Responsible For Providing The Service**

**3. Date Service Implemented (service must be immediately accessible & available to control safety threats)** \_\_\_\_\_

**4. Who will monitor this step and how**

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Safety Need \_\_\_\_\_

**1. Service (Formal/informal; frequency; time needed (e.g., 3 hours per day, 2 times per week))**

**2. Person(s) Responsible For Providing The Service**

**3. Date Service Implemented (service must be immediately accessible & available to control safety threats)** \_\_\_\_\_

**4. Who will monitor this step and how**

---



---

Safety Need \_\_\_\_\_

**1. Service (Formal/informal; frequency; time needed (e.g., 3 hours per day, 2 times per week))**

**2. Person(s) Responsible For Providing The Service**

**3. Date Service Implemented (service must be immediately accessible & available to control safety threats)** \_\_\_\_\_

**4. Who will monitor this step and how**

---



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Safety Need \_\_\_\_\_

1. Service (Formal/informal; frequency; time needed (e.g., 3 hours per day, 2 times per week))

2. Person(s) Responsible For Providing The Service

3. Date Service Implemented (service must be immediately accessible & available to control safety threats) \_\_\_\_\_

4. Who will monitor this step and how

Safety Need \_\_\_\_\_

1. Service (Formal/informal; frequency; time needed (e.g., 3 hours per day, 2 times per week))

2. Person(s) Responsible For Providing The Service

3. Date Service Implemented (service must be immediately accessible & available to control safety threats) \_\_\_\_\_

4. Who will monitor this step and how

Safety Need \_\_\_\_\_

1. Service (Formal/informal; frequency; time needed (e.g., 3 hours per day, 2 times per week))

2. Person(s) Responsible For Providing The Service

3. Date Service Implemented (service must be immediately accessible & available to control safety threats) \_\_\_\_\_

4. Who will monitor this step and how

Safety Need \_\_\_\_\_

1. Service (Formal/informal; frequency; time needed (e.g., 3 hours per day, 2 times per week))

2. Person(s) Responsible For Providing The Service

3. Date Service Implemented (service must be immediately accessible & available to control safety threats) \_\_\_\_\_

4. Who will monitor this step and how

**IV. Identify any professional evaluations needed to understand family conditions which are influencing child safety. Specify who will conduct the evaluations (person or agency name) and arrangements made to have them conducted.**

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**V. Describe other immediate child needs (e.g., physical, emotional, educational, visitation) and steps to address them.**

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**VI. Identify family members' strengths that can address safety needs and contribute to the plan's success.**

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**VII. Date established to reevaluate safety plan** \_\_\_\_\_

**VIII. Signatures**

By signing below, I verify that I participated in this plan's development and will cooperate with implementing the described steps.

**Signature**

**Telephone #**

**Date Signed**

<b><u>Signature</u></b>	<b><u>Telephone #</u></b>	<b><u>Date Signed</u></b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Supervisory Approval:** \_\_\_\_\_

Signature

Date

**FOR DHR USE ONLY - FOLLOW-UP ACTION TAKEN**

(Note: No case shall be closed while a safety plan is in effect.)

Safety plan revised – new plan dated \_\_\_\_\_

Safety plan terminated effective \_\_\_\_\_

Reason plan terminated:

Safety needs incorporated into ISP dated \_\_\_\_\_

Children are safe; additional services not needed; case closed effective \_\_\_\_\_

Other (Specify) \_\_\_\_\_

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Person(S) Responsible For Protecting The Child(Ren)  
For "In-Home" and "Out-Of-Home (Non-Foster Care)" Safety Plans **ONLY**

**I. IDENTIFYING INFORMATION**

Name(s) \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work or Message # (\_\_\_\_)\_\_\_\_-\_\_\_\_ Home Visit Date \_\_\_\_\_

Will the child(ren) be living in the home with the person(s) responsible for providing protection?

Yes  No If "yes," list the names of all other household members.

Other Household Members' Names

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

**II. CLEARANCE OF AGENCY RECORDS AND CENTRAL REGISTRY**

Conduct clearances for (1) all persons responsible for providing protection **and** (2) all other household members if the child(ren) will be living in the home with the person(s) responsible for providing protection.

Date Clearances Conducted \_\_\_\_\_ Information Located?  Yes  No

If "yes," describe the information and include the county name, case name, and case # in which the material is located.

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

**III. ASSESSMENT INFORMATION**

Document your assessment of the person’s protective capacities.

Nature And Duration Of The Persons’ Relationship To The Child(ren)

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Protective Capacities (i.e., physical, mental, emotional)

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Ability And Willingness To Cooperate With DHR (including the person’s availability, reliability, commitment, and trustworthiness)

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Formal And Informal Supports (Family Network) Enabling The Person’s Ability To Protect

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**Documentation Completed By:**

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Signature

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Date

**Documentation Approved By:**

---

Signature

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Date

**DELEGATION OF PARENTAL AUTHORITY**

TO WHOM IT MAY CONCERN:

Pursuant to Code of Alabama 1975, Section 26-2A-7, I, legal custodian of the child(ren) identified below, do hereby delegate to

\_\_\_\_\_  
Print or Type Name(s) of Person(s) To Whom Authority Is Given

\_\_\_\_\_  
Print or Type Address

\_\_\_\_\_  
Print or Type City, State, Zip, and Telephone Number

**a limited power of attorney granting physical custody and authority to make any decision relating to the child(ren)'s physical custody, health, education, or maintenance.**

**Child(ren)'s Name**

**Date Of Birth**

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

This authority includes the power to grant permission or consent for medical treatment, surgery, trips, and participation in athletic events. No power is given to consent to the child(ren)'s marriage or adoption.

This authority expires one (1) year from the date shown below unless cancelled, verbally or in writing, by me prior to that time.

\_\_\_\_\_  
Print or Type Legal Custodian's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print or Type Legal Custodian's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print or Type Legal Custodian's Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or Type Legal Custodian's City, State, Zip

\_\_\_\_\_  
Print or Type Witness Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**\$49 FEE REQUIRED**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

DPS/DHR  
CRIMINAL HISTORY INFORMATION  
CONSENT AND RELEASE FORM  
**(Please print)**

My full name is \_\_\_\_\_

I reside at: \_\_\_\_\_

City of: \_\_\_\_\_

State of: \_\_\_\_\_

I am possessed of sound mind and am legally competent to execute this consent and release. I hereby give consent and authorize the Alabama Department of Public Safety to release any and all criminal history information on me to the Alabama Department of Human Resources, Personnel Division, Criminal History Checks Unit, P.O. Box 304000, Montgomery, AL 36130-4000. This report is submitted in connection with the following home/provider/agency:

Name and Address (**Please print**)

FOR:  applicant for license/approval       employment       volunteer       home study

I do hereby, for myself, my heirs, executors, and administrators, release and forever discharge the Alabama Department of Public Safety and its officers and agents from any and all claims, actions, or causes of action, which may arise as a consequence of the release of the criminal history information. I understand that I will receive a copy of the criminal history report from the Department of Human Resources. I further understand that I have the right to challenge the accuracy of the criminal history report with the Department of Public Safety and have a prompt determination of the validity of that challenge. I certify that I have read this consent and release and that I understand the significance of the same, and in witness thereof I have voluntarily signed my name on this the \_\_\_\_ day of \_\_\_\_\_ 20\_\_.

OTHER NAMES/AKAs: \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
 \_\_\_\_\_ SS# \_\_\_\_\_  
 \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

Witness \_\_\_\_\_ Sworn to and subscribed before me on this the  
 Address \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Witness \_\_\_\_\_ NOTARY PUBLIC  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ My commission expires \_\_\_\_\_

**PLEASE NOTE:** This document must be **witnessed by two (2) witnesses or notarized by a Notary Public.**

SEND MONEY ORDER OR  
 CASHIER'S CHECK OR  
 CERTIFIED CHECK PAYABLE  
 TO:

ALABAMA BUREAU OF INVESTIGATION  
 IDENTIFICATION UNIT  
 P.O. BOX 1511  
 MONTGOMERY, AL 36102-1511

MAIL FORM AND FINGERPRINT CARDS TO:

SEND COPY OF FORM ONLY TO:

ALABAMA DEPT OF HUMAN  
 RESOURCES  
 OFFICE OF CRIMINAL  
 HISTORY CHECKS  
 P.O. BOX 304000  
 MONTGOMERY, AL 36130-4000  
 (334) 353-4937

FINGERPRINT TECHNICIAN:	
<input type="checkbox"/>	FINGERPRINT CARD ISSUED
<input type="checkbox"/>	ELECTRONIC TRANSMISSION TO DPS
SIGNATURE	
DATE	

**NAME/ADDRESS OF HOME/PROVIDER/AGENCY:** \_\_\_\_\_

**MANDATORY CRIMINAL HISTORY CHECK NOTICE:**

Alabama law requires that a criminal history background information check be conducted on applicants for certain DHR positions and on all persons who hold a license or work in a Department of Human Resources licensed child care or adult care home, a foster or adoptive home approved by the Department of Human Resources, or a licensed child placing agency, including all officers and agents of the entity. You are required to provide full, complete, and accurate information on your criminal conviction history upon application for a license or employment. This information shall be used to determine your suitability to provide care to children, the elderly, or disabled individuals. Unless a criminal history background information check report and suitability determination have previously been obtained, you must complete a written request and consent for a criminal history background information check with fingerprints at the time of application for employment. Refusal to complete these documents or providing false information shall result in refusal of employment, approval, or licensure. The term conviction includes a determination of guilt by a trial, by a plea of guilty, or a plea of nolo contendere. Any individual determined to have submitted false information shall be referred to the district attorney or law enforcement for investigation and possible prosecution. An individual who intentionally falsifies any information on the statement is guilty of a Class A misdemeanor, punishable by a fine of not more than two thousand dollars (\$2,000) and imprisonment for not more than one year.

Convictions for any of the following crimes shall make an individual unsuitable for employment, volunteer work, approval, or licensure:

1. Murder, manslaughter, or criminally negligent homicide.
2. A sex crime. A sex crime includes the following:
  - a. Enticing a child to enter a vehicle, room, house, office, or any other space for immoral purposes, as proscribed by Section 13A-6-69 of the Code of Alabama 1975.
  - b. Incest, when the offender is an adult and the victim is a minor, as proscribed by Section 13A-13-3 of the Code of Alabama 1975.
  - c. Kidnapping of a minor, except by a parent, in the first or second degree, as proscribed by Section 13A-6-43 or Section 13A-6-44 of the Code of Alabama 1975.
  - d. Promoting prostitution in the first or second degree, as proscribed by Section 13A-12-111 or Section 13A-12-112 of the Code of Alabama 1975.
  - e. Rape in the first or second degree, as proscribed by Section 13A-6-61 or Section 13A-6-62 of the Code of Alabama 1975.
  - f. Sexual misconduct, as proscribed by Section 13A-6-65 of the Code of Alabama 1975.
  - g. Sexual torture, as proscribed by Section 13A-6-65 of the Code of Alabama 1975.
  - h. Sexual abuse in the first or second degree, as proscribed by Section 13A-6-66 or Section 13A-6-67 of the Code of Alabama 1975.
  - i. Sodomy in the first or second degree, as proscribed by Section 13A-6-63 or Section 13A-6-64 of the Code of Alabama 1975.
  - j. Soliciting a child by computer for the purposes of committing a sexual act and transmittal obscene material to a child by computer as proscribed by Sections 13A-6-110 and 13A-6-111 of the Code of Alabama 1975.
  - k. Violation of the Alabama Child Pornography Act, as proscribed by Sections 13A-12-191, 13A-12-192, 13A-12-196, or 13A-12-197 of the Code of Alabama 1975.
  - l. Any solicitation, attempt, or conspiracy to commit any of the offenses listed in paragraphs a. to k., inclusive.
  - m. A crime listed in the Community Notification Act, Chapter 20 of Title 15 of the Code of Alabama 1975.
3. A crime that involves the physical or mental injury or maltreatment of a child, the elderly, or an individual with disabilities.
4. A crime committed against a child.
5. A crime involving the sale or distribution of a controlled substance.
6. Robbery.
7. Conviction for a violation or attempted violation of an offense committed outside the State of Alabama is a sex crime or any other crime if the offense would be a crime in Alabama.

**CRIMINAL HISTORY STATEMENT**

Have you ever had a suitability determination made by the Department of Human Resources or the Department of Education in connection with a previous criminal history information background check? Yes ( ) No ( ). If yes, send form to DHR.

Have you ever been convicted of a crime? Yes ( ) No ( ). If yes, state on the lines below the date, crime, location, punishment imposed, and whether the victim was a child or an elderly or disabled individual.

\_\_\_\_\_  
Date \_\_\_\_\_ Signature \_\_\_\_\_ Print name \_\_\_\_\_

**FEE PAID BY DHR**

STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

DPS/DHR  
CRIMINAL HISTORY INFORMATION  
CONSENT AND RELEASE FORM  
**(Please print)**

My full name is \_\_\_\_\_

I reside at: \_\_\_\_\_

City of: \_\_\_\_\_ State of: \_\_\_\_\_

I am possessed of sound mind and am legally competent to execute this consent and release. I hereby give consent and authorize the Alabama Department of Public Safety to release any and all criminal history information on me to the Alabama Department of Human Resources, Personnel Division, Criminal History Checks Unit, P.O. Box 304000, Montgomery, AL 36130-4000. This report is submitted in connection with the following home/provider/agency:  
\_\_\_\_\_

**Name and Address (Please print)**

FOR:  applicant for license/approval  employment  volunteer  home study

I do hereby, for myself, my heirs, executors, and administrators, release and forever discharge the Alabama Department of Public Safety and its officers and agents from any and all claims, actions, or causes of action, which may arise as a consequence of the release of the criminal history information. I understand that I will receive a copy of the criminal history report from the Department of Human Resources. I further understand that I have the right to challenge the accuracy of the criminal history report with the Department of Public Safety and have a prompt determination of the validity of that challenge. I certify that I have read this consent and release and that I understand the significance of the same, and in witness thereof I have voluntarily signed my name on this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

OTHER NAMES/AKAs: \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
SS# \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

Witness \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sworn to and subscribed before me on this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Witness \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

NOTARY PUBLIC  
My commission expires \_\_\_\_\_

**PLEASE NOTE:** This document must be **witnessed by two (2) witnesses or notarized by a Notary Public.**

SEND MONEY ORDER OR  
CASHIER'S CHECK OR  
CERTIFIED CHECK PAYABLE  
TO:

ALABAMA BUREAU OF INVESTIGATION  
IDENTIFICATION UNIT  
P.O. BOX 1511  
MONTGOMERY, AL 36102-1511

MAIL FORM AND FINGERPRINT CARDS TO:

SEND COPY OF FORM ONLY TO:

ALABAMA DEPT OF HUMAN  
RESOURCES  
OFFICE OF CRIMINAL  
HISTORY CHECKS  
P.O. BOX 304000

MONTGOMERY, AL 36130-4000  
(334) 353-4937

FINGERPRINT  
TECHNICIAN:  
 FINGERPRINT CARD ISSUED  
 ELECTRONIC TRANSMISSION  
TO DPS

SIGNATURE
DATE

**AEIS - DHR  
CAPTA Referral Form**

**INFANT/TODDLER INFORMATION**

SSN#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Sex: \_\_\_\_\_ Ethnic Origin: \_\_\_\_\_ Home Language: \_\_\_\_\_

**REFERRAL SOURCE INFORMATION**

DHR Caseworker: \_\_\_\_\_ County: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Reason for Referral: **ABUSE** \_\_\_\_\_  
**NEGLECT** \_\_\_\_\_

Is child in Foster Care? YES \_\_\_\_\_ NO \_\_\_\_\_ Does child have an ISP? YES \_\_\_\_\_ NO \_\_\_\_\_

Is child receiving ongoing Child Protective Services (CPS)? YES \_\_\_\_\_ NO \_\_\_\_\_

**CHILD'S CURRENT LIVING SITUATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

\_\_\_\_\_

Relation Type: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Alternate #: ( ) \_\_\_\_\_

\_\_\_\_\_

**Mailing/Physical Address:**

City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

\_\_\_\_\_

Does family have any developmental concerns about the child's development in the areas of: Cognitive, Physical, Communication,

Social/Emotional, or Adaptive? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what are they?

**(STATE OFFICE USE ONLY)**

Date received by SDHR: \_\_\_\_\_ Date received by State AEIS: \_\_\_\_\_

Date Mailed to AEIS/DEIC: \_\_\_\_\_

**(DEIC OFFICE USE ONLY)**

Child Find Referral Activated: \_\_\_\_\_ Child already in AEIS: \_\_\_\_\_ No further action  
needed: \_\_\_\_\_

DHR-FCS-2121 6/2004)

## PLANNED PERMANENT LIVING ARRANGEMENT AGREEMENT

The persons involved in this agreement believe that it is in the best interest of

\_\_\_\_\_ that he/she be allowed to remain in the home of Mr.  
(child)

and Mrs. \_\_\_\_\_ and be raised by them as a member of their  
(foster parents)

family until he/she reaches adulthood. The intent of this agreement is to establish a placement which will exist indefinitely; however, this agreement does not preclude removal of this child under conditions described below.

We, \_\_\_\_\_, foster parents of \_\_\_\_\_  
(foster parents) (child)

agree to be the primary parents for this child until he/she reaches adulthood. We will not ask for him/her to be removed from our home except under serious, unusual circumstances. We agree to share information about his/her adjustment and progress with the \_\_\_\_\_

County Department of Human Resources as requested.

We, \_\_\_\_\_ County Department of Human Resources agree to maintain and support the long-term placement of \_\_\_\_\_  
(child)

in the foster home of Mr. and Mrs. \_\_\_\_\_. We will provide  
(foster parents)

foster care payment, medical services and other support services through the foster care program for children as provided by agency policies. We will continue to hold legal custody of \_\_\_\_\_ unless the court directs otherwise,  
(child)

and we will not disrupt this placement except for reasons which will serve the best interest of the child.

I, \_\_\_\_\_, understand that I will remain in the foster  
(child)

home of Mr. and Mrs. \_\_\_\_\_ because I want to be a part of  
(foster parents)  
this family until I am on my own and self-supporting.

We/I, \_\_\_\_\_, the biological parent(s) of  
(parents)  
\_\_\_\_\_ agree that \_\_\_\_\_ will  
(child) (child)  
remain in the foster home of Mr. and Mrs. \_\_\_\_\_ until  
(foster parents)  
he/she reaches adulthood. We/I will support this placement and help in his/her  
adjustment there. We/I will keep the \_\_\_\_\_ County  
Department of Human Resources and \_\_\_\_\_ advised  
(child)  
of our whereabouts and we/I will pay \$ \_\_\_\_\_ dollars per month to the  
County Department of Human Resources towards \_\_\_\_\_'s  
(child)  
support. We understand we will be kept informed of  
\_\_\_\_\_ 's adjustment and progress by the  
(child)  
\_\_\_\_\_ County Department of Human Resources.

SIGNATURES:

_____	_____	_____	_____
Child	Date		
_____	_____	_____	_____
Foster Mother	Date	Foster Father	Date
_____	_____	_____	_____
Biological Mother	Date	Biological Father	Date
_____	_____	_____	_____
Social Worker	Date	County Director	Date
on behalf of _____		on behalf of _____	
County Department of		County Department of	
Human Resources		Human Resources	

**REQUEST FOR FOSTER CARE TRUST FUNDS**

Please print. This form should be copied locally. Submit original to SDHR, Attn: Office of Foster Care Family Services Partnership

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Co. Case No.: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_ Custody Status: \_\_\_\_\_

Length of Time in Care: \_\_\_\_\_ Permanent Plan: \_\_\_\_\_

DESCRIPTION OF ITEM/SERVICE BEING REQUESTED:

\_\_\_\_\_  
*\*For classes, field trips, conferences, etc. brochures, fliers, descriptions from provider/instructor MUST be attached*

**Discuss child's interest, previous involvement, reason/need for the item/service being requested – the need must be documented in the ISP. ATTACH COPY OF CURRENT ISP**

**What efforts have been made to secure needed funds from other sources (local funds, donations, other agencies, etc.)?**

**TOTAL COST OF REQUESTED ITEM OR SERVICE:** \$ \_\_\_\_\_

**LESS OTHER FUNDS TO BE USED:**

Local/flex funds: - \$ \_\_\_\_\_

Private funds: - \$ \_\_\_\_\_

ILP funds: - \$ \_\_\_\_\_

Other funds, specify source: \_\_\_\_\_ - \$ \_\_\_\_\_

**DATE NEEDED:** \_\_\_\_\_ **\$ \_\_\_\_\_ TOTAL FCTF REQUEST**

Worker Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

County: \_\_\_\_\_ Supervisor's Signature: \_\_\_\_\_

**TO BE COMPLETED BY SDHR**

Date of determination: \_\_\_\_\_ Determination made by: \_\_\_\_\_

Approved, Amount: \_\_\_\_\_ Date County Notified/Letter Sent: \_\_\_\_\_

Disapproved, Reason: \_\_\_\_\_

**ALABAMA DEPARTMENT OF HUMAN RESOURCES**  
**AGREEMENT FOR FOSTER CARE**

I/We, \_\_\_\_\_ hereby request the \_\_\_\_\_ County Department of Human Resources to place my child(ren), named below, in an approved or licensed foster care placement.

Name	Sex	Date Of Birth	Social Security Number
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____

Placement is being requested because \_\_\_\_\_.

I/We do hereby give permission and do authorize the \_\_\_\_\_ County Department of Human Resources to:

- provide supervision during my child(ren)'s placement;
- seek and obtain any medical treatment, including emergency surgery, for my child(ren) that is deemed necessary or is recommended by a licensed physician while in the care of an approved or licensed child care facility; and
- release information about my child(ren) to other individuals/agencies to whom my child(ren) may be referred for services.

I/We do hereby agree to:

- pay the \_\_\_\_\_ County Department of Human Resources \$ \_\_\_\_\_ by the 15th of each month to meet my child(ren)'s expenses;
- abide by the regulations governing the Department of Human Resources' foster care program; and
- keep the \_\_\_\_\_ County Department of Human Resources informed as to my whereabouts and any changes in my situation.

I/We do understand that this agreement can be terminated upon my/our request to the \_\_\_\_\_ County Department of Human Resources.

This agreement will remain in force from \_\_\_\_\_ to \_\_\_\_\_, a period not to exceed 180 days.

\_\_\_\_\_  
Parent/Legal Custodian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
DHR Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Custodian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
County Director's Signature

\_\_\_\_\_  
Date

**AUTHORIZATION FOR COUNTY DESIGNEE TO SIGN/RECEIVE CONFIDENTIAL  
INFORMATION FOR THE FEDERAL PARENT LOCATOR SERVICE FOR FAMILY SERVICES**

By my signature below, I confirm that I am the designated person for my county who will review each enclosed Family Services Locate Data Sheet(s) for accuracy and appropriateness, and help to ensure that it meets the requirements of the Adoption and Safe Families Act of 1997. Also, I will check each locate data sheet(s) for evidence of family violence, and if evidence of family violence is known, help to ensure that it has been duly noted on the appropriate Locate Data Sheet. I understand the importance of safeguarding information, as stated in the agreement between the Child Support Enforcement Partnership and the Family Services Partnership, and acknowledge that this information will be kept confidential and only disclosed to authorized persons as outlined in 42 U.S.C. § 653. I understand that this agreement shall be in effect for the fiscal year beginning October 1 through September 30, in which it is signed, and must be renewed before the start of each fiscal year.

\_\_\_\_\_  
County Submitting Location Request

\_\_\_\_\_  
Signature of Authorized Individual

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of County Director

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

FEDERAL PARENT LOCATOR SERVICE (FPLS) COUNTY DESIGNEE AUTHORIZATION

\_\_\_\_\_ COUNTY

By my signature below, I confirm that I am the designated person for my county who will review each enclosed Family Services Locate Data Sheet(s) for accuracy and appropriateness, and help to ensure that it meets the requirements of the Adoption and Safe Families Act of 1997. I understand the importance of safeguarding information and acknowledge that this information will be kept confidential and only disclosed to authorized persons as outlined in 42 U.S.C. § 653. I understand that this agreement shall be in effect for the fiscal year October 1 through September 30 for the year in which it is signed, and that it must be renewed before the start of each fiscal year.

\_\_\_\_\_  
Signature of Authorized Designee                      Print Name                      Date

\_\_\_\_\_  
Signature of County Director                      Print Name                      Date

## FAMILY SERVICES LOCATE DATA SHEET

**TO:** CSEP – Central Registry / SPLS  
50 Ripley Street  
Montgomery, AL 36130

Date Received by CSE

**FROM:**

SDHR Family Services Contact Person Telephone #

**Case Name** \_\_\_\_\_ **Case #** \_\_\_\_\_

\_\_\_\_\_ **County DHR** **Case Type**  IV-E Foster Care/IV-B  
 \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
 County Contact Person Telephone # Fax #

**Address:** \_\_\_\_\_  
 Street / Mailing City, State Zip

**PARENT INFORMATION:**  Custodial  Non-Custodial

\_\_\_\_\_ First Middle Last  
**Social Security Number(s)** **Date of Birth (or approximate year)** **Driver's License # and State**

**Place of Birth** (City, State, County) \_\_\_\_\_

**Alias** \_\_\_\_\_ **Maiden Name** \_\_\_\_\_

**Mother's Maiden Name** \_\_\_\_\_  
 First Middle Last

**Father's Name** \_\_\_\_\_  
 First Middle Last

**Current Spouse's Name** \_\_\_\_\_  
 First Middle Last

Sex	Race	Hair	Eyes	Height	Weight	Distinguishing Marks (e.g., scars, tattoos)
-----	------	------	------	--------	--------	---

**Last Known Address**  Residence  Mailing

**Last Known Employer** \_\_\_\_\_

**Address** \_\_\_\_\_  
 Street / Mailing City, State Zip

**Telephone #** ( ) \_\_\_\_\_

**Other Information** (e.g., assets, education, policy record, public assistance history)

**History of Domestic Violence or Child Abuse**  Yes  No **Is this person dangerous?**  Yes  No

**Attachments**  Photograph  Other (Specify) \_\_\_\_\_

**For CSE Use Only** **Is there a family violence indicator on this individual?**  Yes  No

**Petitioner** \_\_\_\_\_ **Respondent** \_\_\_\_\_

**Confirmed**  Yes  No  
**Date** \_\_\_\_\_  
**Confirmed**  Yes  No  
**Date** \_\_\_\_\_  
**Federal EIN** \_\_\_\_\_

## FUNDING CERTIFICATION FOR CHILD WELFARE SERVICES

EA, TANF, TITLE XX and WRTI

### SECTION I CASE PARTICIPANTS DATA

1. CASE NAME	2. COUNTY:					3. CASE NUMBER		
4. CASE PARTICIPANTS (ENTER FAMILY MEMBERS NAMES)	5. Relationship	6.*SSN	7. RTRN HOME	8. FC	9. DOB	10. SEX	11. ETHNICITY	12. INCOME(Enter amt and source for each Family Member)
Use separate sheet if more space is needed								
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
					13. TOTAL INCOME: _____ <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY			

FOR DHR USE ONLY

### SECTION II EA CERTIFICATION

**14. Authorization Effective Date** (mm/dd/yy)

<p><b>15. WORKER CERTIFICATION</b></p> <p>1. An emergency exists meeting the definition of Emergency Assistance and the emergency did not arise because an adult family member refused without good cause to accept employment or training. If yes, check (a) or (b) Yes ___ No ___</p> <p>a. ___ The child(ren) has been removed from his/her home into publicly funded care or supervision. OR</p> <p>b. ___ The child(ren) is at risk of such removal</p> <p>2. This application was made on behalf of a child under the age of 21 living with, or within the past six(6) months has lived with a parent or specified relative Yes ___ No ___</p> <p>3. Family declares that there is no income and the worker has no reason to doubt them Yes ___ No ___ OR</p> <p>4. The family's annual income is less than twice the state median income \$57,376. The income has been verified and documentation is recorded in the service file Yes ___ No ___</p>	<p><b>16. ELIGIBILITY VERIFICATION</b></p> <p>1. <input type="checkbox"/> Application signed and worker certification meets criteria of emergency and income eligibility AND</p> <p>2. <input type="checkbox"/> Family did not have any EA Authorizations for this emergency in the past 12 months prior to the above effective date. Last date services can be claimed for FFP under this authorization period _____ mm/dd/yy</p> <p style="text-align: center;">OR</p> <p>3. <input type="checkbox"/> Family has an EA authorization currently in effect. Last date services can be claimed for FFP under the current authorization period _____ OR mm/dd/yy</p> <p>4. <input type="checkbox"/> Family is not eligible for Federal Assistance for the reason listed below:  <b>Denial Reason/Pending</b> _____  <b>Denial Date</b> _____</p>
---	--

**This application is made by the parent or relative who has signed below and/or by a worker on behalf of a child whose parents are unavailable or will not apply for Emergency Assistance. The worker authorizes all assistance and services covered under the State Plan for Emergency Assistance, to be determined to be appropriate and necessary for this child(ren) or family, from the effective date stated above for a period not to exceed 12 months.**

**SECTION III TANF, TITLEXX, WRTI CERTIFICATION**

**SECTION IV FUNDING SOURCE DETERMINATION**

<b>17. Certification Date</b>	<b>18. Funding Disposition</b>
Date Funding Certification Determined	Meets EA___ TANF___ Title XX Certification___ (check more than one if appropriate) WRTI Eligible (check one) _____
<b>TANF, Title XX or WRTI</b> _____ mm/dd/yy	
CERTIFICATION REDETERMINATION DATE: _____ mm/dd/yy <b>(DUE ONE (1) YEAR FROM DETERMINATION or 90 DAYS FROM DETERMINATION DATE IF WRTI PROTECTIVE SERVICE DAY CARE</b>	

**SECTION V TANF/TITLE XX INCOME SCALE**

Maximum Income Scale			Maximum Income Scale			Income Scale for Residential Care Services			Income Scale for Residential Care Services		
#PERSONS	ANNUALLY	MONTHLY	# PERSONS	ANNUALLY	MONTHLY	#PERSONS	ANNUALLY	MONTHLY	# PERSONS	ANNUALLY	MONTHLY
<b>1 Person</b>	<b>\$ 19,140</b>	<b>\$ 1,595</b>	<b>5 Person</b>	<b>\$ 45,220</b>	<b>\$ 3,768</b>	1 Person	\$ 38,352	\$ 3,196	6 Person	\$ 53,028	\$ 4,419
2 Person	\$ 25,660	\$ 2,138	6 Person	\$ 51,740	\$ 4,312	2 Person	\$ 40,092	\$ 3,341	7 Person	\$ 53,580	\$ 4,465
3 Person	\$ 32,180	\$ 2,682	7 Person	\$ 58,260	\$ 4,855	3 Person	\$ 44,172	\$ 3,681	8 Person	\$ 54,132	\$ 4,511
4 Person	\$ 38,700	\$ 3,225	8 Person	\$ 64,780	\$ 5,398	4 Person	\$ 47,136	\$ 3,928	9 Person	\$ 54,684	\$ 4,557
* Add \$ 6,520 annually or \$ 543 monthly for each person when family size exceeds 8.			* Add \$ 6,520 annually or \$ 543 monthly for each person when family size exceeds 8.			5 Person	\$ 50,100	\$ 4,175	10 Person	\$ 55,224	\$ 4,602

I certify that my family and I are currently residing in Alabama and that the information contained herein is a true, accurate, and complete statement of facts according to the best of my knowledge. I hereby authorize the Department of Human Resources to verify information on this form. If any of the family members listed above are approved for services purchased with Title XX , TANF, or WRTI funds, the agency providing those services has my permission to provide the State or appropriate County Department of Human Resources information they possess to assist with determining my family’s continued certification for Title XX, TANF, or WRTI funded services. I agree to report any changes in my family’s income to the Department of Human Resources. The report will be made within 10 days of the change in income. \*Your Social Security Number is required by the Department’s Administrative Rules and maybe used to provide individual identification.

Signature of Parent/Relative/Participant	Signature of Witness (if signed by mark)	Date
Signature of Parent/Relative/Participant	Signature of Witness (if signed by mark)	Date
Signature of Social Worker for Certification of EA		Date
Signature of Social Worker for TANF, Title XX & WRTI		Date

**ASSOCIATION OF ADMINISTRATORS OF THE INTERSTATE COMPACT  
ON THE PLACEMENT OF CHILDREN**

**SENDING STATE'S PRIORITY HOME STUDY REQUEST**

(To be submitted by Social Worker with other required ICPC materials)

Name of child (1) to be placed \_\_\_\_\_ Age \_\_\_\_\_

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

Ethnic group \_\_\_\_\_ DOB \_\_\_\_\_

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

**PROPOSED CARETAKER**

Name \_\_\_\_\_ Marital status: S M Sep. D W  
(circle one)

Living with (name of person) \_\_\_\_\_

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

Telephone: Home # \_\_\_\_\_ Work # \_\_\_\_\_

Social Security # \_\_\_\_\_

Relationship to child identified above: \_\_\_\_\_

Best time of day to contact caretaker \_\_\_\_\_ Employer (if applicable) \_\_\_\_\_

Alternate contact name and address: \_\_\_\_\_

**ASSESSMENT OF CHILD**

Case plan attached?  Yes  No      Financial/medical plan attached?  Yes  No

Special needs: \_\_\_\_\_

Handicaps/Mental and/or physical: \_\_\_\_\_

Service needs/Treatment requirements \_\_\_\_\_

School information \_\_\_\_\_

Other required pertinent information regarding child and family will follow:  Yes  No

Worker's name (please print) \_\_\_\_\_ Telephone # \_\_\_\_\_

Worker's signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor's signature(if required) \_\_\_\_\_ Date \_\_\_\_\_

Telephone # \_\_\_\_\_

(1) If there is more than one child to be placed with the proposed caretaker, list the name of the child(ren) and all requested information on a separate page and attach to this form.



Alabama Department of Human Resources  
**Interstate Compact on the Placement of Children (ICPC) FINANCIAL / MEDICAL PLAN**

Complete **one** form for **each** child. Complete **one** additional form for the **same** child for **each separate resource** being studied.

Child's Name		Resource's Name	
Child's Date of Birth		Child's Social Security Number	
State	County	Date	

FINANCIAL PLAN (check only one)

Description of how the child's shelter, food, clothing and related maintenance needs will be met in the receiving state.

<input type="checkbox"/> Alabama DHR will provide foster care payments. <input type="checkbox"/> The relative resource will apply for a TANF Child-Only Grant* in the receiving state on behalf of the child. (* NOTE: TANF Child-Only Grants are not available in all states.) <input type="checkbox"/> The placement resource has agreed in writing to meet the financial needs of the child. Copy of the written and signed agreement must be attached. <input type="checkbox"/> This is a placement with a parent. The parent is financially responsible for the child. <input type="checkbox"/> Child is SSI eligible. Resource will be made payee for benefits. <input type="checkbox"/> Adoption subsidy is planned and the amount will be determined prior to the date of placement
---

MEDICAL PLAN (check only one)

Description of how the child's medical coverage needs will be met in the receiving state.

<input type="checkbox"/> The child is Title IV-E eligible. Copy of the Title IV-E eligibility document certified by the Revenue Maximization Unit must be attached. The receiving state will arrange for Medicaid coverage based on the Title IV-E Eligibility. <input type="checkbox"/> The child will be eligible for Medicaid in the receiving state under the TANF Child-Only Grant. <input type="checkbox"/> The child is not Title IV-E eligible. Alabama DHR is financially responsible and will provide reimbursement for the child's medical expenditures or make other arrangements as explained in the attached memorandum. <input type="checkbox"/> Child is Medicaid eligible as a recipient of SSI. <input type="checkbox"/> The placement resource has agreed in writing to provide for and meet the medical needs of the child. Copy of the written and signed agreement must be attached. <input type="checkbox"/> This is a placement with a parent. The parent is financially responsible for meeting the medical needs of the child.
---

When a child is placed in another state, the Alabama DHR remains ultimately responsible for the financial and medical needs of the child and must retain jurisdiction over the child as required by Article V of Section 44 – 2 – 20 (Code of Alabama). In the event of a placement disruption or other reason to return the child to Alabama, Alabama DHR may need to escort the returning child and must pay the associated transportation cost. This financial / medical plan will remain in effect during the period of the child's placement in the receiving state.

\_\_\_\_\_  
Social Worker's Signature

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

\_\_\_\_\_  
PRINT Social Worker's Name

\_\_\_\_\_  
PRINT Supervisor's Name

Phone Number (Include Area Code)

Phone Number (Include Area Code)

**CHAFEE FOSTER CARE INDEPENDENCE PROGRAM REQUEST FOR FUNDING  
FISCAL YEAR**

\_\_\_\_\_ Department of Human Resources is requesting financial  
Name of County **assistance to provide independent living services for youth in foster care.**

**NUMBER OF YOUTH ELIGIBLE FOR INDEPENDENT LIVING SERVICES (Part A)**

**TOTAL**

Total Number of Youth Eligible for Independent Living Services	
Number of Children in Nursing Homes Placements	
Number of Children in Deep Hope Placements	
Number of Children who are in Runaway Status	
Number of Youth Participating in Independent Living Services	

List By Age Category	14	15	16	17	18	19	20	TOTAL
Total number of Youth Currently Eligible for Independent Living Services								
Total number of Youth Anticipated To Be Eligible for Independent Living Services								

**INDEPENDENT LIVING EXPENDITURES (Part B)**

Expenditure – B1	Amt. Per Youth	X	# of Youth	=
	TOTAL			
Independent Living Allowance				
Academic Improvement				
Grade Incentives				
College Incentives				
Tutoring				
Graduation Fees				
Other Academic Expenses				
I. L. Group Participation Incentives				
Individualized Independent Living Services				
Aftercare (Start Up Costs)	<b>\$500.00</b>			
Sub Total				

Competency-Based Learning (Development of Independent Living Skills) B2	Unit Cost	X # of Classes/Activities/ Meetings	TOTAL
<b>Life Skills Classes</b> (List number of classes per year)			
<b>Experiential Activities</b> (List number of activities per year)			
<b>Youth Advisory Boards/Councils Meetings</b>			
Sub Total			

	Unit Cost	X # of Items	TOTAL
Training Material – B3			
<b>Workbooks</b>			
<b>Videos</b>			
<b>Visual Aids</b>			
<b>Others (Specify)</b>			
Sub Total			
TOTAL (B 1 + B2 + B3 = Expenditures)			

**ILP RESOURCE DEVELOPMENT FINANCIAL STATEMENT (PART C)**

ANTICIPATED DONATIONS	AMOUNTS
Financial Contributions (Monetary)	
Services (Speakers, Mentors, Trainers, etc.)	
Supplies	
Equipment	
Christmas	
Other	
<b>Total "In Kind" Contributions</b>	

<b>TOTAL EXPENDITURES (PART B)</b>	
MATCHING CONTRIBUTIONS (PART C) (SUBTRACT) -	
<b>COUNTY ILP FUNDS REQUESTED</b>	<b>TOTAL FUNDS REQUEST</b>

**FUNDING REQUESTED FOR HIGHER EDUCATION**

	<b>TOTAL</b>
<b>Number of Potential Higher Education Scholarships</b>	

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Signature of Supervisor/County Director

\_\_\_\_\_  
Telephone # of Person Completing Form

DO NOT WRITE BELOW THIS LINE

Chafee Funds Allocated:                      \$ \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ILP DONOR INFORMATION**

\_\_\_\_\_ County/Group Home

**Donor Type:**             Agency                       Business                       Individual

**Name:** \_\_\_\_\_

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

**City/State/Zip:** \_\_\_\_\_

**Telephone Number:** (    ) \_\_\_\_\_

**Donor Affiliation:**

1.    Is the donor a state or federal employee?                       Yes  No  
      If yes, State employee's SSN or Federal employee's FEI

\_\_\_\_\_

2.    Is the donation, in whole or part, from federal sources?     Yes  No  
      If yes, **do not submit** as a donation.

\_\_\_\_\_  
Social Worker's Signature

\_\_\_\_\_  
Date

## Independent Living Program Supporting Statement For Non-Financial Donations

\_\_\_\_\_ County/Group Home

**VOLUNTEER ACTIVITIES**

1. I volunteered \_\_\_\_\_ hour(s) to assist youth in the Independent Living Program.
2. My profession/job is \_\_\_\_\_.
3. My customary fee/hourly rate is \$\_\_\_\_\_.

**SPACE**

1. I donated \_\_\_\_\_ square feet of space to the Independent Living Program.  
(estimated)
2. The space was used for \_\_\_\_\_.
3. A reasonable rental rate for the time period used was \_\_\_\_\_.

**MISCELLANEOUS**

The following item(s) have been donated to the Independent Living Program (list each item and its value; if additional space is needed, use the back of this form).

ITEM	VALUE
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

\_\_\_\_\_  
Donor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
DHR Representative's Signature

\_\_\_\_\_  
Date

**ALABAMA INDEPENDENT LIVING PROGRAM QUARTERLY REPORT OF MATCH DOCUMENTATION**

<b>County/Group Home:</b>				<b>Quarter/Year:</b>	
<b>Person Completing Report:</b>				<b>Phone #:</b>	
<b>VOLUNTEER ACTIVITIES</b>					
<b>Date</b>	<b>Activity Type</b>	<b>Volunteer Name</b>	<b># Hours</b>	<b>P/U</b>	<b>Value</b>
<b>TOTAL VALUE VOLUNTEER ACTIVITIES</b>					
<b>SPACE</b>					
<b>Date</b>	<b>Purpose/Activity Type</b>	<b>Donor</b>	<b>Square Feet</b>	<b>Value</b>	
<b>TOTAL VALUE SPACE</b>					
<b>MISCELLANEOUS ITEMS</b>					
<b>Date</b>	<b>Item</b>	<b>Donor</b>	<b>Value</b>		
<b>TOTAL VALUE MISCELLANEOUS ITEMS</b>					
<b>FINANCIAL DONATIONS</b>					
<b>Date</b>	<b>Donation Type</b>	<b>Donor</b>	<b>Value</b>		
<b>TOTAL VALUE FINANCIAL DONATIONS</b>					
<b>GRAND TOTAL</b>					
(Volunteer Activities + Space + Miscellaneous Items + Financial Donations)					

No Donations Received This Quarter

\_\_\_\_\_  
Signature of Person Completing Report

\_\_\_\_\_  
Date

**QUARTERLY ILP REPORT**  
FY \_\_\_\_\_ Quarter- \_\_\_\_\_

**DUE** \_\_\_\_\_

\_\_\_\_\_ County

**Phone Number:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**A. Funding:**

**Unencumbered Funds Available \$** \_\_\_\_\_

**Encumbered Funds Available** | **\$** \_\_\_\_\_

**Additional Funds Needed \$** \_\_\_\_\_

ALL LOCAL ILP FUNDS MUST BE EXPENDED PRIOR TO THE END OF THE FISCAL YEAR (\_\_\_\_\_  
\_\_\_\_\_. THEREFORE, PLEASE SPEND THE FUNDS BY MID-AUGUST TO ENSURE ALL PAYMENTS  
CLEAR AND THERE IS A MINIMAL BALANCE BY THAT TIME.

**Match Amount Submitted this Quarter:** \$ \_\_\_\_\_

**Attach Match Documentation Form**

**B. Activities:**

PLEASE CHECK THE METHOD OF IL INSTRUCTION PROVIDED IN THE QUARTER

_____ <b>ILP Group Sessions</b>	_____ <b>Computer</b>
_____ <b>ILP Individual Instruction</b>	_____ <b>Software</b>
_____ <b>Field Trips</b>	_____ <b>Training</b>
_____ <b>Retreat</b>	_____ <b>Training Resources</b>
_____ <b>Experiential Independent Living</b>	_____ <b>Other</b>

What activities are planned for the next quarter?

**C. County ILP Needs Assessment:**

**Identify any agency needs you may have (training for staff, Development of Teen Advisory Boards, ILP Policy and Procedures, Daniel memorial assessment forms or any other materials for ILP Training):**

\_\_\_\_\_  
**Signature of Person Completing Form**

\_\_\_\_\_  
**Date of Completion**

**INDEPENDENT LIVING PROGRAM RECEIPT OF PAYMENT**

\_\_\_\_\_ **County DHR**

**Youth Name:** \_\_\_\_\_

**Case No.:** \_\_\_\_\_

\$ \_\_\_\_\_ is being given to me for an Independent Living

- Incentive
- Experiential activity
- Aftercare payment

I understand this money cannot be used for room and board or for any purpose contrary to the State Department of Human Resources policies and federal, state, or local laws.

The money will be spent on **(for experiential activity and aftercare payment)**

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

I have completed the following previously established expectations/steps that were required to be completed prior to receiving the money **(for incentives only)**. I understand this money may be used for any reasonable purpose. I also agree to tell my social worker, when asked, how I spent this money. I understand that I may be asked to provide a receipt for the items purchased with the money.

\_\_\_\_\_  
Youth's Signature

\_\_\_\_\_  
Date

**I certify that this youth is eligible to receive these funds.**

\_\_\_\_\_  
DHR Caseworker's Signature

\_\_\_\_\_  
Date

**I concur with the substance of this transaction and approve disbursement of these funds.**

\_\_\_\_\_  
County Director

\_\_\_\_\_  
Date

## ALABAMA INDEPENDENT LIVING PROGRAM (ILP) DISCHARGE SUMMARY

Youth's Name: \_\_\_\_\_ Case # \_\_\_\_\_

County: \_\_\_\_\_ Custody Release date: \_\_\_\_\_

New mailing address: \_\_\_\_\_

Sex:  Male  Female Race: \_\_\_\_\_

# of months in foster care: \_\_\_\_\_ # of foster care placements: \_\_\_\_\_

Age at discharge (Check one):  14  15  16  17  18  19  
 20  21

**Independent living services provided while in foster care (Check all that apply):**

- educational assistance  life skills training  teen conferences/retreats/workshops  
 other (explain) \_\_\_\_\_

**Indicate the highest skill level attained at the time of discharge for each life skills category:**

	<u>Life Skill Category</u>	Minimum	Intermediate	Adequate	Exceptional
a.	Money Management/ Consumer Awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Food Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Personal Appearance and Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Educational Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Job Seeking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Job Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Emergency and Safety Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Knowledge of Community Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	Interpersonal Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	Legal Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n.	Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**County Independent Living Program (ILP) Evaluation**  
**Alabama Department of Human Resources**

Period Covered: \_\_\_\_\_

1. Name of County: \_\_\_\_\_

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

Phone: \_\_\_\_\_

2. Please indicate the general use of independent living funds by the DHR Independent Living Program (ILP) for the period listed above:

- |  |   |
|--|---|
| <input type="checkbox"/> ILP Group Sessions              | <input type="checkbox"/> Computer Software  |
| <input type="checkbox"/> ILP Individual Instruction      | <input type="checkbox"/> Field Trips        |
| <input type="checkbox"/> Training Equipment              | <input type="checkbox"/> Training Resources |
| <input type="checkbox"/> Retreat                         | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Experiential Independent Living |   |

3. Indicate ILP Training Activities Provided to Youth in DHR Custody for the Period Listed Above. Please include details as stated in the instructions: (attach additional pages as necessary)

ILP Group Sessions: \_\_\_\_\_

ILP Individual Instruction: \_\_\_\_\_

Field Trips: \_\_\_\_\_

Teen Conferences: \_\_\_\_\_

Retreat: \_\_\_\_\_

Experiential Independent Activities: \_\_\_\_\_

Other: \_\_\_\_\_

4. Number of DHR custody teens in county participating	_____
Number of DHR teens from foster family homes	_____
Number of other teens participating	_____
<b>TOTAL</b>	_____

5. Number of DHR custody youth who are living in independent living housing \_\_\_\_\_

6. Number of DHR custody youth that are living in transitional housing \_\_\_\_\_

7. What do you see as the major problems facing foster teens? Indicate suggestions for further assistance.

---

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---

---

8. Other Comments: \_\_\_\_\_

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Group Home Independent Living Program (ILP) Evaluation  
Alabama Department of Human Resources

**LIST THE DHR TEENS THAT PARTICIPATED IN YOUR ILP**

**NAME**

**COUNTY**

1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
15.	_____	_____

\_\_\_\_\_  
**Signature of Person Completing Form**

\_\_\_\_\_  
**Date of Completion**

**ILP SURVEY OF CLIENTS AND SERVICES**

**PERIOD COVERED:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

<b>Total Number of ILP Teens</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>TOTAL</b>
----------------------------------	-----------	-----------	-----------	-----------	-----------	-----------	-----------	-----------	--------------

**GENDER:**

**Total Number of Males** \_\_\_\_\_

**Total Number of Females** \_\_\_\_\_

**DURATION OF FOSTER CARE:**

**TOTAL NUMBER**

Less than 6 mo. \_\_\_\_\_  
 6 mo. to 1 yr. \_\_\_\_\_  
 1 yr. to 3 yrs. \_\_\_\_\_  
 3 yrs. to 5 yrs. \_\_\_\_\_  
 5 yrs. to 10 yrs. \_\_\_\_\_  
 More than 10 yrs. \_\_\_\_\_

**MOST RECENT LIVING ARRANGEMENTS:**

**TOTAL NUMBER**

**Related Homes** \_\_\_\_\_  
**Foster Board Home** \_\_\_\_\_  
**Foster Related Home** \_\_\_\_\_  
**Group Home** \_\_\_\_\_  
**Group Home/Shelter** \_\_\_\_\_  
**Child Care Institution** \_\_\_\_\_  
**Child Care Institution Shelter** \_\_\_\_\_  
**DYS Operated Facility** \_\_\_\_\_  
**Mental Health Operated Facility** \_\_\_\_\_  
**Maternity Home** \_\_\_\_\_  
**Nursing Home** \_\_\_\_\_  
**Cerebral Palsy Center** \_\_\_\_\_  
**Runaway Status** \_\_\_\_\_  
**Hospital** \_\_\_\_\_  
**Independent Living** \_\_\_\_\_  
**Other** \_\_\_\_\_

**MARITAL STATUS:**

**Total Number:** \_\_\_\_\_ **Single** \_\_\_\_\_ **Married** \_\_\_\_\_

**SPECIAL NEEDS:**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Total Number:** \_\_\_\_\_

**PARENTAL STATUS:**

**TOTAL NUMBER**

**W / out Child** \_\_\_\_\_  
With Child \_\_\_\_\_  
**Pregnant** \_\_\_\_\_  
**Father of Unborn** \_\_\_\_\_

**EDUCATION:**

**TOTAL NUMBER**

Middle School/Jr. High \_\_\_\_\_  
In HS/GED \_\_\_\_\_  
**Finished HS/GED** \_\_\_\_\_  
**In Voc Training** \_\_\_\_\_  
**In College** \_\_\_\_\_

**EMPLOYED:**

**TOTAL NUMBER:**

Full time \_\_\_\_\_  
**Part Time** \_\_\_\_\_

**DISCHARGES:**

**Total Number Discharged in FY** \_\_\_\_\_

**PARTICIPATION IN ILP ACTIVITIES:**

**TOTAL NUMBER** \_\_\_\_\_

**Total Number that Participated in:**

**EDUCATIONAL ATTAINMENT: EMPLOYMENT:**

**Educational Workshop** \_\_\_\_\_ **Job Seeking** \_\_\_\_\_  
**Other** \_\_\_\_\_ **Career Planning** \_\_\_\_\_  
**Job Retention** \_\_\_\_\_  
**Other** \_\_\_\_\_

**Avoidance of Dependency:**

**Budgeting** \_\_\_\_\_  
**Other** \_\_\_\_\_

**Homelessness:**

**Housing Maintenance** \_\_\_\_\_  
**Securing Housing** \_\_\_\_\_  
**Roommate Selection** \_\_\_\_\_  
**Other** \_\_\_\_\_

**Health:**

**Nutrition** \_\_\_\_\_  
**First Aid & Safety** \_\_\_\_\_  
**Prenatal Care** \_\_\_\_\_  
**Other** \_\_\_\_\_

**Nonmarital Childbirth:**

**Sexuality** \_\_\_\_\_

**Other** \_\_\_\_\_

**Incarceration:**

**Respect for Others** \_\_\_\_\_

**Use of illegal drugs/alcohol** \_\_\_\_\_

Other

High Risk:            Family Development:  
Self Worth \_\_\_\_\_    Child Development  
Other \_\_\_\_\_        Child Care  
**Child Discipline**  
Other

**Training Collaboration:**

**Yes** \_\_\_\_\_

**No** \_\_\_\_\_

**Community Linkages:**

**Contributing to Community** \_\_\_\_\_

**Voting** \_\_\_\_\_

**Use of Community Resources** \_\_\_\_\_

**Other** \_\_\_\_\_

**Other:**

**Region/Countywide Workshop** \_\_\_\_\_

**State ILP Teen Conference** \_\_\_\_\_

**County ILP Teen Group** \_\_\_\_\_

**ILP Teen Board:**

**County** \_\_\_\_\_

**Regional** \_\_\_\_\_

**Other** \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PERSON COMPLETING FORM

\_\_\_\_\_  
DATE FORM COMPLETED

## CASE PLANNING ADDENDUM

Case Name

County

Case #

Gender      Select

Date Of Birth

Ethnicity

Case No.

### Case Planning Addendum

Date Child Most Recently Entered  
Out-Of-Home Care

Date Initially Completed

Date Last Updated

**I. REASON FOR CHILD’S PLACEMENT IN OUT-OF-HOME CARE**

(Describe the conditions and/or circumstances that resulted in this child’s placement in out-of-home care.)

**II. REASONABLE EFFORTS TO PREVENT CHILD’S REMOVAL FROM HOME**

(Select the reasonable efforts statement (A. or B.) that applies to this child’s situation and enter the required documentation.)

A.      **Reasonable efforts were made to prevent this child’s removal from home.**  
(Describe the services offered and provided to prevent removal from the home.)

B.      **Reasonable efforts were not required / appropriate due to an emergency situation.**  
(Describe the emergency situation and why reasonable efforts were not required / appropriate.)

**III. PLACEMENT INFORMATION**

**1. Current Out-Of-Home Care Provider**

(Enter name; street address; mailing address if different from street address; city; state; zip; phone #s for work, home & messages)

**Placement  
Type:**

**Is this placement approved or  
licensed by a State agency?**

Select

Select Agency Name

**2. Is this the least restrictive setting that can meet this child’s needs?**

Select

**Is it a family-like setting?**

Select

**If the placement is not a family-like setting, explain why it is the least restrictive setting for this child.**

**3. Is this placement in close proximity to this child’s home?**

Select

**Explain**

**4. Are this child and any siblings placed together?**

Select

**If “No” is selected, explain why siblings are placed apart.**

**5. Is this placement consistent with the child’s best interests and special needs?**

Select

**Explain**

## CASE PLANNING ADDENDUM

Case Name

County

Case #

### IV. STEPS AND SERVICES FOR REUNIFICATION, ADJUSTMENT TO OUT-OF-HOME CARE, AND ACHIEVING THE PERMANENCY GOAL

1. Describe the needs which must be addressed prior to a safe reunification.
2. Describe steps (including services) previously taken to reunify the child with family.
3. Describe steps (including services) that need to be taken to reunify the child with family.
4. Describe the steps that are being taken, including services provided to the child and out-of-home care provider, to facilitate the child's proper care and adjustment and address the child's needs while in out-of-home care.
5. Describe steps (including services) that need to be taken to achieve the permanency goal.  
(Complete this item for all permanency goals except "return to parent.")

### V. HEALTH / MEDICAL INFORMATION

1. **Child's Primary Health Care Provider** (Include name, address, city, state, zip and phone number.)
2. **Location of Health And Immunization Records**
3. **Known Medical Conditions**
4. **Current Medications And Known Allergies To Medications**
5. **Other Relevant Health / Medical Information**

### VI. EDUCATION INFORMATION

N/A Child is not school age (includes pre-school & Head Start)

1. **Current Or Last Education Provider** (Begin with kindergarten and include name, address, city, state, zip and phone number.)
2. **Location Of School Records**

## CASE PLANNING ADDENDUM

Case Name

County

Case #

- |           |  |                                  |  |
|-----------|--|----------------------------------|--|
| <b>3.</b> | <b>Current Grade And Performance Levels</b>  | <b>Grade</b>                     | <b>Performance</b>                             |
| <b>4.</b> | <b>Is this child in Special Education?</b> Select<br>Enter additional special education information as needed                      | <b>If "Yes, date of last IEP</b> | <b>Most current IEP in case record?</b> Select |
| <b>5.</b> | <b>Describe the proximity of the child's out-of-home placement to the school the child was enrolled in prior to entering care.</b> |                                  |  |
| <b>6.</b> | <b>Other relevant education information</b>  |                                  |  |

**VII. OTHER RELEVANT INFORMATION**

- |           |  |   |  |        |
|-----------|--|---|--|--------|
| <b>1.</b> | <b>Is this child age 14 years or older</b>   | Select  | <b>If "Yes," has a level of functioning assessment been completed?</b> | Select |
|           |  |   | <b>If "No," what is the assessment's anticipated completion date</b>   |        |
| <b>2.</b> | <b>Are independent living (IL) services being provided</b>                                   |   | Select   |        |
|           | <b>If "Yes," select outcomes to be achieved by providing IL services.</b>                    |   |  |        |
|           | <input type="checkbox"/> Improved Attainment of Employment                                   | <input type="checkbox"/> Avoidance Of Homelessness  | <input type="checkbox"/> Improved Attainment of Education              |        |
|           | <input type="checkbox"/> Avoidance Of Non-Marital Childbirth                                 | <input type="checkbox"/> Avoidance Of Incarceration | <input type="checkbox"/> Avoidance Of Dependency                       |        |
|           |  |   | <input type="checkbox"/> Avoidance Of Other High-Risk Behaviors        |        |
|           | <b>If "No," explain why services are not being provided.</b>                                 |   |  |        |
| <b>3.</b> | <b>Have restrictions been placed on visiting, telephone, or mail contacts?</b>               |   | Select   |        |
|           | If "Yes," enter explanation here   |   |  |        |
| <b>4.</b> | <b>Is medication, seclusion, or restraint being used to manage this child's behavior(s)?</b> |   | Select   |        |
|           | Does the child have a behavior management plan?  | Select  | If "Yes," was the plan authorized by the ISP team?                     | Select |
|           | Date plan authorized by the ISP team   |   | Date plan due to be reviewed by the ISP team                           |        |
|           | Location of the behavior management plan   |   |  |        |

**Addendum completed by** enter worker's name

**Addendum approved by** enter supervisor's name

I hereby certify that this information is based on the ISP development process.

\_\_\_\_\_  
Worker's Signature

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

## CASE PLANNING ADDENDUM

**Case Name**

**County**

**Case #**

Date Completed

Date Approved

(Select One of the Following)

- Addendum sent to parents / legal custodians (other than DHR) on \_\_\_\_\_ .
- Addendum not sent to parents / legal custodians (other than DHR) because \_\_\_\_\_

# COMPREHENSIVE FAMILY ASSESSMENT

Case Name

County

Case #

Initially completed

Comprehensive Family Assessment  
Current update completed

## INFORMATION FROM THE CASE RECORD

1. FAMILY DESCRIPTION / SETTING
2. ORIGINAL REASON THE FAMILY'S CASE WAS OPENED FOR SERVICES
3. REASON THE FAMILY IS CURRENTLY RECEIVING SERVICES
4. FAMILY MEMBERS' PRIOR INVOLVEMENT WITH DHR

## INFORMATION FROM THE FAMILY AND OTHER PERTINENT INDIVIDUALS

1. PARENT / CAREGIVER FUNCTIONING      enter parent's name

Family History

Educational History And Intellectual Development

Relevant Medical Background And Physical Development

Employment / Vocational History

N/A

Psychological / Psychiatric Treatment History And Emotional Development

# COMPREHENSIVE FAMILY ASSESSMENT

Case Name

County

Case #

Military Service History  N/A

Legal History  N/A

Alcohol / Drug Use History

Description / Summary Of Significant Issues Being Experienced By The Parent

Mental Status Examination (i.e., orientation to person, place, and time)

Additional Information

2. **CHILD FUNCTIONING** enter child's name

Family History

Educational History And Intellectual Development

Relevant Medical Background And Physical Development

Employment / Vocational History  N/A

Psychological / Psychiatric Treatment History And Emotional Development

Military Service History  N/A

# COMPREHENSIVE FAMILY ASSESSMENT

Case Name

County

Case #

Legal History       N/A

Alcohol / Drug Use History

Description / Summary Of Significant Issues Being Experienced By The Child

Mental Status Examination (i.e., orientation to person, place, and time)

Select One:       DSM Diagnosis  
                          V629                      Other Unspecified Psychosocial Circumstance

Additional Information

### 3. FAMILY FUNCTIONING

### 4. THE FAMILY'S COMMUNITY

### **WORKER'S PROFESSIONAL ANALYSIS AND CONCLUSIONS**

-----  
Requirements met for an intake evaluation (Medicaid rehabilitative services).       Yes       No

**Completed by** enter worker's name

**Approved by** enter supervisor's name

\_\_\_\_\_  
Worker's Signature

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

Effective 4/1/05

# COMPREHENSIVE FAMILY ASSESSMENT

**Case Name**

**County**

**Case #**

\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Date Approved



**INDIVIDUALIZED SERVICE PLAN**

**Family Name**

**County**

**Case #**

<b>Parent/Primary Caregiver</b> Custodial Parent or Primary Caregiver other than parent	<b>Relationship To Children</b>

<b>Child's Name</b>	<b>Sex</b>	<b>DOB</b>	<b>Permanency Goal</b>	<b>Date Established</b>	<b>Target Date</b>	<b>Concurrent Planning Goal</b>	<b>Date Established</b>
	Select						
	Select						
	Select						
	Select						
	Select						
	Select						
	Select						
	Select						

Options for permanency goal and concurrent planning goal are:

Remain With Parent

Return To Parent

Permanent Relative Placement With Transfer Of Custody To The Relative

Permanent Relative Placement With DHR Retaining Custody

Adoption By Current Foster Parent

Adoption With No Identified Resource

Another Planned Permanent Living Arrangement, Court Approved

Adult Custodial Care

**INDIVIDUALIZED SERVICE PLAN**

**Family Name**

**County**

**Case #**

Discuss “current reason” with the ISP team at each meeting so that everyone has the same understanding about DHR’s involvement with the family.

**CURRENT REASON DHR IS INVOLVED WITH YOUR FAMILY**

**FAMILY MEMBERS’ STRENGTHS** (List strengths for each family member as identified during assessment; that are directly related to the reason DHR is involved with the family; and that can be used to address identified needs.)


**WHAT MUST HAPPEN FOR DHR TO NO LONGER BE INVOLVED WITH YOUR FAMILY**

**FAMILY MEMBERS’ NEEDS** (List needs for each family member as identified during assessment; that are directly related to the reason DHR is involved with the family; and that need to be addressed for the children to have a safe home to grow up in. It is important to remember that these needs may change as the family’s circumstances change or new issues arise.)


**INDIVIDUALIZED SERVICE PLAN**

**Family Name**

**County**

**Case #**

**NEED:**

**GOAL:**

<b>STEP:</b>					<u>Medicaid Rehab Info</u>
<b>DATES:</b>	<u>Added</u>	<u>Started</u>	<u>Due</u>	<u>Completed</u>	
<b>COMMENTS:</b>					
<b>STEP:</b>					<u>Medicaid Rehab Info</u>
<b>DATES:</b>	<u>Added</u>	<u>Started</u>	<u>Due</u>	<u>Completed</u>	
<b>COMMENTS:</b>					
<b>STEP:</b>					<u>Medicaid Rehab Info</u>
<b>DATES:</b>	<u>Added</u>	<u>Started</u>	<u>Due</u>	<u>Completed</u>	
<b>COMMENTS:</b>					
<b>STEP:</b>					<u>Medicaid Rehab Info</u>
<b>DATES:</b>	<u>Added</u>	<u>Started</u>	<u>Due</u>	<u>Completed</u>	
<b>COMMENTS:</b>					
<b>STEP:</b>					<u>Medicaid Rehab Info</u>
<b>DATES:</b>	<u>Added</u>	<u>Started</u>	<u>Due</u>	<u>Completed</u>	
<b>COMMENTS:</b>					
<b>STEP:</b>					<u>Medicaid Rehab Info</u>
<b>DATES:</b>	<u>Added</u>	<u>Started</u>	<u>Due</u>	<u>Completed</u>	
<b>COMMENTS:</b>					

**GENERAL COMMENTS** Including Input Obtained From Team Members Unable To Attend This Meeting (e.g., Teacher, GALs, Physician)

**DOCUMENTS PROVIDED TO PARENTS** With An Explanation Of Their Meaning

**INDIVIDUALIZED SERVICE PLAN**

**Family Name**

**County**

**Case #**

*Civil Rights Pamphlet*

Date

*Rights Of Parents & Children*

Date

*Freedom Of Choice Verification  
(for Medicaid recipients ONLY)*

Date

*Parents Of Children In Foster Care  
(for foster care cases ONLY)*

Date

Worker's Name

Supervisor's Name

\_\_\_\_\_  
Worker's Signature

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

Date Completed

Date Approved

**Date Case Most Recently Opened For Services:**

**Date Of Initial ISP:**

**Dates Of ISP Reviews**

**TO BE COMPLETED BY WORKER FOR MEDICAID ELIGIBLE CHILDREN ONLY**

Child's Name

Date of most recent EPSDT  
screening

Will the screening expire before the next  
ISP review?

If yes, enter date child referred  
for screening.

Select

Select

Select

Select

**TO BE COMPLETED BY SUPERVISOR ONLY WHEN MEDICAID REHABILITATIVE SERVICES ARE AUTHORIZED**

(Select One)

Treatment plan / ISP has been reviewed and updated.

Treatment plan / ISP has been reviewed and continues without change.

Supervisor's Name

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

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

**Invitation LETTER to family member**

\_\_\_\_\_  
Date

Family Member  
Address  
City, State Zip

Re: Child and Family Name

Dear

An individualized service plan meeting is scheduled at \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_  
(Time) (Date)  
\_\_\_\_\_  
(Location)

The purpose of this meeting is \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

Others invited to attend are \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

If you are unable to attend this meeting at the scheduled date, time or location, or if you need transportation, childcare or other help to make your attendance possible and we have not already discussed this, please call me by \_\_\_\_\_ at \_\_\_\_\_.  
(Date)

Sincerely,

\_\_\_\_\_  
DHR Social Worker

**Invitation LETTER to ISP Team Member / Participant**

\_\_\_\_\_  
Date

ISP Team Member / Participant  
Address  
City, State Zip

Re: Child and Family Name

Dear

You are invited to attend a meeting to discuss the individualized service plan for \_\_\_\_\_ . The meeting is scheduled at \_\_\_\_\_ on \_\_\_\_\_ (Time)  
\_\_\_\_\_, at \_\_\_\_\_ (Date) \_\_\_\_\_ (Location).

The purpose of this meeting is \_\_\_\_\_

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

Others invited to attend are \_\_\_\_\_

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

Prior to the meeting, please list any strengths and needs you have identified for family members as we will be discussing services to address the needs. If you are unable to attend this meeting at the scheduled date, time or location, please call me by \_\_\_\_\_ at \_\_\_\_\_.

Sincerely,

\_\_\_\_\_  
DHR Social Worker

**MULTI-DISCIPLINARY CHILD PROTECTION TEAM REFERRAL FORM**

**I. IDENTIFYING INFORMATION**

Case Name \_\_\_\_\_  
County \_\_\_\_\_ DHR Case # \_\_\_\_\_  
DHR Worker \_\_\_\_\_ DHR Supervisor \_\_\_\_\_  
Telephone # \_\_\_\_\_ Telephone # \_\_\_\_\_

**II. REFERRAL INFORMATION**

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

Referral Reason (Check all that apply)

- Child Safety
- Treatment Needs Unclear
- Other (Specify) \_\_\_\_\_
- Foster Care Crisis
- Arbitrate Difference In Treatment Plan
- Adoption Crisis
- Coordinate Resources

Child(ren) To Be Presented (Include name, age, and sex)

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

Family Profile (Members Of Child's Household)

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

Family Situation (e.g., issues/crises and needs, living conditions, extended family support)

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

Medical, Educational, And/Or Psychological Needs And Results Of Any Tests Or Evaluations

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

Summary Of DHR's Work With The Family (including assessment of child safety in the home)

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

Other Professionals/Agencies Directly Involved With The Family

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

Worker's Signature

Date

**III. MULTI-DISCIPLINARY TEAM'S ASSESSMENT AND RECOMMENDATIONS**

**Assessment** \_\_\_\_\_

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

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

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

**Recommendations** \_\_\_\_\_

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

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

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

**Comments** \_\_\_\_\_

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

**IV. DISPOSITION**

Team Will Review Case \_\_\_\_\_  
Date

Team Is Closing Case \_\_\_\_\_  
Date

**Date Assessment/Recommendations Given/Sent To DHR Worker** \_\_\_\_\_

\_\_\_\_\_  
Team Coordinator's Signature

\_\_\_\_\_  
Date





**MULTI-DISCIPLINARY CHILD PROTECTION TEAM MEMBER COMMITMENT AND  
CONFIDENTIALITY AGREEMENT**

In an effort to better serve children and families, I recognize the benefits of associated agencies cooperating and collaborating on child protection cases. Hence, I do voluntarily agree to serve as a consultant and share my professional expertise as a member of the \_\_\_\_\_ County Multi-Disciplinary Child Protection Team.

I have read Code of Alabama, 1975, Section 26-14-8 (copy attached) which provides for the confidentiality of child abuse/neglect reports and records. I understand that I am bound by the provisions of this law, and I agree to keep confidential all case information discussed during Multi-Disciplinary Team meetings.

\_\_\_\_\_  
Team Member's Name (Please Print or Type)

\_\_\_\_\_  
Team Member's Agency or Affiliation (Please Print or Type)

\_\_\_\_\_  
Team Member's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
County Director's Signature

\_\_\_\_\_  
Date

**Reporting of Child Abuse or Neglect Statewide Central Registry**  
**Code of Alabama 1975, § 26-14-8**

(a) For the purposes of this section, the following words shall have the following meanings, respectively:

- (1) INDICATED. When credible evidence and professional judgment substantiates that an alleged perpetrator is responsible for child abuse or neglect.
- (2) NOT INDICATED. When credible evidence and professional judgment does not substantiate that an alleged perpetrator is responsible for child abuse or neglect.

(b) The Department of Human Resources shall establish a statewide central registry for reports of child abuse and neglect made pursuant to this chapter. The central registry shall contain, but shall not be limited to:

- (1) All information in the written report;
- (2) Record of the final disposition of the report, including services offered and services accepted;
- (3) The names and identifying data, dates and circumstances of any persons requesting or receiving information from the registry; provided, however, that requests for information and responses where no report exists may be destroyed after three years from the date of the request;
- (4) The plan for rehabilitative treatment; and
- (5) Any other information which might be helpful in furthering the purposes of this chapter.

(c) The Department of Human Resources shall establish and enforce reasonable rules and regulations governing the custody, use and preservation of the reports and records of child abuse and neglect. Child abuse and neglect reports and records shall be limited to the purposes for which they are furnished and by the provisions of law under which they may be furnished. The reports and records of child abuse and neglect and related information or testimony shall be confidential, and shall not be used or disclosed for any purposes other than:

- (1) To permit their use to prevent or to discover abuse or neglect of children through the information contained therein, except reports or records in cases determined to be "not indicated" shall not be used or disclosed for purposes of employment or other background checks; or
- (2) For investigation of child abuse or neglect by the police or other law enforcement agency; or
- (3) For use by a grand jury upon its determination that access to such reports and records is necessary in the conduct of its official business; or
- (4) For use by a court where it finds that such information is necessary for the determination of an issue before the court; or
- (5) For use by any person engaged in bona fide research who is authorized to have access to such information by the Commissioner of the Department of Human Resources; or
- (6) For use by any person authorized by a court to act as a representative for an abused or neglected child who is the subject of a report; or
- (7) For use by a physician who has before him a child whom he reasonably suspects may be abused or neglected; or
- (8) For use by an attorney or guardian ad litem in representing or defending a child or its parents or guardians in a court proceeding related to abuse or neglect of said child; or
- (9) For use by federal, state, or local governmental entities, social service agencies of another state, or any agent of such entities, having a need for the information in order to carry out their responsibilities under law to protect children from abuse and neglect; or
- (10) For use by child abuse citizen review or quality assurance or multidisciplinary review panels; or
- (11) For use by child fatality review panels; or

(12) For public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality; the term "near fatality" means an act that, as certified by a physician, places the child in serious or critical condition. Information identifying by name persons other than the victim shall not be disclosed.

(d) The names of persons or information in the investigative report placed on the state's central registry which may be made available to the alleged perpetrator's employer, prospective employer, or others are those cases that the Department of Human Resources or the investigative hearing officer has determined child abuse or neglect to be indicated.

(e) In the case of any child abuse or neglect investigation which is determined to be "not indicated," the alleged perpetrator may request after five years from the completion of the investigation that his or her name be expunged from the central registry so long as the Department of Human Resources has received no further reports concerning the alleged perpetrator during said five years, at which time the department shall expunge said name.

(f) Nothing in this section shall be construed as restricting the ability of a department to refuse to disclose identifying information concerning the individual initiating a report or complaint alleging suspected instances of child abuse or neglect, except that the department may not refuse such a disclosure in cases in which a court orders such disclosure after the court has reviewed, in camera, the record of the department related to the report or complaint and has determined that it has reason to believe that the person making the report knowingly made a false report.

(g) Any person receiving reports or records of child abuse or neglect or related information under this section shall maintain the confidentiality of the documents and information and not disclose it except as authorized by law.

(h) Any violation of the provision of confidentiality shall be a Class A misdemeanor.

*(Acts 1975, No. 1124, p. 2213, &sect;1; Acts 1992, 2nd Ex. Sess., No. 92-704, p. 176, &sect;2; Act 98-371, p. 673, &sect;1.)*

**MULTI-DISCIPLINARY CHILD PROTECTION TEAM ANNUAL REPORT**

This form is used to compile the annual team progress report for the Joint Legislative Committee on Children and Youth. Part I must be completed and submitted to the State Department of Human Resources, Family Services Office of Child Protective Services by September 30th of each year. Part II is completed to request needed changes in the County Operational Plan.

**PART I** (Submit to State Department of Human Resources, Family Services Office of Child Protective Services by September 30<sup>th</sup>)

1. There is a functioning Multi-Disciplinary Team in my county.  YES  NO

If yes, provide the date the team was organized \_\_\_\_\_  
Month Year

If no, provide reason(s) why \_\_\_\_\_

2. The Team is composed of the following professionals (Check the professional affiliations represented and enter the total number of current teams members.)

<u>Professional Affiliation</u>	<u>Total</u>	<u>Professional Affiliation</u>	<u>Total</u>
<input type="checkbox"/> Education _____		<input type="checkbox"/> Medical _____	
<input type="checkbox"/> Department of Human Resources _____		<input type="checkbox"/> Law Enforcement _____	
<input type="checkbox"/> Other (Identify by profession) _____		<input type="checkbox"/> District Attorney's Office _____	
_____		_____	

3. What profession is represented by the Team Coordinator? \_\_\_\_\_

4. How often does the Team meet? \_\_\_\_\_

5. Number of initial referrals presented this reporting year \_\_\_\_\_

6. Number of cases reviewed for follow-up this reporting year \_\_\_\_\_

7. Team Functions (select all that apply) and briefly describe the Team's activities in selected functions.

Advisory Case Consultation \_\_\_\_\_

Education \_\_\_\_\_

Referral \_\_\_\_\_

Resource Development \_\_\_\_\_

Treatment \_\_\_\_\_

Other (Specify) \_\_\_\_\_

8. Impressions Of Team (Enter percentages that indicate how the following individuals view the Team.)

<u>Rating</u>	<u>DHR Staff</u>	<u>Core Team Members</u>
1. Waste of time – no value	_____	_____
2. Time-consuming, but serves a need	_____	_____
3. Very helpful and productive; well worth the time invested	_____	_____
9. Describe any problems noted with the Team (e.g., lack of or lagging commitment by Team members; high Team member turnover; resentment of the Team by DHR staff)		
_____		
_____		
_____		
10. Other Accomplishment or Comments _____		
_____		

**PART II Request To Change County Operational Plan** (Complete and submit as needed.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Team Coordinator's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
DHR County Director's Signature

\_\_\_\_\_  
Date

Approved       Disapproved

\_\_\_\_\_  
Commission, State Department of Human Resources

\_\_\_\_\_  
Date

**Progress Notes/Monthly Summary of Progress/Combination**  
(Circle One)

**See attached directions for completion.**

**NOTE:** Items 1-9 and 12 should be completed on the Progress Notes for each service delivery. For the Monthly Progress of Summary, items 10-12 must be completed. The Summary and the most current Progress Notes can be combined into one reporting form. Units billed must not exceed Medicaid Rehabilitative Service units unless specifically outlined in the ISP and 1878.

Attach sign in sheets or have client sign here:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Attach any tools used (e.g., lists, activities, charts, genograms, improvement scales)

**Family Name:**

**DHR Case Number:**

**Person Providing Service:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<b>1. Persons Present</b>	<b>2. Place of Service Provision</b>	<b>3. Date of Service</b>
<b>4. Beginning Time of Service</b>	<b>5. Ending Time of Service</b>	<b>6. Medicaid Rehab Service Provided</b> (If Crisis Intervention, specific crisis;

<p><b>7a. Specific Goals/Objectives of Service (Refer to ISP)</b></p> <p><b>7b. Your Work on the Identified Goal</b></p> <p><b>7c. Behaviorally Specific Outcomes Based Upon Work</b></p>	<p><b>7d. Goal Accomplished?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>7e. Date Accomplished</b></p>
<hr/>	
<p><b>8a. Specific Goals/Objectives of Service (Refer to ISP)</b></p> <p><b>8b. Your Work on the Identified Goal</b></p> <p><b>8c. Behaviorally Specific Outcomes Based Upon Work</b></p>	<p><b>8d. Goal Accomplished?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>8e. Date Accomplished</b></p>
<hr/>	
<hr/>	

<p><b>9a. Specific Goals/Objectives of Service (Refer to ISP)</b></p> <p><b>9b. Your Work on the Identified Goal</b></p> <p><b>9c. Behaviorally Specific Outcomes Based Upon Work</b></p>	<p><b>9d. Goal Accomplished?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>9e. Date Accomplished</b></p>
<hr/>	
<p><b>10. List Any Noted Barriers to Outcomes</b></p>	
<p><b>11. Recommended Next Steps</b></p>	
<p><b>12. Observations</b></p>	

**Overall Assessment:**



**Progress Notes Form No. 1 (August 2003)**

**REFERRAL FORM**  
**(To Be Used Only When Provider Did Not Attend ISP Meeting)**

Date of Referral

Referring Worker

Worker's Phone Number

Case Name

Case Number

Contact Telephone Number

Direction to home/location of service delivery

**Family Members** (Include mother, father, other caretakers, children, significant others to family)

	Name	Age	Relationship	Current Grade/last completed	In-home (Y/N)	Location, if N; e.g., TFC, FC, Residential	Need for Service Below (Y/N)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Check all that apply and identify the person in need of the service and the frequency.

Categories

Category	Recipient (by Number Above)	Frequency
<input type="checkbox"/> Anger management		
<input type="checkbox"/> Assessment services		
<input type="checkbox"/> Behavioral aide/behavioral management		
<input type="checkbox"/> Budgeting/financial management/assistance		
<input type="checkbox"/> Child with special needs (type of need)		
<input type="checkbox"/> Counseling		
<input type="checkbox"/> Crisis intervention		
<input type="checkbox"/> Diagnostic testing		
<input type="checkbox"/> Domestic violence services		
<input type="checkbox"/> Drug testing		
<input type="checkbox"/> Educational support		
<input type="checkbox"/> Employment/vocational assistance		
<input type="checkbox"/> Family preservation		
<input type="checkbox"/> Homemaker		
<input type="checkbox"/> Household management services		
<input type="checkbox"/> Housing		



**DHR ADULT PROTECTIVE SERVICES PROGRAM REFERRAL**

**IDENTIFYING INFORMATION**

Name:		Case #:
DOB:	Sex:	Race:
Total Monthly Income and Source		SSN:
Current Placement (Name & Type):		
Address:		
City/State/Zip:		Telephone #:
Anticipated Discharge Date		
Referral Reason (If not for on-going foster care, specify physical or mental disability, whether anyone is available to protect, and attach a copy of the 798 report.):		
Nearest Family/Relative Name:		
Address:		
City/State/Zip:		Telephone #:
Referring Worker Name:		Telephone #:
Supervisor's Name:		Telephone #:

**DOCUMENTATION ATTACHED**

<input type="checkbox"/> ISP Dated	<input type="checkbox"/> Medical Dated	<input type="checkbox"/> Social Summary
<input type="checkbox"/> Psychological/Psychiatric Evaluation(s) Dated	<input type="checkbox"/> DHR-ASD-798	
<input type="checkbox"/> Narrative Recording	<input type="checkbox"/> Other	

\_\_\_\_\_  
Referring Worker's Signature Date

**For Adult Protective Services Program Use Only**

<input type="checkbox"/> Referral Accepted	APS Worker Name:	Telephone #:
<input type="checkbox"/> Conference Scheduled	Date/Time/Location:	
<input type="checkbox"/> Referral Pending	Reason Pending:	
<input type="checkbox"/> Referral Denied	Reason Denied:	
APS Supervisor Name:		Telephone #:

\_\_\_\_\_  
APS Supervisor's Signature Date

## DISCHARGE DOCUMENTS AND INFORMATION VERIFICATION FORM

Youth's Name \_\_\_\_\_

Case # \_\_\_\_\_

### DOCUMENTS:

- |   |  |
|---|--|
| <input type="checkbox"/> Birth Certificate (original)   | <input type="checkbox"/> Social Security card (original)       |
| <input type="checkbox"/> Medical Records  | <input type="checkbox"/> School Records                        |
| <input type="checkbox"/> Lifebook   | <input type="checkbox"/> <i>Rights of Parents and Children</i> |
| <input type="checkbox"/> Federal, State, And Community Resources Available To Assist with Smooth Transitions Into Adulthood | <input type="checkbox"/> Other _____                           |

### INFORMATION:

- The services you have been receiving through the Department of Human Resources (DHR) were authorized during individualized service plan (ISP) meetings. These child welfare services will not be available to you once your case has been closed and you are no longer being served by DHR. Various federal, state, and community agencies offer services to help with your transition into living as an adult and appropriate referrals have been made.
- If you find yourself in a situation where you are unable to continue living independently and you do not have another adult (family member or friend) who can help you, please contact your local DHR office. Services may be available until your twenty first (21st) birthday.
- Name and telephone numbers to contact DHR

\_\_\_\_\_  
Social Worker

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
County DHR

\_\_\_\_\_  
Daytime Telephone Number

\_\_\_\_\_  
After Hours Emergency Telephone Number

The signatures below verify that \_\_\_\_\_  
Youth's or Responsible Caregiver's Name

has received the documents checked above and that the information provided is understood.

\_\_\_\_\_  
Youth's or Responsible Caregiver's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
DHR Worker's Signature

\_\_\_\_\_  
Date

**INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST**

**TO:**

**FROM:**

SECTION I - IDENTIFYING DATA			
Notice is given of intent to place - Name of Child:		Ethnicity: Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine/unknown	
Social Security Number:		Race:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian/ Other Pacific Islander
Sex:	Date of Birth	Title IV-E determination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White
Name of Mother:		Name of Father:	
Name of Agency or Person Responsible for Planning for Child:			Phone:
Address:			
Name of Agency or Person Financially Responsible for Child:			Phone:
Address:			

SECTION II - PLACEMENT INFORMATION	
Name of Person(s) or Facility Child is to be placed with:	Soc Sec # (optional): Soc Sec # (optional):
Address:	Phone:
<b>Type of Care Requested:</b> <input type="checkbox"/> Foster Family Home <input type="checkbox"/> Residential Treatment Center <input type="checkbox"/> Group Home Care <input type="checkbox"/> Institutional Care-Article VI, Adjudicated Delinquent <input type="checkbox"/> Child Caring Institution	<input type="checkbox"/> Parent <input type="checkbox"/> Relative (Not Parent) Relationship: _____ <input type="checkbox"/> Other: _____  <input type="checkbox"/> ADOPTION <input type="checkbox"/> IV-E Subsidy <input type="checkbox"/> Non IV-E Subsidy To Be Finalized In: <input type="checkbox"/> Sending State <input type="checkbox"/> Receiving State
<b>Current Legal Status of Child:</b> <input type="checkbox"/> Sending Agency Custody/Guardianship <input type="checkbox"/> Parent Relative Custody/Guardianship <input type="checkbox"/> Court Jurisdiction Only	<input type="checkbox"/> Protective Supervision <input type="checkbox"/> Parental Rights Terminated-Right to Place for Adoption <input type="checkbox"/> Unaccompanied Refugee Minor <input type="checkbox"/> Other: _____

SECTION III - SERVICES REQUESTED		
<b>Initial Report Requested (if applicable):</b> <input type="checkbox"/> Parent Home Study <input type="checkbox"/> Relative Home Study <input type="checkbox"/> Adoptive Home Study <input type="checkbox"/> Foster Home Study	<b>Supervisory Services Requested:</b> <input type="checkbox"/> Request Receiving State to Arrange Supervision <input type="checkbox"/> Another Agency Agreed to Supervise <input type="checkbox"/> Sending Agency to Supervise	<b>Supervisory Reports Requested:</b> <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Upon Request <input type="checkbox"/> Other: _____

Name and Address of Supervising Agency in Receiving State:			
<b>Enclosed:</b> <input type="checkbox"/> Child's Social History <input type="checkbox"/> Home Study of Placement Resource	<input type="checkbox"/> Court Order <input type="checkbox"/> ICWA Enclosure	<input type="checkbox"/> Financial/Medical Plan <input type="checkbox"/> IV-E Eligibility Documentation	<input type="checkbox"/> Other Enclosures

Signature of Sending Agency or Person:	Date:
Signature of Sending State Compact Administrator, Deputy or Alternate:	Date:

SECTION IV - ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC	
<input type="checkbox"/> Placement may be made	<input type="checkbox"/> Placement shall not be made
<b>REMARKS:</b>	
Signature of Receiving State Compact Administrator, Deputy or Alternate:	Date:

**INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REPORT ON CHILD'S PLACEMENT STATUS**

**TO:**

**FROM:**

**SECTION I - IDENTIFYING INFORMATION**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

**SECTION II - PLACEMENT STATUS**

Initial Placement of Child in Receiving State **Date Child Placed in Receiving State:** \_\_\_\_\_  
 Name of Resource: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Type of Care: \_\_\_\_\_

Placement Change **Effective Date of Change:** \_\_\_\_\_  
 Name of Resource: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Type of Care: \_\_\_\_\_

**SECTION III - COMPACT PLACEMENT TERMINATION**

Adoption Finalized  In Sending State  In Receiving State  Court Order Attached  
 Child Reached Majority/Legally Emancipated  
 Legal Custody Returned to Parent(s)  Court Order Attached  
 Legal Custody Given to Relative  Court Order Attached  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Treatment Completed  
 Sending State's Jurisdiction Terminated with the Concurrence of the Receiving State  
 Unilateral Termination  
 Child Returned to Sending State  
 Child Has Moved to Another State  
 Proposed Placement Request Withdrawn  
 Name of Placement Resource: \_\_\_\_\_

Approved Resource Will Not Be Used for Placement  
 Name of Approved Placement : \_\_\_\_\_

Other (Specify): \_\_\_\_\_

**Date of Termination:** \_\_\_\_\_

**SECTION IV - SIGNATURES**

Person/Agency Supplying Information: \_\_\_\_\_ Date: \_\_\_\_\_

Compact Administrator, Deputy or Alternate: \_\_\_\_\_ Date: \_\_\_\_\_

# ICPC Transmittal Sheet

## ICPC TRANSMITTAL SHEET

**IDENTIFYING INFORMATION**      **COUNTY:** \_\_\_\_\_ **CASE #** \_\_\_\_\_

<u>Children</u>	<u>Birthdate</u>	<u>Social Security #</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____

**Legal Mother** \_\_\_\_\_ **Legal Father:** \_\_\_\_\_

**Placement Resource:** \_\_\_\_\_

	# Copies Required
<input type="checkbox"/> <b>ICPC REFERRAL TO ANOTHER STATE</b>	
<input type="checkbox"/> Cover Letter (Include financial/medical plan)	3
<input type="checkbox"/> Social Summary (Include case plan)	3
<input type="checkbox"/> Children's Summary	3
<input type="checkbox"/> Court Documents	3
<input type="checkbox"/> ICPC 100A's (PSD-BFC-1238)	5
<input type="checkbox"/> Psychological (if applicable)	3
<input type="checkbox"/> Medical Information (if applicable)	3
<input type="checkbox"/> School Records (if applicable)	3
<input type="checkbox"/> Reports from Residential Treatment Programs (if applicable)	3
<input type="checkbox"/> Title IV-E Eligibility (if applicable)	3
<input type="checkbox"/> <b>PLACEMENT CONFIRMATION/CHANGES/TERMINATION</b>	
<input type="checkbox"/> Cover Letter (if needed)	3
<input type="checkbox"/> ICPC 100B's (PSD-BFC-1239)	3
<input type="checkbox"/> Court Documents	3
<input type="checkbox"/> Additional Information	3
<input type="checkbox"/> <b>SUBMITTING A HOME STUDY</b>	
<input type="checkbox"/> Cover Letter to other State	3
<input type="checkbox"/> Home Study	3
<input type="checkbox"/> <b>REQUESTING A QUARTERLY SUPERVISORY REPORT</b>	
<input type="checkbox"/> Letter to other State	3
<input type="checkbox"/> <b>SUBMITTING A QUARTERLY SUPERVISORY REPORT</b>	3
<input type="checkbox"/> <b>REQUESTING OR SUBMITTING ADDITIONAL INFORMATION</b>	
<input type="checkbox"/> Letter to other State	3

Date Submitted to SDHR \_\_\_\_\_

Worker's Name \_\_\_\_\_

Date Sent by SDHR to other State \_\_\_\_\_

Supervisor's Name \_\_\_\_\_

DHR-FSP-1766 (8/03)

ICPC - INS – Change in Study

Microsoft Word - Document1

File Edit View Insert Format Tools Table Window Help

Normal Arial 12 B I U

1 2 3 4 5 6 7

 **State of Alabama**  
**Department of Human Resources**  
50 Ripley Street  
S. Gordon Persons Bldg.  
Montgomery, Alabama 36130

---

11/09/04

[Mr. Fred Alexander](#)  
[Immigration and Naturalization Service](#)  
[77 Forsythe St., S.W., Room 285](#)  
[Atlanta, GA 30303](#)

Attn: [Eloise Franklin, Investigator](#)

Dear Sir or Madam:

A home study was forwarded to your office [redacted] regarding the following family:  
[redacted].

Enclosed please find an addendum to their home study. The family [redacted].

Sincerely,

[Robert C Coley, Programmer Analyst, Assoc](#)  
ICPC Office

Page 1 Sec 1 1/1 At 5.8" Ln 25 Col 1 REC TRK EXT OVR WPH

# ICPC INS – VISA Request

Microsoft Word - Document1

File Edit View Insert Format Tools Table Window Help

Normal Arial 11 B I U

1 2 3 4 5 6 7

 **State of Alabama**  
**Department of Human Resources**  
50 Ripley Street  
S. Gordon Persons Bldg.  
Montgomery, Alabama 36130

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11/09/04

Mr. Fred Alexander  
Immigration and Naturalization Service  
77 Forsythe St., S.W., Room 285  
Atlanta, GA 30303

Attention: Eloise Franklin, Investigator

Dear Sir or Madam:

RE: Child: [redacted]  
Adoptive Parents: [redacted]

This letter is in reference to the proposed placement of the above named child in the home of [redacted]. The summary of the approved home study was forwarded to your office on [redacted]. Alabama's pre-adoption requirements have been met and approval is given for placement.

We hope this information will be helpful in issuing a visa for the child.

Sincerely,

Page 1 Sec 1 1/1 At 5.7" Ln 26 Col 4 REC TRK EXT OVR WPH

ICPC - INS – Unidentified Resource

The screenshot shows a Microsoft Word 2003 window titled "Microsoft Word - Document1". The interface includes a menu bar (File, Edit, View, Insert, Format, Tools, Table, Window, Help), a toolbar with icons for file operations and editing, and a formatting toolbar with options for font (Normal, Arial, size 11), bold, italic, underline, and alignment. The document content is a letter on a white background with a grey border. At the top left is the Great Seal of the State of Alabama. The header text reads: "State of Alabama", "Department of Human Resources", "50 Ripley Street", "S. Gordon Persons Bldg.", "Montgomery, Alabama 36130". A horizontal line follows. The date "11/09/04" is centered. The recipient's address is: "Mr. Fred Alexander", "Immigration and Naturalization Service", "77 Forsythe St., S.W., Room 285", "Atlanta, GA 30303". The attention line is "Attn: Eloise Franklin, Investigator". The salutation is "Dear Sir or Madam:". The subject line is "RE: [redacted]". The first paragraph states: "We are writing in reference to the above named individuals. We understand that Mr. and Mrs. [redacted] will be forwarding I-600 forms with the necessary papers regarding the proposed placement of a child from [redacted]. They are working with [redacted] and we do not believe that a child has been assigned." The second paragraph states: "A study has been made of the home and a copy of the approved home study is enclosed. It was completed and approved by [redacted]." The third paragraph states: "Alabama did not complete criminal record clearances through the FBI as the INS obtains these records." The fourth paragraph states: "We do not know if Mr. and Mrs. [redacted] will experience problems adopting the child in Alabama. Alabama's pre-adoption requirements have not been met. We understand that the child is to be adopted in [redacted] and the adoption and the adoption is to be finalized before the child enters this country." The fifth paragraph states: "We hope this information will be helpful in issuing a visa for the child". The status bar at the bottom shows "Page 1", "Sec 1", "1/1", "At 6.8\"", "Ln 35", "Col 36", and several icons including "REC", "TRK", "EXT", "OVR", "WPH", and a red "X" icon.

# ICPC - Other Country Unidentified Resource

Microsoft Word - Document1

File Edit View Insert Format Tools Table Window Help

Normal Arial 11 B I U

1 2 3 4 5 6 7

 **State of Alabama**  
**Department of Human Resources**  
50 Ripley Street  
S. Gordon Persons Bldg.  
Montgomery, Alabama 36130

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11/09/04

[Mr. Fred Alexander](#)  
[Immigration and Naturalization Service](#)  
[77 Forsythe St., S.W., Room 285](#)  
[Atlanta, GA 30303](#)

Attn: [Eloise Franklin, Investigator](#)

Dear Sir or Madam:

RE: [REDACTED]

We are writing in reference to the above named individuals. We understand that Mr. and Mrs. [REDACTED] will be forwarding I-600 forms with the necessary papers regarding the proposed placement of a child from [REDACTED]. They are working with [REDACTED] and we do not believe that a child has been assigned.

A study has been made of the home and a copy of the approved home study is enclosed. It was completed and approved by [REDACTED].

Alabama did not complete criminal record clearances through the FBI as the INS obtains these records.

We do not know if Mr. and Mrs. [REDACTED] will experience problems adopting the child in Alabama. Alabama's pre-adoption requirements have not been met. We understand that we will be receiving additional information about the child prior to placement. Upon its receipt we will notify your office.

We hope this information will be helpful in issuing a visa for the child.

Page 1 Sec 1 1/1 At 5.5" Ln 28 Col 45 REC TRK EXT OVR WPH

# ICPC - Other Country VISA Request

Microsoft Word - Document1

File Edit View Insert Format Tools Table Window Help

Normal Arial 11 B I U

1 2 3 4 5 6 7

 **State of Alabama**  
**Department of Human Resources**  
50 Ripley Street  
S. Gordon Persons Bldg.  
Montgomery, Alabama 36130

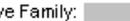
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11/09/04



Dear 

This letter is written to verify that the following family has met the pre-adoptive requirements for the State of Alabama and that the readoption is permissible in the State of Alabama, the state in which the adopted child will reside.

Adoptive Family:   
Child: 

Based on this confirmation, we hope that you will be able to issue the child's visa as soon as possible.

Sincerely,

Robert C Coley, Programmer Analyst,

Page 1 Sec 1 1/1 At 2.9" Ln 10 Col 1 REC TRK EXT OVR WPH

# ICPC - Request For Travel – Child Only

Microsoft Word - Document1

File Edit View Insert Format Tools Table Window Help

Normal Arial 12 B I U

1 2 3 4 5 6 7

 **State of Alabama**  
**Department of Human Resources**  
50 Ripley Street  
S. Gordon Persons Bldg.  
Montgomery, Alabama 36130

---

**MEMORANDUM**

11/18/04

**TO:** [Honorable Bob Riley](#)  
Governor

**FROM:** [Mr Page Walley, Commissioner](#)  
Department of Human Resources

**SUBJECT:** Out of State Travel Request  
[Test Child](#)

The attached out of state travel request relates to an ICPC matter. The child, [Test Child](#), who is in the custody of the [Baldwin](#), is being placed with a relative in [Montgomery, Alabama](#), who was approved through ICPC policy.

Page 1 Sec 1 1/1 At 7.7" Ln 34 Col 6 REC TRK EXT OVR WPH

# ICPC – Request For Travel, Child and Caseworker

Microsoft Word - Document1

File Edit View Insert Format Tools Table Window Help

Normal Arial 12 B I U

1 2 3 4 5 6 7

 **State of Alabama**  
**Department of Human Resources**  
50 Ripley Street  
S. Gordon Persons Bldg.  
Montgomery, Alabama 36130

---

**MEMORANDUM**

11/09/04

**TO:** [Honorable Bob Riley](#)  
Governor

**FROM:** [Mr Page Walley, Commissioner](#)  
Department of Human Resources

**SUBJECT:** Out of State Travel Request  
[REDACTED]

The attached out of state travel request relates to an ICPC matter. The child, [REDACTED], who is in the custody of the [REDACTED], is being placed with a relative in [REDACTED], who was approved through ICPC policy.

It was necessary for a worker, [REDACTED], to accompany the child as the child is only [REDACTED] years old.

Your approval of this request is appreciated.

Page 1 Sec 1 1/1 At 6.3" Ln 27 Col 32 REC TRK EXT OVR WPH

**FAMILY CONSENT TO RELEASE OF INFORMATION**

1. I/We hereby authorize:

- (a) The Department of Human Resources (DHR) to obtain relevant confidential information and records about me and/or my family maintained by:  
\_\_\_\_\_
  
- (b) DHR and members of my child and family planning team to share relevant information and records with each other as necessary to provide services to my family and/or me.
  
- (c) DHR and members of my child and family planning team to disclose personal identifying information concerning my family members to others, as necessary, to protect or provide services to my family and/or me.

2. I may revoke or alter this consent at any time, verbally or in writing. This consent will automatically expire on enter month enter day, enter year unless re-executed.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Age-appropriate Child's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Age-appropriate Child's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature And Title

\_\_\_\_\_  
Date



Nature And Duration Of The Persons' Relationship To The Child(ren)

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Protective Capacities (i.e., physical, mental, emotional)

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Ability And Willingness To Cooperate With DHR (including the person's availability, reliability, commitment, and trustworthiness)

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Formal And Informal Supports (Family Network) Enabling The Person's Ability To Protect

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**Documentation Completed By:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Documentation Approved By:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Mrs Jane Q Public  
Chairperson of the board

**Adult Service Due Process Letter**  
**MONTGOMERY COUNTY**  
**DEPARTMENT OF HUMAN RESOURCES**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

**Confidential**  
(Current Date)

*(Person Allegedly Responsible)*  
*(Address 1)*  
*(Address 2)*  
*(City, State ZIP)*

Dear *(Title) (Last Name)*:

The Department of Human Resources has completed its investigation regarding the allegations that you have Abused/Neglected or Exploited an adult. Our investigation shows reasonable cause to believe the complaint is Indicated; i.e., true (and/or that information contained in the investigative report should be disseminated to protect other vulnerable persons). The investigation reveals the following:

Name of Victim: *{Person Identified at Risk}*

Allegation(s)	Allegation Description(s)	Disposition(s)	Location If Known	Incident Date If Known
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The Department intends to share the results and information contained in the report of this investigation with your employer or licensing and/or certifying agency and may choose to send this information to future or prospective employers or licensing and/or certifying agencies for the protection of elderly and/or disabled or other vulnerable persons. However, before making a final determination on the allegations of abuse, neglect, or exploitation, we are offering you the opportunity to have an administrative hearing to contest our findings. The hearing is investigative in nature and is designed to obtain the facts in an atmosphere which allows you to respond to the allegations made against you.

At the hearing, the Department will bear the burden of proving the allegations against you and will present witnesses and evidence in support of the allegations. You may be represented by a lawyer or other person at the hearing, cross-examine witnesses, present additional information, testify, and present your own witnesses if you wish. You also have the right, upon request, to be provided a written or oral summary of the information gathered in the investigation which will be presented at the hearing.

You must notify us in writing within ten (10) departmental working days of the date of the receipt of this letter at the address shown at the top of this letter if you wish to have a hearing in this matter. Your written request must be received by the Department by the 10<sup>th</sup> day. If we do not hear from you within this time, your opportunity for a hearing will be considered waived. We will then proceed to advise your employer, licensing and/or certifying agency of your findings and may notify future or prospective employers, licensing and/or certifying agencies of our findings as necessary for the protection of other vulnerable persons.

Sincerely,

{Name}



Mrs Jane Q Public  
Chairperson of the board

**Adult Service Attorney General Letter**  
**MONTGOMERY COUNTY**  
**DEPARTMENT OF HUMAN RESOURCES**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

**Confidential**  
(Current Date)

Mr. Bruce Lieberman, Special Agent  
Alabama State Attorney General's Office  
Medicaid Fraud Control Unit  
11 South Union Street  
Montgomery, AL 36130

Re: Indicated Adult Abuse/Neglect/Exploitation  
Case Name:  
DHR #:

Dear Mr. Lieberman:

As requested, enclosed, please find the completed investigation on the above named case.

Sincerely,

{Name}  
Protective Services Worker

APPROVED:

{Name}  
Protective Services Supervisor



Mrs Jane Q Public  
Chairperson of the board

**Adult Service Facility Director Letter, Not Upheld**

**MONTGOMERY COUNTY  
DEPARTMENT OF HUMAN RESOURCES**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

**Confidential**  
*(Current Date)*

*(Facility Director/Administrator)*  
*(Address 1)*  
*(Address 2)*  
*(City, State ZIP)*

Re: Case Name:  
DHR #:  
Person Identified at Risk:  
Person Allegedly Responsible:

Dear *(Title) (Last Name)*:

This is to inform you that an Administrative Hearing was held on {user inserted date}.

The hearing officer's final decision was that the Department of Human Resources did not prove the above named person abused, neglected, or exploited an adult as reported to our Department on *(received date)*.

Sincerely,

{Name}  
Protective Services Worker

APPROVED:

{Name}  
Protective Services Supervisor

*Letterhead - disposition option 2*



Mrs Jane Q Public  
Chairperson of the board

**Adult Service Facility Director Letter, Upheld**  
**MONTGOMERY COUNTY**  
**DEPARTMENT OF HUMAN RESOURCES**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

**Confidential**  
(Current Date)

*(Facility Director/Administrator)*  
*(Address 1)*  
*(Address 2)*  
*(City, State ZIP)*

Re: Case Name:  
DHR #:  
Person Identified at Risk:  
Person Allegedly Responsible:

Dear *(Title) (Last Name)*:

An Administrative Hearing has been held regarding an adult protective services investigation involving the above named Person(s) employed, approved, licensed, or certified by you or your agency. The hearing officer has upheld the Department of Human Resources' disposition(s) on the following allegation(s) of abuse/neglect/exploitation.

Allegation(s)	Allegation Description(s)	Disposition(s)
---------------	---------------------------	----------------

The basis for the disposition is: {user entered text}.

We are disclosing this information to you for the purpose of discovering and/or preventing further abuse/neglect/exploitation. This information is confidential and the contents of this letter must be used only for this purpose.

Sincerely,

{Name}  
Protective Services Worker

APPROVED:

{Name}  
Protective Services Supervisor



Mrs Jane Q Public  
Chairperson of the board

**Adult Service Notice of Inappropriate Referral**  
**MONTGOMERY COUNTY**  
**DEPARTMENT OF HUMAN RESOURCES**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

**Confidential**  
(Current Date)

(Reporter)  
(Address 1)  
(Address 2)  
(City, State ZIP)

Re: Case Name:  
DHR #:

Dear (Title) (Last Name):

This is in regards to your report of suspected Adult Abuse/Neglect/Exploitation received in this office on {received date}.

Your complaint cannot be investigated because {reference value for AANE Notice of Inappropriate Referral}.

If you feel that there is more information you can supply to constitute a report of Adult Abuse/Neglect/Exploitation, please resubmit your report. If there are any questions, please feel free to call me at (worker phone #).

Sincerely,

{Name}  
Protective Services Worker

APPROVED:

{Name}  
Protective Services Supervisor



Mrs Jane Q Public  
Chairperson of the board

**Adult Service Request For Hearing**  
**MONTGOMERY COUNTY**  
**DEPARTMENT OF HUMAN RESOURCES**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

**Confidential**  
*(Current Date)*

Doris Ball  
Office of Adult Services  
Adult Services Partnership  
State Department of Human Resources

Re: Request for Administrative Hearing  
Case Name:  
DHR #:  
Person Identified at Risk:  
Person Allegedly Responsible:

Dear Mrs. Ball:

Enclosed is a copy of the letter received from the person allegedly responsible requesting an Administrative Hearing.

Sincerely,

{Name}  
Protective Services Worker

APPROVED:

{Name}  
Protective Services Supervisor

**DAY CARE SERVICES FOR ADULTS INITIAL ASSESSMENT/REEVALUATION**

(To be used in conjunction with DHR-APSP-1897, Adult Protective Services Client Case Plan Initial and Reviews)

Client: \_\_\_\_\_ County: \_\_\_\_\_ Date of Contact: \_\_\_\_\_

Provider: \_\_\_\_\_ Initial Assessment  Six-month Reevaluation 

1. Date DHR-APSP 1897 completed. \_\_\_\_\_
2. In which setting is the client receiving adult day care service? a. Center  b. Home
3. Does the client have special transportation needs?  Yes  No

If yes, explain: \_\_\_\_\_

4. Is the client receiving adult day care:
- A. Full-time (averaging more than 25 hours/week)
- B. Part-time (averaging 25 hours or less/week)

5. What is the basis used to determine the number of hours needed for care? \_\_\_\_\_

6. Date of most recent medical: \_\_\_\_\_

7. What is client's condition since last evaluation?

- a. Improved  b. Deteriorated  c. Remained Stable

Explain: \_\_\_\_\_

## 8. Appropriateness for the service:

- A. Does day care meet the client's/family's needs? Yes  No

If no, explain: \_\_\_\_\_

- B. Does client require supervision outside the home for a portion of a 24-hour day? Yes  No

- C. Does client need assistance with activities of daily living for a portion of a 24-hour day? Yes  No

9. Have the following forms been completed?

- DHR-ASD-500, Emergency Information (Original given to provider & copy in client's record)
- PSD-OCG-724, Purchase of Services Authorization (Original given to provider & copy in client's record)

10. Should day care be: a. Continued as planned  b. Modified

Explain: \_\_\_\_\_

11. Does client have sufficient funds to pay for day care services?  Yes  No

Explain: \_\_\_\_\_

Worker's signature \_\_\_\_\_ Date form completed: \_\_\_\_\_

### ADULT DAY CARE TRANSPORTATION AGREEMENT

The \_\_\_(name of center/home) Adult Day Care Center/Home, located at \_\_\_ (address) hereby agrees to provide transportation to and/or from this center/home for persons for whom this service is authorized by the \_\_\_ (name of county) County Department of Pensions and Security.

The following conditions will be met:

1. The driver will hold a valid Alabama driver's license. For a day care center, the driver will be someone other than the center director.
2. The vehicle used for transporting clients will be safe and in good working condition.
3. All passengers will use safety belts at all time when the vehicle is in motion.
4. All passengers will enter and leave the vehicle from the curb side.
5. The driver will wait until the client enters the building, either the client's home or the day care center/home.
6. The number of passengers will be limited to the legal vehicle capacity.
7. All doors will be locked wherever the vehicle is in motion.
8. Insurance will be provided by \_\_\_ (name of insurance company) in the following amounts:

Bodily injury per person \_\_\_

Bodily injury per occurrence \_\_\_

Property damage \_\_\_

Medical coverage per person \_\_\_

Uninsured motorist \_\_\_

The center/home agrees that it will indemnify and save harmless the County Department and the State Department of Pensions and Security against any and all liability, loss, damages, costs, or expenses which the County Department and/or the State Department may hereafter sustain, incur, or be required and/or ordered to pay.

- (1) by reason of any service recipient's suffering personal injury, death, or property loss or damage while being transported to and from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the center/home or any officer, agent, employee, or volunteer thereof; or
- (2) by reason of any service recipient's causing injury to or damage to the property of another person at any time when the center/home, or any officer, agent, employee, or volunteer thereof has undertaken or is furnishing the transportation called for under this agreement; or
- (3) by reason of any officer, agent, employee, or volunteer thereof suffering personal injury, death, or property loss or damage.

In the event that any action, suit, or proceeding is brought against said State Department or the County Department upon any matter herein indemnified against, said State Department shall as soon as practicable cause notice in writing thereof to be given to the center/home by certified mail.

The center/home shall comply will all applicable laws, ordinances, and codes of the federal, state, and local governments.

The department of Pensions and Security will be billed only for transportation actually provided.

Adult day care transportation payment will be made by the State Department of Pensions and Security at the following rates:

\_\_\_ Per one-way trip per client

\_\_\_ Per round trip per client

Signed \_\_\_\_\_ Signed \_\_\_\_\_

Title \_\_\_\_\_ County Director

(for the center/home)

Signed \_\_\_\_\_

Commissioner

State Department of Pensions and Security

Date \_\_\_\_\_

**Adult service DENIAL LETTER**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant Name)

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City, State, Zip Code)

Dear \_\_\_\_\_

Thank you for your recent interest in becoming an Adult Foster Care Provider. Your concern for others and your desire to help some of our vulnerable clients is truly appreciated. However, because of other factors that we have discussed, we are not able to approve your home as a foster home at this time. If your situation changes in the future, please feel free to contact us again.

Sincerely,

\_\_\_\_\_  
Social Worker

Approved:

\_\_\_\_\_  
Supervisor

**FOSTER CARE SERVICES FOR ADULTS INITIAL ASSESSMENT/REEVALUATION**  
(To be used in conjunction with DHR-APSP-1897, Adult Protective Services Case Plan Initial and Reviews)

Client's Name: \_\_\_\_\_ County: \_\_\_\_\_

Date(s) of Interview (s): \_\_\_\_\_

Date DHR-APSP-1897 completed: \_\_\_\_\_

**Section I Eligibility and Need for Adult Foster Care Services**

- 1. Does client meet the criteria for persons to be served in adult foster care? 
  - a. Can live safely outside of an institution:
  - b. Unable to live alone because of incapacitates or infirmities:
  - c. No family able, willing or available to provide necessary care to the client:
  - d. Not a member of the foster family

Comments: \_\_\_\_\_

- 2. Is foster care the result of a: (Check all that apply)
  - a. Indicated protective service investigation?  Yes  No
  - b. Client agreement to placement?  Yes  No
  - c. Court order?  Yes  No If yes, give date and details:  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_

- 3. What is client's level of foster care?
  - a. Basic Adult Foster Care
  - b. Specialized Adult Foster Care  Give physical or mental disability: \_\_\_\_\_
  - c. Model Waiver Program  (Entered care prior to 1993)

- 4. Indicate services(s) needed by client.
  - a. Assistance with conducting a prescribed exercise routine
  - b. Changing bandages or dressing on the advice of physician
  - c. Supervision of self-administration of medications
  - d. Assistance in the use of prostheses or ambulation aid
  - e. Assistance in locomotion
  - f. Maintaining an acceptable state of cleanliness
  - g. Maintaining adequate nutritional standards in the purchase and preparation of food
  - h. Maintaining orientation to time, place and events
  - i. Performing other activities needed to help when illness or disability prevents client from adequately doing so:

**Section II: Placement Readiness**

1. Date Foster Care Program explained to client: \_\_\_\_\_

Client expresses understanding:  Yes  No

2. Date Pre-placement visit made? \_\_\_\_\_ If prevented, explain: \_\_\_\_\_

3. DHR-ASD-500, Emergency Information, Adult Day Care/Foster Care, completed?  Yes  No

4. Client and provider completed Adult Foster Care Payment Agreement (DHR-ASD-1332)  Yes  No

a. Includes payment for additional services and supplies?  Yes  No

If yes, does client retain sufficient amount of income for personal needs?  Yes  No

If no, explain: \_\_\_\_\_

b. Is agreement for room and board payment less than 75% of the SSI standard?  Yes  No

If yes give reason and notify APSP Consultant:

\_\_\_\_\_

\_\_\_\_\_

c. If client receives less than SSI maximum benefit, has the Social Security Administration been notified of the placement?  Yes  No

5. Date of Placement: \_\_\_\_\_ Provider's Name: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Worker's signature \_\_\_\_\_ Date form completed:

**HOMEMAKER SERVICES FOR ADULTS INITIAL ASSESSMENT/REEVALUATION**

(To be used in conjunction with DHR-APSP 1897, Adult Services Client Case Plan Initial and Reviews)

Client's Name: \_\_\_\_\_ Worker: \_\_\_\_\_

Homemaker/Agency: \_\_\_\_\_ County: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

1. Date DHR-APSP 1897 was completed: \_\_\_\_\_
2. Are there tasks necessary for the maintenance of the home and for the client's well being that cannot be done or should not be done by the client because the effect of doing those tasks would be detrimental to the well being of the client?  Yes  No
3. Why is the client unable to perform these tasks? \_\_\_\_\_
4. Does the client have anyone able, willing, and available to perform these tasks?  Yes  No  
If yes, explain the need for homemaker services: \_\_\_\_\_
5. Who made the referral for homemaker services? Name/Relationship: \_\_\_\_\_
6. Date worker explained the role of the homemaker to the client. \_\_\_\_\_
7. Has the client agreed to the services listed on PSD-BSA-821 or DHR-ASD-1508, Adult Services Contract Referral?  Yes  No  
Copy given to the client?  Yes  No
8. Will the homemaker handle the client's money on certain occasions?  Yes  No  
If yes, approximate amounts to be handled: \_\_\_\_\_  
DHR-ASD-1449 completed correctly and stapled to PSD-BSA-719?  Yes  No
9. Does the client have supplies available for homemaker's use?  Yes  No  
If no, explain how supplies will be secured: \_\_\_\_\_
10. Does client have sufficient funds to pay for homemaker services?  Yes  No  
If yes, explain; \_\_\_\_\_

Worker's Signature: \_\_\_\_\_

Date Form Completed: \_\_\_\_\_



Mrs Jane Q Public  
Chairperson of the board

**Adult Interagency Referral Letter**  
**MONTGOMERY COUNTY**  
**DEPARTMENT OF HUMAN RESOURCES**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

**Confidential**  
*(Current Date)*

To: *(Adult Interagency Referral, Agency Reference value)*

Attention: *(Adult Interagency Referral, Attention Reference value)*

Re: Adult Abuse, Neglect, and/or Exploitation Report  
Case Name:  
DHR #:  
Person Identified at Risk:

Attached: Department of Human Resources Report of Adult Abuse/Neglect/Exploitation

From: {Name}  
Adult Protective Services

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Adult LETTER FOR SUSPENSION OF APPROVAL**

Date

BY CERTIFIED MAIL AND REGULAR MAIL

Name of Foster Care Provider  
Address

RE: SUSPENSION AND REVOCATION OF  
APPROVAL TO OPERATE ADULT  
FOSTER CARE at (Address)

Dear \_\_\_\_\_:

This letter is to inform you that the Department of Human Resources has sufficient reason to believe that the approval issued to you effective (date) to (date) for the operation of adult foster care at (address) should be REVOKED. The statutory authority for this REVOCATION is found in the Code of Alabama 1975, Section 38-2-6 (18) and 41-22-19 (c)(d).

The basis (bases) for this REVOCATION is that a safe and caring environment has not been provided because:  
*Example:* On (date) you failed to follow doctor's instructions to take Mr. \_\_\_\_\_ to the Emergency Room of \_\_\_\_\_ Hospital. In addition, you accepted Mr. \_\_\_\_\_, an unrelated individual, into your home without a placement by the County Department.

In accordance with the Code of Alabama 1975, Section 38-2-6(18) and Section 41-22-19, you are entitled to a hearing. In addition, you may voluntarily relinquish your approval. You must notify us in writing within ten (10) departmental working days of the date of the receipt of this letter at the address shown at the top of this letter if you wish to have a hearing in this matter. Your written request must be received by the Department by the 10<sup>th</sup> day. You will be notified of the date, time, and place of the hearing by the Administrative Hearing Officer by separate letter.

If you have any questions, please contact (social worker) at (telephone #).

Sincerely,

\_\_\_\_\_  
(Social Worker's Signature)

\_\_\_\_\_  
Approved: (County Supervisor's signature)

ATTACHMENTS (if any)

Copies to:  
Carolyn Lapsley, Deputy Commissioner for  
Children and Family Services  
Doris Ball, Director, Adult Protective Services  
Legal counsel (specify if known)  
Bill Prendergast, Administrative Hearing Officer  
\_\_\_\_\_, Director, \_\_\_\_\_ County  
Department of Human Resources

## ADULT MEDICAL STATEMENT

Dear Dr. \_\_\_\_\_ :

The individuals listed below are part of a household that has applied to become an approved DHR Adult Foster Care Home. DHR foster homes provide residential care in a family setting for elderly and disabled adults who are no longer able to live alone but have no family able or willing to provide the care. Our policy requires that all members of the foster home be free of communicable disease and whether the applicant/provider is able to provide care for an elderly or disabled person. Please verify that these individuals have been evaluated for tuberculosis and provide the dates of the latest test.

### Medical Statement

#### Household Members

1. \_\_\_\_\_, applicant/provider
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

These individuals have been found to be free of communicable and infectious diseases. If not, please explain below and indicate if there are any particular groups or clients which should/should not be served in this family home.

Physician's Name

Date of Signature

Other Comments:

**ADULT PROTECTIVE SERVICES SAFE CASE CLOSURE**  
**(optional)**

**Case Name:** \_\_\_\_\_  
**Case Number:** \_\_\_\_\_  
**Worker Name:** \_\_\_\_\_

1. Can the adult be located?  Yes  No  
If no; efforts to locate include:  
 Sending letter to last known address.  
 Search of City Directory.  
 Search of telephone directory.  
 Search of Medicaid / MSIQ screen.  
 Search of Food Stamps and / or TANF records  
 Requesting address from other providers when known  
 Other: \_\_\_\_\_
2. When was the last contact with the adult? \_\_\_\_\_  
Has there been an unmet need or concern regarding this adult in the last six months? If so, explain:  
\_\_\_\_\_  
\_\_\_\_\_  
What was the original referral / primary need of this adult? \_\_\_\_\_  
\_\_\_\_\_
3. How was this need met? \_\_\_\_\_
4. Has the adult indicated further problems?  Yes  No If so, list: \_\_\_\_\_  
\_\_\_\_\_
5. Is this a court-ordered case?  Yes  No If yes, does it meet the criteria for dismissing the court case?  
(Ch. 11-F, p. 79)  Yes  No  Not Applicable
6. Is the adult receiving any of these agency services?  None  
 Protective Services,  Homemaker,  Foster Care,  Daycare,  Mental Health Counseling,   
Targeted Case Management,  Emergency Shelter Care,  Nursing Home Limited Payment,  Other:  
\_\_\_\_\_
7. Is the adult receiving services from another agency?  Yes  No If so, list:  
\_\_\_\_\_
8. Is the adult able to make reports on their own behalf of abuse, neglect, or exploitation?  Yes  No  
If not, does the adult have someone willing and able to provide protection and make decisions on their  
behalf?  Yes  No If yes, name: \_\_\_\_\_
9. Is there risk of substantial harm to the adult without agency intervention?  Yes.  No. If yes, explain:  
\_\_\_\_\_
10. Has case history been discussed with supervisor?  Yes  No
11. Does worker or supervisor feel this adult could be better helped by another agency?  
 Yes.  No. If so, list and date referral: \_\_\_\_\_

I recommend this case for safe closure for the following reason(s):  
 The client has died.  
 The client cannot be located.  
 The client has moved out of State.

---

- Services have been provided, the objectives met, and there is no longer a need for protective intervention.
- Necessary services are being provided from other sources and DHR protective services are no longer necessary.
- The client refuses services and it has been professionally determined that he/ she is capable of preventing his own abuse, neglect, or exploitation.
- A caregiver is available who can protect the client.
- The client is placed voluntarily with relatives, nursing home, or assisted living facility and no changes or problems are anticipated and there is no court order requiring protective services.

---

\_\_\_\_\_ (Worker's signature)

----- (Date)

I  concur  do not concur with this decision:

\_\_\_\_\_ (Supervisor's signature)

----- (Date)

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Used for Record Review by APS Consultant on this date: \_\_\_\_\_

\_\_\_\_\_ (Consultant's signature)

## Adult Risk Assessment

### I. CASE IDENTIFICATION

ADULT 1 \_\_\_\_\_  
 ADULT 2 \_\_\_\_\_

Living Arrangement \_\_\_\_\_  
 Living Arrangement \_\_\_\_\_

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

### II. RISK FACTORS

APPEARANCE/ MOBILITY	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Bedridden				
Chairbound				
Dirty Clothes				
Fecal or Urine Odor				
Gait				
Housebound				
Inappropriate Dress				
Other				
Personal Hygiene				
Wheelchair				

DAILY LIVING	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Bathing				
Cleaning				
Cooking				
Dressing				
Feeding				
Other				
Shopping				
Toileting				

ECONOMIC SITUATION	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Failure to Pay Bills				
Giving Money Away				
Hoarding				
Inaccurate/No Knowledge of Finances				
Irresponsible Credit Purchases				
Large Amounts of Cash				
Mismanagement of Resources By Others				
Other				
Squandering				
Unable/Unwilling to Manage Property				
Uncashed Checks				

EDUCATION	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Little access to public				

education				
No access to public education				
Other				

ENVIRONMENT	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Bugs/Pests				
Electrical				
Fire Hazard				
Food Supply				
Heating				
Housekeeping				
Inadequate Caregiver				
Inadequate Supervision				
Lack of Community Resources				
No Available Caregiver				
Other				
Pets				
Stove				
Structure				
Toilet				
Water				

HEALTH	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Broken Bones				
Bruises, Welts				
Chest Pain				
Dehydration				
Dizziness				
HIV/AIDS Victim				
Headaches				
Hearing Impaired				
Inadequate Nutrition				
Lack of Medical Care				
Lack of Medical Care				
Malnourishment				
Non Responsive				
Other				
Problems With Medications				
Refusal to Accept Medical Care				
Scars, Burns				
Shortness of Breath				
Skin Breakdown				
Speech Impaired				
Symptoms of Sexual Abuse				
Unexplained Bleeding				
Vision Impaired				
Weight Loss				
Wounds				

MENTAL/ EMOTIONAL	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Alcohol or Drug Abuse				
Anxiety				
Autism				
Combative				
Confusion				
Dementia				
Fear				
Grieving				
Hallucinations				
Head Injury				
Inappropriate Sexual Behavior				
Insomnia				
Loss of Appetite				
Loss of Esteem				
MR/MI/Emotional				
Not Taking Psychotropic Drugs				
Orientation to Person				
Orientation to Place				
Orientation to Time				
Other				
Refusal To Accept Psychiatric Care				
Suicidal				

Suspiciousness				
Threat of Harm To Self or Others				
Untreated Mental Condition				
Wandering				

SOCIALIZATION/ RECREATIONAL	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Few or No Recreational Activities				
Intimidation				
Isolation				
Other				

TRANSPORTATION	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
Hazardous Driving				
No Private Transportation				
No Public Transportation				
Other				

VOCATIONAL	ADULT 1		ADULT 2	
	At Risk	Description	At Risk	Description
No Vocational Skills				
No Vocational Training				
Other				

**III. RESULTS**

CATEGORY	ADULT 1	ADULT 2
Appearance/ Mobility		
Daily Living		
Economic Situation		
Education		
Environment		
Health		
Mental/Emotional		
Socialization/Recreational		
Transportation		
Vocational		

**Decision**  Immediate Risk  Open Case  Close Case

**V. SUMMARY:**

10-7-05

**Adult Services Requisition For Medical Examinations**  
**ADULT SERVICES REQUISITION FOR MEDICAL**

**SAMPLE I**  
**EXAMINATIONS**

FOR PERIOD ENDING April 2, 2005

NAME OF DOCTOR	Mailing address	SERVICE				TOTAL
		AMOUNT EACH CATEGORY	XXAPS	XXX	XXXX	
<b>FOSTER CARE</b>						
Dr. Joe Jones	P.O. Box 121 Anywhere, AL 36000	\$10				\$10
Dr. Al Adams	345 Rose St. Anywhere AL 36000	\$10				\$10
		\$20				\$20
<b>DAY CARE</b>						
Dr. Paul Pill	6921 Main St. Anywhere AL 36000	\$10				\$10
Dr. Sue Star	418 Tulip Trail Anywhere, AL 36000	\$10				\$10
		\$20				\$20

## APPLICATION FOR ADULT PROTECTIVE SERVICES

DHR-FSP 1966 Revised 6-03

Name _____		County _____	
Resident Address _____			
SSN _____	Your Social Security number is required by the Department in order to provide an individual identification, a mechanism of matching information received about you and identification for purposes of services provided.		
Case No. _____			
Date of Birth _____	Race _____	Sex _____	Telephone # _____
<b>SERVICES REQUESTED</b>			
Targeted Case Management <input type="checkbox"/>	Homemaker <input type="checkbox"/>	Mental Health Counseling <input type="checkbox"/>	
Day Care <input type="checkbox"/>	Limited Nursing Home Payment <input type="checkbox"/>	Diagnosis and Evaluation <input type="checkbox"/>	
Foster Care <input type="checkbox"/>	Emergency Shelter <input type="checkbox"/>	Case Management (Non-TCM) <input type="checkbox"/>	
<b>ELIGIBILITY FOR ADULT PROTECTIVE SERVICES FOR INDIVIDUALS</b>			
Is the applicant at risk of Abuse, Neglect and, or Exploitation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the applicant at risk of institutionalization? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>TCM ONLY</b>			
Is applicant a resident of a total care facility. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does applicant receive services through a home and community based waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>HEALTH INSURANCE INFORMATION</b>			
Does applicant have health insurance other than Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Policy Holders Name _____			
Contract/Policy Number _____			
Name of Insurance Company _____			
Address of Insurance Company _____			
<b>APPLICANT CERTIFICATION</b>			
<p>I request the Alabama Department of Human Resources provide the above listed services for me. I certify that I am currently residing in Alabama and that the information herein is a true and complete statement of facts according to the best of my knowledge. I agree to let my County Department of Human Resources know of any changes that occur in my address, income or membership in my family or changes in why I originally needed the service. I understand that if I deliberately give false or incomplete information or fail to report changes in the information received on this form, such misrepresentation is subject to possibility of prosecution for fraud. I authorize the DHR to verify information on this form. I have been given a statement of my right to appeal. If purchased services for which I have applied are approved, the provider agency may give to State or County Department of Human Resources information to assess my continued eligibility for services.</p>			
<p style="text-align: center;"><b>Signature</b> _____</p>			<p style="text-align: center;"><b>Date</b> _____</p>
<b>RELEASE OF INFORMATION</b>			
I <input type="checkbox"/> consent <input type="checkbox"/> do not consent, to the release of information from my case record to other agencies/individuals to whom I may be referred for services.			
Signature _____			Date _____
Provide following information on person assisting in completion of application.			
Name _____		Title/Relationship _____	
Address _____		Phone _____	

Civil rights pamphlet given

**GENERAL LIABILITY/DRIVER INFORMATION**  
**DEPARTMENT OF HUMAN RESOURCES**  
 Adult Protective Services

General Liability/Driver Information  
 DHR COUNTY \_\_\_\_\_

Send Completed Form To:  
 Shirley Bailey  
 SDHR-APS  
 50 Ripley Street  
 Montgomery, AL 36130-4000

FULL NAME OF PROVIDER	ADDRESS – STREET CITY, STATE, ZIP CODE	AL DRIVERS LICENSE #	SOCIAL SECURITY #	DATE OF BIRTH	PRIMARY DRIVER		CHECK ONE	
					YES/NO	YES/NO	ADD/DELETE	

\_\_\_\_\_  
 COUNTY DIRECTOR OR DESIGNEE

\_\_\_\_\_  
 DATE

**DHR-FSD-1968      STATE OF ALABAMA  
DEPARTMENT OF HUMAN RESOURCES  
NOTICE OF REDUCTION/TERMINATION OF SERVICES**

Name \_\_\_\_\_  
And \_\_\_\_\_  
Address \_\_\_\_\_

Date of Notice \_\_\_\_\_

County \_\_\_\_\_

Case No. \_\_\_\_\_

**ATTENTION: THIS NOTICE HAS NOTHING TO DO WITH ANY CHECK YOU RECEIVE**

---

**Section I.**

---

This is to notify you of action taken on your request for services for you and/or members of your family.

A. Effective \_\_\_\_\_ the \_\_\_\_\_ service you and/or members  
(Date) of your family have been receiving will be reduced to \_\_\_\_\_.

See Section II below for the reason and policy reference which are the basis for this decision.

B. Effective \_\_\_\_\_ this department will no longer provide \_\_\_\_\_.  
(Date)

---

**Section II.**

---

The reason for this action is \_\_\_\_\_  
\_\_\_\_\_.

The policy for this action is \_\_\_\_\_  
\_\_\_\_\_.

If you have questions regarding this notice or need other services, contact this office or have someone do so for you. If you are dissatisfied and want to ask for a conference, informal review or formal hearing, read the information on the back of this notice.

Copy to Provider \_\_\_\_\_  
Per Client Permission      Provider Name      Social Worker      Date

**Department of Human Resources  
HIPAA privacy AUTHORIZATION**

**Client Name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

*We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.*

**USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION**

*A representative of the **Alabama Department of Human Resources** must answer these questions completely before providing this authorization form to you. **DO NOT SIGN A BLANK FORM.** You or your personal representative should read the descriptions below before signing this form.*

**Who will disclose the information?** The person(s) or class of persons authorized to disclose the information is described below:

\_\_\_\_\_  
(DHR staff working on case)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Who will use and/or receive the information?** The person(s) or class of persons authorized to use and/or receive the information is described below:

\_\_\_\_\_  
(ISP/case planning team members, court officials, and attorneys)  
\_\_\_\_\_  
\_\_\_\_\_

**What information will be used or disclosed?** The description below should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed:

\_\_\_\_\_  
(All medical information)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Psychiatric/psychotherapy notes and reports)  
\_\_\_\_\_  
\_\_\_\_\_

**What is the purpose of the use or disclosure?** The purposes for which the information will be used or disclosed are described below:

\_\_\_\_\_  
(Case planning, treatment, payment, monitoring)  
\_\_\_\_\_  
\_\_\_\_\_

**When will this authorization expire?** The date or event that will trigger the expiration of this authorization should be described below.

\_\_\_\_\_  
(When DHR case is closed)  
\_\_\_\_\_

## SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.

You have a right to refuse to sign this authorization. Unless services are court ordered, eligibility, availability, treatment, and payment for department services is conditioned on your signed authorization.

You have a right to see and copy the information described on this authorization form in accordance with our record access policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based upon your authorization. To revoke this authorization, please write to your Department of Human Resources caseworker.

## SIGNATURE

*I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

\_\_\_\_\_  
Signature of Client or Personal Representative

\_\_\_\_\_  
Print Name of Client or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

**CONTACT INFORMATION**

*The contact information of the client or personal representative who signed this form should be filled in below:*

Address:

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

Telephone:

\_\_\_\_\_ (daytime)

\_\_\_\_\_ (evening)

Email Address (optional):

\_\_\_\_\_

***THE CLIENT OR HIS OR HER PERSONAL REPRESENTATIVE SHOULD BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.***

## Initial Adult FC Provider Approval Check list

Prospective Provider Name : \_\_\_\_\_ County \_\_\_\_\_  
Case Number \_\_\_\_\_

### Dates

#### **Inquiry**

Received by: SDHR \_\_\_\_\_ County \_\_\_\_\_

#### **Application**

Provided to Prospective Applicant: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Completed application received: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

#### **Orientation for Applicant and Substitute Caregiver**

Arranged by phone or mail: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Completed: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Place: \_\_\_\_\_

#### **Initial Training for Applicant and Substitute Caregiver**

Arranged: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Completed: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Place: \_\_\_\_\_  
Booklet-Minimum Standards for Adult Foster Homes for Adults  
Issued and Reviewed with Applicant: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

#### **Criminal History/Background Check**

Arrange for fingerprinting:

Applicant: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Mandatory Criminal History Check Notice form signed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Criminal History Consent and Release form signed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Applicant's adult household members: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Mandatory Criminal History Check Notice form signed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Criminal History Consent and Release form signed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Substitute Caregiver: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Mandatory Criminal History Check Notice form signed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Criminal History Consent and Release form signed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

#### **Fingerprinting completed:**

Applicant:  
Two complete sets of fingerprints (card) or live scan done \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Cards and forms mailed or live scan process completed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Applicant's adult household members:  
Two complete sets of fingerprints (card) or live scan done \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Cards and forms mailed or live scan process completed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Substitute Caregiver

Two complete sets of fingerprints (card) or live scan done \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Cards and forms mailed or live scan process completed \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

#### **Results received:**

Applicant: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Applicant's adult household members: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Substitute Caregiver: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

### Dates

#### **AAN/E and CAN Central Registry Clearance from State and/or County**

Applicant: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Applicant's Adult Household Members: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Substitute Caregiver: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

#### **Secure Medicals**

Medical forms given to:

Applicant:  Yes  No \_\_\_\_\_  
Applicant's Household Members:  Yes  No \_\_\_\_\_  
Substitute Caregiver:  Yes  No \_\_\_\_\_

Completed medical forms received from:

Applicant:  Yes  No \_\_\_\_\_  
Applicant's household members:  Yes  No \_\_\_\_\_  
Substitute Caregiver:  Yes  No \_\_\_\_\_

**Secure Verification of Rabies Vaccinations for all pets**

Pet No. 1:  Yes  No \_\_\_\_\_  
Pet No. 2:  Yes  No \_\_\_\_\_

**References Contacted (3 required)**

Applicant:  Yes  No \_\_\_\_\_  
Substitute Caregiver:  Yes  No \_\_\_\_\_

**Home Study**

Home study completed:  Yes  No \_\_\_\_\_

**Home Meets Standards and Regulations:**  Yes  No

If no, has denial letter been sent:  Yes  No \_\_\_\_\_  
Reason for denial: \_\_\_\_\_

**Temporary Approval Granted:** Applicants that have met all requirements except the return of a completed criminal history background check and the subsequent suitability determination. SDHR APS approval given:  Yes  No

Date of Temporary Approval: \_\_\_\_\_

**Application Approved:**  Yes  No

Date Approved: \_\_\_\_\_

Approval Mailed to Applicant:  Yes  No \_\_\_\_\_

**Liability Insurance Coverage**

SDHR (ATT: Shirley Bailey):  Yes  No \_\_\_\_\_

Caseworker's Signature \_\_\_\_\_

Date \_\_\_\_\_

**DHR INVESTIGATION OF REPORT RECEIVED  
ALLEGING ADULT ABUSE, NEGLECT AND/OR EXPLOITATION**

**This fact sheet is to answer questions you as an administrator may have regarding the role and responsibilities of the Department of Human Resources in investigating allegations of abuse, neglect and/or exploitation which have been received concerning a resident of your facility.**

---

Client/Resident's Name: Room #:

Social Worker's Name: Phone #:

Supervisor's Name: Phone #:

Director's Name: County:

---

Date form provided to Facility Director:

---

General Nature of This Complaint:

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The Adult Protective Services Act of 1976, (Section 38-9-1 through 38-9-11 Code of Alabama) authorizes DHR to receive, record and investigate complaints alleging abuse/neglect/exploitation of an adult.

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Seven (7) days is the time frame specified in the Adult Protective Services Act for DHR to investigate complaints received.

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The client's welfare is the focus of the DHR investigation, not the guilt or innocence of someone else.

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Prior to any information or report on the results of the investigation being given to the administrator, DHR regulations may require the person allegedly responsible to be given the opportunity for an investigative hearing. The legal basis for this is Golden v. Hornsby, Case NO. 89-H-1266-N (M.D. Ala July 22, 1990). There may be a delay of several months dependent on the circumstances surrounding the investigation and due to the time necessary to hold the hearing. An exception to the release of information prior to the hearing may be made when the Department considers that a client/resident may be in imminent danger of abuse, neglect, or exploitation.

---

Procedure for conducting the investigation will vary somewhat due to the specific nature of the complaint. However, policy directs the DHR worker to:

1. Interview the alleged victim (client/resident/person identified at risk).
2. Discuss the allegations with the person allegedly responsible.
3. Interview those involved with or knowledgeable about the client/resident's care and well-being.
4. Review the client/resident's medical chart on an as-needed basis for documentation of care/services given and observations noted.
5. Determine whether the client/resident has been abused, neglected and/or exploited as defined in Section 38-9-2, Code of Alabama:
  - a) "Abuse" means the infliction of physical pain, injury, or the willful deprivation by a caregiver or other person of services necessary to maintain mental and physical health.
  - b) "Sexual Abuse" is any conduct defined as a crime in the Code of Alabama Sections 13 A-6-60 through 13 A-6-70, inclusive.
  - c) "Emotional Abuse" means the willful or reckless infliction of emotional or mental anguish or the use of a physical or chemical restraint, medications or isolation as punishment.
  - d) "Neglect" means the failure of a caregiver to provide food, shelter, clothing, medical services, and health care for the person unable to care for himself; or the failure of the person to provide these basic needs for himself when the failure is the result of the person's mental or physical inability.
  - e) "Exploitation" means the expenditure, diminution or use of property, assets or resources of a person subject to protection under the provisions of this chapter without the express voluntary consent of that person or his legally authorized representative.

**6. Determine if the client resident is an adult in need of protective service.**

“Adult in need of protective services” as defined in Section 38-9-2, is a person 18 years of age or older whose behavior indicates that he is mentally incapable of adequately caring for himself and his interests without serious consequences to himself or others; or who because of physical or mental impairment is unable to protect himself from abuse, neglect or exploitation; and who has no guardian or relative or other appropriate person able, willing, and available to assume the kind and degree of protection and supervision required under the circumstances.

7. Develop a plan to protect the client/resident if the client/resident meets this definition.

---

According to 338-9-6(e), Code of Alabama, any record of the Department pertaining to an adult in need of protective services shall not be open for public inspection.

Unless otherwise ordered by the Court, the name of the reporter of suspected abuse, neglect, or exploitation is kept confidential.

---

Immunity is offered in Section 38-9-9, Code of Alabama:

“Any person, firm or corporation making or participating in the making of a report pursuant to this chapter or participating in a judicial proceeding resulting therefrom shall in so doing be immune from any liability, civil or criminal, that might otherwise be incurred or imposed.”

---

State Department of Human Resources Elder Abuse Hotline – 1-800-458-7214.

DEPARTMENT OF HUMAN RESOURCES

ADULT SERVICE NOTICE OF APPLICATION FOR SERVICES

Name

And

Address

[Empty rectangular box for Name, Address, and other details]

Date of Notice \_\_\_\_\_

County \_\_\_\_\_

Case No. \_\_\_\_\_

**ATTENTION: THIS NOTICE HAS NOTHING TO DO WITH ANY CHECK YOU RECEIVE**

This is to notify you of action taken on your request for services for you and/or members of your family.

Your application for \_\_\_\_\_ has been APPROVED.

Your application for \_\_\_\_\_ has been DISAPPROVED.

The reason for this action is \_\_\_\_\_

The policy for this action is \_\_\_\_\_

Your application for \_\_\_\_\_ has been APPROVED.

The service is not available at this time due to the limit placed on the number of clients that can receive the service. Your name will be placed on a waiting list and you will be notified when the service can be provided for you and/or your family.

If you have questions regarding this notice or need other services, contact this office or have someone do so for you. If you are dissatisfied and want to ask for a conference, informal review or formal hearing, read the information on the back of this notice.

Copy to Provider \_\_\_\_\_  
Per Client Permission \_\_\_\_\_ Provider Name \_\_\_\_\_ Social Worker \_\_\_\_\_ Date \_\_\_\_\_

# Adult Service Public Assistance Eligibility Data

## PUBLIC ASSISTANCE ELIGIBILITY DATA

CASE NUMBER \_\_\_\_\_ CATEGORY (CODE) \_\_\_\_\_ COUNTY (CODE) \_\_\_\_\_ DATE OF APPLICATION \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

PRESENT \_\_\_\_\_ CHANGE TO \_\_\_\_\_

PAYEE \_\_\_\_\_ PAYEE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

ZIP CODE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 PRESENT  CHANGE TO  PRESENT  CHANGE TO

BUDGET DEFICIT \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 AMOUNT OF ENTITLEMENT \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 RECOUPMENT:  
 AMOUNT OF MONTHLY DEDUCTION \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 AMOUNT OF BALANCE DUE \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 EXCEPTIONAL NEED BUDGETED \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 AMOUNT OF INCOME/RESOURCES \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 AMOUNT OF SERVICE FEE \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 AMOUNT OF RSDI \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 AMOUNT OF CHECK \$ \_\_\_\_\_

TYPE CASE CODE \_\_\_\_\_  
 SS INDICATOR \_\_\_\_\_  
 MARITAL STATUS/DWELLING CODE \_\_\_\_\_  
 FOOD STAMP PARTICIPATION CODE \_\_\_\_\_  
 TYPE OF INCOME \_\_\_\_\_  
 NUMBER IN BUDGET GROUP \_\_\_\_\_  
 NO. OF CHILDREN ELIGIBLE \_\_\_\_\_  
 NO. OF NEEDY ADULT RELATIVES \_\_\_\_\_  
 CASE STATUS \_\_\_\_\_ NEW \_\_\_\_\_ REOPENED \_\_\_\_\_  
 THIRD PARTY INSURANCE \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_  
 WORKLOAD CODE \_\_\_\_\_

AWARD   
 TERMINATION   
 REASON CODE \_\_\_\_\_  
 CHANGE OF STATUS   
 TRANSFER DATA (AWARD)  
 PREVIOUS COUNTY \_\_\_\_\_  
 PREVIOUS CATEGORY \_\_\_\_\_  
 PREVIOUS CASE NUMBER \_\_\_\_\_  
 TRANSFER DATA (TERMINATIONS)  
 COUNTY TRANSFERRED TO \_\_\_\_\_  
 CATEGORY TRANSFERRED TO \_\_\_\_\_

REVIEW COMPLETED  
 OTHER (SPECIFY) \_\_\_\_\_  
 NEXT ACTION DUE:  
 TYPE \_\_\_\_\_ DATE \_\_\_\_\_  
 INTERACTION \_\_\_\_\_  
 COUNTY \_\_\_\_\_  
 DEPARTMENT OF HUMAN RESOURCES  
 SIGNATURE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 REMARKS: \_\_\_\_\_

NAME	RACE	SEX	ENTITLE DATE			SOCIAL SECURITY (IF APPLICABLE)		MEDICAL ELIGIBILITY		
			MO.	DAY	YR.	CLAIM NUMBER	ACCOUNT NUMBER	MO.	DAY	YEAR
RECIPIENT IN ADULT CATEGORY										
00										
NEEDY ADULT(S) IN ADJ										
RECIPIENT COUNT:										
01										
02										
03										
CHILDREN:										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
CHILDREN ELIGIBLE FOR MEDICAL ASSISTANCE ONLY (TITLE XIX)										
31										
32										
33										



**REQUISITION FOR Adult Day Care Home Transportation Payments**

**FOR PERIOD ENDING** \_\_\_\_\_ ~~April 2,~~ 2005

**Name of Adult Day Care  
Home**

XXXXXXXXXXXXXXXXXXXX Mailing address

Amount each Category

TOTAL

Mrs. Gail Green

159 Howard Ave.  
Anywhere, AL 36000

XXAPS	XXX	XXXX	XXXX	
\$20				\$20

**REQUISITION FOR Adult Day Care Home Payments**

**FOR PERIOD ENDING** \_\_\_\_\_ ~~April 2,~~ 2005

Name of Provider

XXXXXXXXXXXXXXXXXXXX Mailing address

Amount each Category

TOTAL

Mrs. Gail Green

159 Howard Ave.  
Anywhere, AL 36000

XXAPS	XXX	XXXX	XXXX	
\$				

**REQUISITION FOR Adult Emergency Shelter Care**

**FOR PERIOD ENDING** \_\_\_\_\_ April 2, 2005

XXXXXXXXXXXXXXXXXX	Name of Provider Mailing address	XXXXXXXXXXXXXXXXXX				TOTAL
		XXAPS	XXX	XXXX	XXXX	
Mrs. Betty Blue	153 Howard Ave. Anywhere, AL 36000	18				\$360

**REQUISITION FOR Adult Foster Care Service Fee**

**FOR PERIOD ENDING** \_\_\_\_\_ **April 2, 2005**

XXXXXXXXXXXXXXXXX Mailing address	Name of Provider				TOTAL
	AMOUNT EACH CATEGORY				
	XXAPS	XXX	XXXX	XXXX	
Mrs. Betty Blue 153 Howard Ave. Anywhere, AL 36000	\$25				\$25

AGREEMENT TO PROVIDE DAY CARE FOR ADULTS ELIGIBLE FOR PSD SERVICES

State of Alabama  
PSD- 293  
March, 1976

STATE OF ALABAMA  
DEPARTMENT OF PENSIONS AND SECURITY

AGREEMENT TO PROVIDE DAY CARE FOR ADULTS ELIGIBLE FOR PSD SERVICES

This agreement made at \_\_\_\_\_, Alabama the \_\_\_\_\_  
day of \_\_\_\_\_, 19 \_\_\_\_\_, by and between the Department of Pensions  
(city) (day)  
(month) and Security and \_\_\_\_\_ adult day care center/  
(name of center or family)  
home located at \_\_\_\_\_  
(address)

This agreement shall be effective from \_\_\_\_\_ and  
(date)  
continue in force until \_\_\_\_\_, and may be subject to  
(date)  
renewal.

The provider of day care for adults agrees to the following conditions:

1. To provide care for impaired adults, 18 years of age or older, for a portion of a 24 hour day in a protective setting. This includes the provision of shelter, supervision, and nutritious meals and snacks for the adults participating in the day care program.
2. To operate the center/home for the provision of day care service from \_\_\_\_\_ to \_\_\_\_\_, Monday through Friday,  
(time) (time)  
state holidays excepted.
3. To utilize buildings and furnishings in conformity with the Minimum Standards for Day Care Centers for Adults or the Minimum Standards for Day Care Homes for Adults.
4. To provide services for up to a maximum of \_\_\_\_\_ adults.  
(number)
5. To offer the adults the opportunity to take part in activities of interest to the participants and geared to their capabilities. Centers must have a planned program of varied activities which would require some active participation by the persons in day care.
6. To maintain records and submit reports as required by the Department of Pensions and Security and to notify the \_\_\_\_\_ County  
(name of county)  
Department of the adults' attendance in accordance with established procedures. The provider of day care shall make all records relating to this agreement available to the Department of Pensions and Security and/or Federal officials upon request.

7. To cooperate with the \_\_\_\_\_ County Department of Pensions and Security and to adhere to PSD policies regarding the provision of day care for adults.  
(name of county)
8. To comply with the requirements of the Civil Rights Act of 1964, as indicated by the signing of PSD-168, "Statement of Compliance with Title VI of the Civil Rights Act of 1964."
9. To comply with the requirements for safeguarding client information in accordance with Pensions and Security directives.
10. To accept into the day care program only those adults referred by the Department of Pensions and Security. (This item applies to adult day care homes only.)

\*\*\*\*\*

The Department of Pensions and Security agrees to the following conditions:

1. To make payment to the adult day care provider by check drawn to the order of \_\_\_\_\_ . Payment must be in accordance with State policy regarding payments for service and with the following monthly rates depending on the type and amount of service rendered:  
 \_\_\_\_\_ for full-time day care for each adult.  
 (amount)  
 \_\_\_\_\_ for part-time day care for each adult.  
 (amount)
2. To determine eligibility for services and need for day care, and to authorize the service for people who are determined eligible.
3. To inform applicants for service and recipients of service of their rights to fair hearings.
4. To assist and advise the provider of day care for adults.

\*\*\*\*\*

This agreement may be terminated under the following conditions:

1. The provider of day care for adults may terminate this agreement by giving the Department of Pensions and Security thirty (30) days notice in advance.
2. The provider of day care for adults may terminate this agreement without notice in advance in the event of an emergency affecting the provider of adult day care, such as illness, death, or fire.
3. The Department of Pensions and Security may terminate this agreement by giving the provider of day care for adults thirty (30) days notice in advance.
4. In case of emergency, the Department of Pensions and Security reserves the right to terminate this agreement without prior notice to the provider of adult day care.

\_\_\_\_\_ County Department of Pensions and Security  
 (name of county)  
 has determined that as of \_\_\_\_\_ the above named center/home meets  
 (date)  
 the minimum standards for adult day care centers/homes established by the  
 Department of Pensions and Security.

Signed:

\_\_\_\_\_, Director  
 \_\_\_\_\_ County Department  
 of Pensions and Security

\_\_\_\_\_  
 Provider of Day Care for Adults  
 \_\_\_\_\_  
 Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

ADULT DAY CARE/FOSTER CARE EMERGENCY INFORMATION

ALABAMA DEPARTMENT OF HUMAN RESOURCES  
EMERGENCY INFORMATION  
ADULT DAY CARE/ADULT FOSTER CARE

Name \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_\_

DHR Case No.: \_\_\_\_\_ Social Worker \_\_\_\_\_ Office Phone No: \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Office Phone \_\_\_\_\_ After Hours Phone \_\_\_\_\_

Client under treatment for: \_\_\_\_\_

Doctor's special instructions (diet, medications, allergies, etc.) \_\_\_\_\_

Doctor's instructions regarding day-to-day health routine: \_\_\_\_\_

\_\_\_\_\_ Date next check-up is due \_\_\_\_\_

INFORMATION APPLICABLE TO DAY CARE ONLY

Person with whom client lives: Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Friend who could be called in event of emergency: Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

INFORMATION APPLICABLE TO FOSTER CARE ONLY

Social Security No. \_\_\_\_\_ SS Claim No. \_\_\_\_\_ Religion \_\_\_\_\_

Insurance: Type \_\_\_\_\_ Location of Policy \_\_\_\_\_

Name of Church \_\_\_\_\_ Name of Minister \_\_\_\_\_

Minister's Phone \_\_\_\_\_ Address \_\_\_\_\_

Name of Nearest Relative \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

After hours emergency Phone No. For DHR: \_\_\_\_\_

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT AND TRANSPORTATION

Authorization is given for the provision of emergency medical treatment and transportation, in the event incapacitation prohibits my giving oral or written permission at the required time.

Client \_\_\_\_\_ OR \_\_\_\_\_  
Responsible Person

Date \_\_\_\_\_ Date \_\_\_\_\_

APPROVAL TO PROVIDE FOSTER CARE FOR ADULTS

STATE OF ALABAMA

DEPARTMENT OF HUMAN RESOURCES

APPROVAL TO PROVIDE FOSTER CARE FOR ADULTS

This is to CERTIFY that \_\_\_\_\_ locate  
at \_\_\_\_\_, is hereby approved b  
the \_\_\_\_\_ County Department of Human Resources t  
provide foster care for adults according to standards established by the Stat  
Department of Human Resources and with the following conditions:

Number of persons in foster care at any one time \_\_\_\_\_  
Sex of such persons \_\_\_\_\_  
Special provisions \_\_\_\_\_

This approval shall be in force from the \_\_\_\_\_ day of \_\_\_\_\_  
19 \_\_\_\_, to the \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_. It may be revoked fo  
reasonable and just cause at any time, or cancelled by mutual agreement.

Issued this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_.

\_\_\_\_\_  
Director

\_\_\_\_\_  
County  
Department of Human Resources



# ADULT SERVICES INTERVIEW NOTIFICATION

BSA PSD 5/80 110 (Formerly)	_____ COUNTY DEPARTMENT OF PENSIONS AND SECURITY INTERVIEW NOTIFICATION
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; margin-bottom: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> </div>	DATE _____  CASE NO. _____  FS NO. _____

**I HAVE CHECKED ONLY THE PART(S) OF THIS LETTER APPLICABLE TO YOU.**

I need to talk with you about \_\_\_\_\_

---

	<u>Date</u>		<u>Time</u>	
<input type="checkbox"/> Please meet me at the				
<input type="checkbox"/> County Office on	_____	at	_____	
<input type="checkbox"/> Food Stamp Office	_____	at	_____	
<input type="checkbox"/> Other _____	_____	at	_____	
<input type="checkbox"/> I will visit you in your home on	_____	at	_____	
<input type="checkbox"/> I will contact you by telephone on	_____	at	_____	
<input type="checkbox"/> Please call me at _____ on	_____	at	_____	

**ITEMS TO BRING WITH YOU OR HAVE READY FOR ME TO SEE WHEN I VISIT YOU:**

<input type="checkbox"/> Proof of age for _____ _____ <input type="checkbox"/> Proof of wages (pay stubs, etc.) <input type="checkbox"/> Proof of other income (SSI, VA, social security, etc.) <input type="checkbox"/> Employer's address and phone number <input type="checkbox"/> Rent receipts and/or utility receipts <input type="checkbox"/> Social Security cards for you and your child(ren) <input type="checkbox"/> Bank book and statements  <input type="checkbox"/> Other(s), listed below: _____	<input type="checkbox"/> Car Payment Book(s) <input type="checkbox"/> Written statement from the person you pay to take care of your child(ren), giving the amount <input type="checkbox"/> Tax receipt on property you own <input type="checkbox"/> Any life or burial insurance policy you have on yourself or child(ren) <input type="checkbox"/> Any NEW information you have on the absent father/mother of your child(ren)
---	--

It is important that I talk with you. If you cannot be available at the time shown above, please call me immediately at \_\_\_\_\_.

If I am not in the office, please leave a message for me. Thank you.

\_\_\_\_\_  
Worker's Signature

PSD-BSA-686 (11-83)  
 THIS FORM SUPERSEDES PSD-110 REVISED 8/78. PREVIOUS EDITIONS MAY BE USED.

ADULT SERVICE APPROVAL TO PROVIDE DAY CARE  
STATE OF ALABAMA  
DEPARTMENT OF PENSIONS AND SECURITY  
Montgomery

APPROVAL TO PROVIDE DAY CARE FOR ADULTS

\_\_\_\_\_  
Name(s)

\_\_\_\_\_  
Address  
\_\_\_\_\_

Dear

This is to advise you that your home has been approved by the \_\_\_\_\_  
\_\_\_\_\_ County Department of Pensions and Security to  
provide day care for adults according to standards established by the  
State Department of Pensions and Security and with the following conditions

Number of persons in day care at any one time \_\_\_\_\_

Special provisions \_\_\_\_\_

\_\_\_\_\_  
For this purpose, your home will be under the supervision of the  
\_\_\_\_\_ County Department of Pensions and Security.

This approval is subject to renewal one year from date of issuance  
and may be withdrawn for reasonable and just cause.

Issued this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

The \_\_\_\_\_ County  
Department of Pensions and Security

By \_\_\_\_\_

**ADULT SERVICES NURSING HOME AGREEMENT**  
**ALABAMA DEPARTMENT OF HUMAN RESOURCES**  
**ADULT SERVICES NURSING HOME AGREEMENT**

The \_\_\_\_\_ County Department of Human Resources (hereinafter referred to as "the Department") enters into this agreement with the \_\_\_\_\_ Health Care Center or Nursing Home (hereinafter referred to as "the Nursing Facility") to obtain certain services and goods for \_\_\_\_\_ which are not otherwise provided by Medicaid/Medicare or other third party provider at a specified price as stated in this agreement.

The Department agrees to pay a maximum of one hundred fifty dollars (\$150) per quarter for the above-named client effective through \_\_\_\_\_, for actual documented costs. Payment can only be made for (a) drugs and/or medical treatment not covered by Alabama Medicaid; and (b) personal items/services not covered by Medicaid. The Nursing Facility must certify to the Department that billed medications and treatments are not covered by Medicaid/Medicare or other third party providers. The Nursing Facility agrees to submit a quarterly itemized statement for the above-named client to the Department for payment as agreed herein.

The obligation to provide patient/client care or services is to be the same as that required under present laws and rules governing the Department and Nursing Facilities. No terms agreed to in this document are to be interpreted as imposing additional legal obligations upon the Department or the Nursing Facility to provide patient/client care or services.

This is a financial agreement only between the undersigned parties. The terms of this contract shall be for a period beginning on \_\_\_\_\_, and ending on \_\_\_\_\_. This agreement may be extended based on the availability of funds, provided both parties agree to the extension and a notification of the extension is sent to the facility by the Department. It is expressly understood and agreed by the parties that any and all payments provided for in this agreement will under no circumstances constitute a debt of the State of Alabama as prohibited by Section 213, CONSTITUTION OF ALABAMA 1901, as amended by Amendment No. 26.

\_\_\_\_\_  
DHR Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Nursing Facility Representative

\_\_\_\_\_  
Date

DHR-ASD-1778  
June 1994

Distribution: White - Nursing Home  
Yellow - Client Case Record

Re: \_\_\_\_\_

DHR Case No: \_\_\_\_\_

Dear Sir or Madam:

Your facility, \_\_\_\_\_, currently has an agreement with the \_\_\_\_\_ County Department of Human Resources whereby the Department of Human Resources has agreed to pay up to \$150.00 per quarter for certain expenses of the above-named client. The Department of Human Resources wishes to extend this agreement for a period of one (1) additional year. The terms of this extension are the same as those in the original agreement.

Please contact the \_\_\_\_\_ County Department of Human Resources at \_\_\_\_\_ if you do not wish to have this agreement extended, or if you have any questions concerning the extension.

Sincerely,

\_\_\_\_\_  
Social Worker

AS AUTHORIZATION FOR D&E/MHC SERVICES

ADULT SERVICES

AUTHORIZATION FOR D&E/MHC SERVICES

TO: \_\_\_\_\_  
(Provider's Name)

FROM: \_\_\_\_\_ County Department of  
Human Resources

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Provider's Address)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(County Department's Address)

RE: \_\_\_\_\_  
(Client's Name)

\_\_\_\_\_ (Case No.) \_\_\_\_\_ (Category of Elig.)

SERVICE AUTHORIZED: This is to authorize the following D&E/MHC service(s) for the above named client. See reverse for definitions of these services. One unit equals 30 minutes

- /  D&E Maximum payment is \$ \_\_\_ per unit for \_\_\_ units of service
- /  MHC-I Maximum payment is \$ \_\_\_ per unit for \_\_\_ units of service.
- /  MHC-F Maximum payment is \$ \_\_\_ per unit for \_\_\_ units of service.
- /  MHC-G Maximum payment is \$ \_\_\_ per unit for \_\_\_ units of service.

CLIENT NEEDS: Specific needs to be met by mental health services.

- 1.
- 2.
- 3.
- 4.

REIMBURSEMENT PROCEDURE: Billing forms must show the client's name, DHR case number, specific service(s) rendered (D&E and/or MHC-I, F, or G), the number of units of service provided, and the total amount of the bill. The bill should be returned to the County Department, at the address above, within 60 days.

NOTE: A report on the service(s) provided the client must be attached to the bill for said service(s) prior to the bill being paid by the County Department. For D&E, the report must be the D&E. For MHC, the report may be a summary of the counseling sessions, however, the County Department may request additional information.

\_\_\_\_\_  
(Social Worker Signature)

\_\_\_\_\_  
(Date)

AS HOMEMAKER SERVICE CONTRACT

FD-302

2/80

HOMEMAKER SERVICE CONTRACT

Name of Person to be Served \_\_\_\_\_ Case No. \_\_\_\_\_

Name of Homemaker \_\_\_\_\_

Service to be Provided: Monday - \_\_\_\_\_ to \_\_\_\_\_
Tuesday - \_\_\_\_\_ to \_\_\_\_\_
Wednesday - \_\_\_\_\_ to \_\_\_\_\_
Thursday - \_\_\_\_\_ to \_\_\_\_\_
Friday - \_\_\_\_\_ to \_\_\_\_\_

Beginning Date of This Contract \_\_\_\_\_

The Homemaker is to: (List tasks to be performed and how often for each.)
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Your homemaker is not a maid. She (or he) is part of a team of people who are trying to help you stay at home as safely and comfortably as possible. The tasks listed on this contract for the homemaker to do are those you and the team have decided on; please do not ask your homemaker to change the contract in any way. Your social worker is the person you need to talk to if you feel this contract needs to be changed. Your social worker is \_\_\_\_\_ at telephone number \_\_\_\_\_.

If you cannot reach your social worker, you may call \_\_\_\_\_ at number \_\_\_\_\_. The homemaker is required to leave your home as soon as the assigned tasks have been completed.

NOTE: The homemaker is a state employee. As such, she earns a certain amount of vacation time and sick leave, and she is not required to work on state holidays. If you have a telephone, you will be notified when the homemaker is not to come to your home. There may be times when we will have to notify you at the last minute.

Present plans call for homemaker services to be provided until (date) \_\_\_\_\_. At that time your social worker will consider whether homemaker service is to be stopped or continued.

Client Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

Social Worker Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

Revision No. 39
February 5, 1980
-BSA-821
formerly PSD-362)

AS FOSTER CARE PAYMENT AGREEMENT/TRANSPORTATION AUTHORIZATION

ALABAMA DEPARTMENT OF HUMAN RESOURCES  
ADULT FOSTER CARE PAYMENT AGREEMENT/TRANSPORTATION AUTHORIZATION

Name of Foster Care Client \_\_\_\_\_ Case No. \_\_\_\_\_

Name of Foster Care Provider \_\_\_\_\_ Resource Case No. \_\_\_\_\_

Effective Date \_\_\_\_\_ Renewal Date \_\_\_\_\_

For the provision of foster care, the following amount is to be paid on or before the 5th of each month by \_\_\_\_\_ to \_\_\_\_\_:

ROOM and BOARD \$ \_\_\_\_\_. Includes food, shelter, household supplies, fuel, lights, and water.

SERVICE FEE \$ \_\_\_\_\_.

ADDITIONAL SERVICES AND SUPPLIES \$ \_\_\_\_\_. Includes:

Laundry \_\_\_\_\_  
Medicine chest supplies \_\_\_\_\_  
Prescription Medicine \_\_\_\_\_

Transportation \_\_\_\_\_  
Personal Hygiene Items \_\_\_\_\_  
List (1) \_\_\_\_\_ (4) \_\_\_\_\_  
(2) \_\_\_\_\_ (5) \_\_\_\_\_  
(3) \_\_\_\_\_ (6) \_\_\_\_\_  
Other (specify) \_\_\_\_\_  
Cosmetics \_\_\_\_\_  
Burial Insurance \_\_\_\_\_

TOTAL MONTHLY PAYMENT \$ \_\_\_\_\_.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Worker's Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorization is given for transportation to be provided by the foster care provider. The provider must have a valid Alabama driver's license and vehicle liability insurance.

Client \_\_\_\_\_ OR \_\_\_\_\_ Responsible Person

Date \_\_\_\_\_ Date \_\_\_\_\_

# AS EMERGENCY SHELTER AGREEMENT

ALABAMA DEPARTMENT OF HUMAN RESOURCES

## EMERGENCY SHELTER CARE AGREEMENT

This Agreement is entered into between the \_\_\_\_\_ County Department of Human Resources and \_\_\_\_\_ (provider). Under the terms of this agreement, \_\_\_\_\_ (provider) agrees to provide emergency shelter care for a period up to 28 days for the following elderly or disabled adult:

Name	Date of Birth or Age
------	----------------------

The provider of emergency shelter care for adults agrees to the following conditions:

1. To provide care for 24 hours per day in a protective setting. This includes the provision of shelter, supervision, and nutritious meals and snacks.
2. To operate the home for the provision of emergency shelter care seven days a week, including State holidays.
3. To maintain records and submit reports as required by the Department of Human Resources and to make all records available upon request.
4. To comply with the requirements of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973.
5. To comply with the requirements for safeguarding client information in accordance with Department directives.
6. To notify the County Department 10 days in advance of an expected temporary closing; e.g., vacation, and as soon as possible for an unexpected temporary closing; e.g., illness.

The Department of Human Resources agrees to the following conditions:

1. To ensure payment is made to the emergency shelter care provider. Payment must be in accordance with State policy regarding payments for adult shelter care of \$18 per day for each adult.
2. To assist and advise the provider of emergency shelter care for adults.
3. To submit DHR-ASD-500, "Emergency Information" to provider upon Adult's entry into the home.

This Agreement may be terminated by either party by giving thirty (30) days advance notice. The Agreement may be terminated without advance notice under the following conditions:

1. In the event of an emergency affecting the provider, such as illness, death, or fire.
2. In case of emergency, the Department of Human Resources reserves the right to terminate this agreement.

\_\_\_\_\_  
(Worker's Signature)

\_\_\_\_\_  
(Provider's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

AS HOMEMAKER/SOCIAL WORKER RECEIPT

HOMEMAKER/SOCIAL WORKER RECEIPT

\_\_\_\_\_ COUNTY DEPARTMENT OF HUMAN RESOURCES

Section I

I, \_\_\_\_\_, received from \_\_\_\_\_  
Homemaker/Social Worker Client

\$ \_\_\_\_\_ for payment of \_\_\_\_\_

\_\_\_\_\_  
Homemaker/Social Worker Date

\_\_\_\_\_  
Client's Signature Date

Section II

\$ \_\_\_\_\_ Returned

\_\_\_\_\_ Receipts Returned

\_\_\_\_\_  
Homemaker/Social Worker Date

\_\_\_\_\_  
Client's Signature Date

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

# REPORT OF ADULT SUSPECTED TO BE ANE

DHR-ASD-798  
August 1996

DEPARTMENT OF HUMAN RESOURCES

## REPORT OF ADULT SUSPECTED TO BE ABUSED, NEGLECTED OR EXPLOITED

COUNTY NAME	COUNTY NO.	DHR CASE NO.	WORKER RECEIVING REPORT	DATE REC'D IN COUNTY
-------------	------------	--------------	-------------------------	----------------------

TYPE <input type="checkbox"/> ABUSE <input type="checkbox"/> NEGLECT <input type="checkbox"/> EXPLOITATION	CODE	DATE OF INCIDENT
LOCATION <input type="checkbox"/> IN-HOME <input type="checkbox"/> OUT OF HOME (NH/Hosp) <input type="checkbox"/> OUT OF HOME (Other)		TIME

Last Name	First Name	MI	Sex	Race	Date of Birth	Social Security #
Address				Zip		Phone #

DESCRIPTION OF CLIENT/DIRECTIONS TO LOCATE

SPONSOR/RESPONSIBLE PARTY

<input type="checkbox"/> ADD ALLEGED PERPETRATOR					
Last Name	First Name	MI	Relationship to Victim	Phone#	
Address			Social Security #	Sex	Race    DOB
Last Name	First Name	MI	Relationship to Victim	Phone#	
Address			Social Security #	Sex	Race    DOB

Victim	Perpetrator	Victim	Perpetrator	Victim	Perpetrator
_____	_____ Physical Dependence	_____	_____ Behavioral Disorders	_____	_____ Substance Abuse
_____	_____ Emotional Problems	_____	_____ Mental Retardation	_____	_____ Other _____
_____	_____ Mental Problems	_____	_____ Economic Dependence		

Alleged Nature of Incident	Alleged Result of Incident
_____ Physical Abuse	_____ Physical Injury or Risk    Location of Injury _____
_____ Sexual Abuse	_____ Sexual Injury or Risk
_____ Psychological / Emotional Abuse	_____ Improper Medical Care
_____ Exploitation	_____ Psychological / Emotional Injury
_____ Physical Neglect ( __ Self / __ Others)	_____ Financial Injury
_____ Environmental Neglect ( __ Self / __ Others)	_____ Poor Physical Condition
_____ Medical Neglect ( __ Self / __ Others)	_____ Isolation
_____ Psychological / Emotional Neglect ( __ Self / __ Others)	_____ Potentially Dangerous Environment
_____ Other (Specify) _____	_____ Unknown
	_____ Other (Specify) _____

MANDATORY REPORTER

Reporter's Statement of Incident \_\_\_\_\_

Witness Name and How to Contact \_\_\_\_\_

Report Initially Received by     Police     Sheriff     DHR     Hotline     Other

Name or Signature of Reporter \_\_\_\_\_

Address/Phone Number of Reporter \_\_\_\_\_

Relationship of Reporter to Victim:     Relative \_\_\_\_\_ (Specify Relationship)

Court Representative     Ombudsman     Other \_\_\_\_\_ (Title)

Allegation	Alleged Perpetrator I	Alleged Perpetrator II	Remained In	Placed In
_____ Founded	_____ Founded	_____ Founded	_____ Own Home	_____ Relative Home
_____ Unfounded	_____ Unfounded	_____ Unfounded	_____ Other Setting	_____ FC    _____ ALF    _____ NH
_____ Undetermined	_____ Undetermined	_____ Undetermined		_____ Hospital
	_____ Requested adm. hearing	_____ Requested adm. hearing		_____ State Mental Inst.    _____ Other MI / MR Fac.
			_____ Deceased	_____ Other _____

Name or Signature of Worker COMPLETING Investigation \_\_\_\_\_    Worker's Social Security # \_\_\_\_\_

Date Investigation Initiated	Date Investigation Completed	Case Referred To:	DATE ENTRY DATE:
		<input type="checkbox"/> Court <input type="checkbox"/> Law Enforcement <input type="checkbox"/> District Attorney	

Distribution:    White: Client Case Record    Yellow: SDHR    Pink: County Special File

**AUTHORIZATION OF ADULT DAY CARE HOME TRANSPORTATION**

STATE OF ALABAMA  
 PSD-296  
 June, 1976

AUTHORIZATION OF ADULT DAY CARE <sup>Home</sup> TRANSPORTATION

Name of Adult Day Care Center/Home \_\_\_\_\_

Address \_\_\_\_\_

You are hereby authorized to provide transportation for \_\_\_\_\_

(name of client) \_\_\_\_\_, case no. \_\_\_\_\_, category \_\_\_\_\_

, from \_\_\_\_\_ (address)

to your day care center/home and/or from your day care center/home to

\_\_\_\_\_ (address)

This service is authorized from \_\_\_\_\_ to \_\_\_\_\_ (date to begin) (date to end)

on the following schedule each week.

	Transportation to Center/Home	Transportation from Center/Home
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Adult day care transportation payment will be made according to the agreement signed \_\_\_\_\_ (date)

Signed \_\_\_\_\_  
 Adult Service Worker

\_\_\_\_\_ County Department  
 of Pensions and Security

1 copy to adult day care center/home

1 copy to service record

APPLICATION TO PROVIDE HOME DAY CARE FOR ADULTS

State of Alabama  
PSD-234  
August, 1974

APPLICATION TO PROVIDE HOME DAY CARE FOR ADULTS

Applicant \_\_\_\_\_  
Last Name First Name D.O.B. Race S. S. No.

Spouse \_\_\_\_\_  
Last Name First Name D.O.B. Race S. S. No.

Address \_\_\_\_\_

Full directions for reaching home \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone No. \_\_\_\_\_

How many persons would you want in day care at any one time? (No more than 4) \_\_\_\_\_

Describe the number and size of rooms to be used by persons in day care, also porches, outdoor space, etc.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you are interested in providing day care other than 8 a.m. to 5 p.m., what hours do you have in mind? \_\_\_\_\_

If you are the only adult in your home during the day, what arrangements would you have for the help of another adult in event of emergency?  
\_\_\_\_\_  
\_\_\_\_\_

Source of income \_\_\_\_\_ Monthly income \_\_\_\_\_

Other Members of Household, Including Own Children

Name	D.O.B.	Relationship to Applicant	Occupation or Grade in School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How did you become interested in day care for adults? \_\_\_\_\_

Why do you wish to provide day care for adults now? \_\_\_\_\_

References: Please list three persons not related to you whom you have known for at least two years.

_____	_____	_____
Name	Address	Phone No.
_____	_____	_____
Name	Address	Phone No.
_____	_____	_____
Name	Address	Phone No.

DAY CARE HOME AGREEMENT

I (or we) agree, if approved to provide day care for adults:

1. To accept only persons referred by the County Department of Pensions and Security.
2. To allow the representative of the County Department of Pensions and Security (the PSD worker) to visit my home at any reasonable time (usually by appointment), and to provide the opportunity for the worker to interview the person in day care in private, upon request.
3. To observe and share information about the well-being of the person in day care with the PSD worker and to report any unusual sickness, accident or disturbing behavior to the PSD worker.
4. To accept the supervision of the County Department of Pensions and Security and to cooperate with the PSD worker in following suggestions and recommendations regarding the health and well-being of the person(s) in day care.
5. To accept the PSD worker's decision to remove the person(s) from day care when, in the worker's opinion, such removal is indicated.
6. To maintain good physical standards in my home, giving consideration to the safety, light, heat, ventilation, cleanliness and sanitation, and to comply with local regulations concerning these matters.
7. To report to the County Department of Pensions and Security any change of address or any serious or continued illness in my family.

\_\_\_\_\_  
Signature of applicant Date \_\_\_\_\_

\_\_\_\_\_  
Signature of spouse Date \_\_\_\_\_

AS CONTRACT REFERRAL/AGREEMENT

/ / E/D Waiver  
/ / Title XX

ADULT SERVICES CONTRACT REFERRAL/AGREEMENT

TO: (1) \_\_\_\_\_  
Agency Contract No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

FROM: (2) \_\_\_\_\_  
Case Manager/Social Worker DHR Telephone No. \_\_\_\_\_

\_\_\_\_\_ County Department of Human Resources

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

REGARDING: (3) \_\_\_\_\_  
Client's Last Name First Name MI DHR Case No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Social Security No. \_\_\_\_\_

Responsible Person \_\_\_\_\_ Telephone No. \_\_\_\_\_

The above named Adult Services client is being referred to you for the following service(s) effective (4) \_\_\_\_\_

\_\_\_\_\_ Homemaker \_\_\_\_\_ Personal Care \_\_\_\_\_ Unskilled Respite Care \_\_\_\_\_ Skilled Respite Care \_\_\_\_\_

The frequency of service, requested schedule (if indicated), and specific duties authorized are as follows: (5)

Homemaker (Circle one: E/D Waiver or Title XX)

Personal Care (E/D Waiver only)

Frequency \_\_\_\_\_  
# hours/day # days/week  
Requested Schedule \_\_\_\_\_

Frequency \_\_\_\_\_  
# hours/day # days/week  
Requested Schedule \_\_\_\_\_

Specific Duties Authorized

Specific Duties Authorized

- Cleaning \_\_\_\_\_
- Sweeping \_\_\_\_\_
- Dusting \_\_\_\_\_
- Changing bed linens \_\_\_\_\_
- Cleaning stove/refrigerator \_\_\_\_\_
- Laundry \_\_\_\_\_
- Ironing \_\_\_\_\_
- Mending \_\_\_\_\_
- Mopping \_\_\_\_\_
- Meal Planning \_\_\_\_\_
  - Special diet \_\_\_\_\_
  - Marketing \_\_\_\_\_
  - Preparing \_\_\_\_\_
  - Serving \_\_\_\_\_
- Correspondence \_\_\_\_\_
- Teaching household management \_\_\_\_\_
- Helping client with treatment prescribed by Doctor (specify) \_\_\_\_\_

- Assisting with hygiene (specify) \_\_\_\_\_
  - Dressing \_\_\_\_\_
  - Bathing \_\_\_\_\_
  - Eating \_\_\_\_\_
  - Shaving \_\_\_\_\_
- Assisting with Transfer \_\_\_\_\_
- Assisting with Ambulation \_\_\_\_\_
  - Bladder \_\_\_\_\_
  - Bowel \_\_\_\_\_
  - Bed Pan \_\_\_\_\_
- Assisting with medications that are self administered by the individual \_\_\_\_\_
- Meal Planning \_\_\_\_\_
- Preparation \_\_\_\_\_
- Maintaining sanitation (specify) \_\_\_\_\_

- Reminding client to take medication \_\_\_\_\_
- Transportation \_\_\_\_\_
- Running errands \_\_\_\_\_
- Assisting with personal hygiene (specify) \_\_\_\_\_

- Arranging furniture \_\_\_\_\_
- Accompanying client to medical facilities for diagnosis/treatment (specify) \_\_\_\_\_

AS FOSTER CARE REAPPROVAL

ALABAMA DEPARTMENT OF HUMAN RESOURCES

Page \_\_\_\_\_

ADULT FOSTER HOME REAPPROVAL

Provider(s) \_\_\_\_\_ County \_\_\_\_\_  
 Address \_\_\_\_\_ Case No. \_\_\_\_\_  
 \_\_\_\_\_ Worker \_\_\_\_\_  
 \_\_\_\_\_ Date of Interviews \_\_\_\_\_  
 Phone No. \_\_\_\_\_

**Section I: Client(s) to Be Served**

1. Any change in provider's interest: Number of Clients \_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_  
 Social Habits \_\_\_\_\_ Limitations \_\_\_\_\_
2. Willing to provide Emergency Shelter Care? Yes \_\_\_\_ No \_\_\_\_ Willing to  
 provide out of the home respite care for Adult Foster Care Waiver clients?  
 Yes \_\_\_\_ No \_\_\_\_

**Section II: Foster Family**

1. Renewal "Application to Provide Foster Care for Adults" completed?  
 Yes \_\_\_\_ No \_\_\_\_
2. Note changes in family composition, finances, employment, character and  
 suitability: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Family medical statements current? Yes \_\_\_\_ No \_\_\_\_ If no, explain \_\_\_\_\_  
 \_\_\_\_\_ . Date next medical statement due \_\_\_\_\_
4. Has provider(s) received any additional training since last evaluation?  
 Yes \_\_\_\_ No \_\_\_\_ If yes, Date \_\_\_\_\_  
 Title \_\_\_\_\_ Place \_\_\_\_\_ Sponsor \_\_\_\_\_  
 \_\_\_\_\_

**Section III: Foster Home**

1. Any change in provider's residence? Yes \_\_\_\_ No \_\_\_\_
2. Note changes in space provided for client, transportation, provision of  
 meals, substitute caregivers, etc. \_\_\_\_\_  
 \_\_\_\_\_

**Section IV: Minimum Standards for Foster Homes for Adults**

1. Does home continue to conform to standards and regulations? Yes \_\_\_ No \_\_\_  
If no, explain \_\_\_\_\_  
\_\_\_\_\_
2. Current certificate of vaccination as required by law reviewed? Yes \_\_\_  
No \_\_\_ NA \_\_\_ If no, explain \_\_\_\_\_  
\_\_\_\_\_
3. Fire extinguisher checked by worker and in working order? Yes \_\_\_ No \_\_\_  
If no, explain \_\_\_\_\_  
\_\_\_\_\_
4. Smoke detectors tested by worker and operated properly? Yes \_\_\_ No \_\_\_  
If no, explain \_\_\_\_\_  
\_\_\_\_\_

**Section V. Reference Contacts for Foster Family**

1. Name \_\_\_\_\_ Address/Phone No. \_\_\_\_\_  
Relationship \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_
2. Name \_\_\_\_\_ Address/Phone No. \_\_\_\_\_  
Relationship \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_
3. Name \_\_\_\_\_ Address/Phone No. \_\_\_\_\_  
Relationship \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_

**Section VI: Reference Contacts for Primary Substitute Caregiver**

1. Name \_\_\_\_\_ Address/Phone No. \_\_\_\_\_  
Relationship \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_
2. Name \_\_\_\_\_ Address/Phone No. \_\_\_\_\_  
Relationship \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_
3. Name \_\_\_\_\_ Address/Phone No. \_\_\_\_\_  
Relationship \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_



AS FOSTER HOME STUDY

ALABAMA DEPARTMENT OF HUMAN RESOURCES  
ADULT FOSTER HOME STUDY

Page \_\_\_

Applicant \_\_\_\_\_ County \_\_\_\_\_  
Applicant \_\_\_\_\_ Case No. \_\_\_\_\_  
Address \_\_\_\_\_ Worker \_\_\_\_\_  
\_\_\_\_\_ Dates of Interviews \_\_\_\_\_  
Telephone No. \_\_\_\_\_

Section I: Client Population of Interest To Applicant(s)

- Age Range: 65 or over \_\_\_\_\_ 45 through 64 \_\_\_\_\_ 18 through 44 \_\_\_\_\_
- Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ No Preference \_\_\_\_\_
- Limitations: Physically Handicapped \_\_\_\_\_ Mentally Ill \_\_\_\_\_  
Mentally Retarded \_\_\_\_\_
- Social Habits: Smokes \_\_\_\_\_ Drinks \_\_\_\_\_ Attends Church Regularly \_\_\_\_\_  
Receives visits from family and friends \_\_\_\_\_
- Would Applicant(s) consider providing Emergency Shelter Care? Yes \_\_\_\_\_  
No \_\_\_\_\_ Out of the home respite care for Adult Foster Care Waiver client?  
Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Section II: Foster Family

- Applicant(s): Age \_\_\_\_\_  
Applicant #1 Applicant #2  
Can read and write? \_\_\_\_\_  
Applicant #1 Applicant #2
- Household Members: Number \_\_\_\_\_ All willing to accept foster client?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If no, explain \_\_\_\_\_
- Medical Statement/Tuberculin Tests Results: On file for each family  
member? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of most recent statement(s) \_\_\_\_\_  
Date of next statement(s) \_\_\_\_\_
- Finances: Total family income \$ \_\_\_\_\_ Sufficient to meet family  
needs? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, explain \_\_\_\_\_
- Employment: \_\_\_\_\_  
Normal work hours \_\_\_\_\_  
Applicant #1 Applicant #2  
Will work interfere with providing foster care? Yes \_\_\_\_\_ No \_\_\_\_\_  
explain \_\_\_\_\_

6. Character and Suitability: Does applicant(s) or any member of foster family have a criminal record? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide details \_\_\_\_\_

Has applicant(s) or any member of foster family ever been investigated for abuse, neglect or exploitation of a child or adult? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_

7. Experience/Training: Does applicant(s) have experience working with the elderly and disabled? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Dates \_\_\_\_\_ Skills \_\_\_\_\_  
Where \_\_\_\_\_  
acquired \_\_\_\_\_

Has applicant(s) received training to work with the elderly and disabled? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Date \_\_\_\_\_ Place \_\_\_\_\_  
By whom or what agency \_\_\_\_\_ Description of Training \_\_\_\_\_

8. Transportation: To be provided \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for medical \_\_\_\_\_ non-medical \_\_\_\_\_ needs. If no, what plans can be made for transportation needed by client \_\_\_\_\_

Provider has valid Alabama Driver's License \_\_\_\_\_ Liability Insurance \_\_\_\_\_

9. Substitute Caregiver(s): Under what circumstances will be used \_\_\_\_\_

Name, Address, and Phone Number \_\_\_\_\_

Name, Address, and Phone Number \_\_\_\_\_

**Section III: Foster Home: Indicate yes, no or n/a for each item below:**

1. Location: Urban \_\_\_\_\_ Rural \_\_\_\_\_ Is foster home accessible to: church \_\_\_\_\_  
doctor's office \_\_\_\_\_ hospital \_\_\_\_\_ shopping center \_\_\_\_\_  
grocery store \_\_\_\_\_ recreation \_\_\_\_\_ activity center \_\_\_\_\_  
public transportation \_\_\_\_\_

2. Telephone accessibility: In home \_\_\_\_\_. If not, have arrangements been confirmed with two neighbors for 24 hour access \_\_\_\_\_

3. Health, Fire and Safety Features/Standards:

Check compliance, non-compliance or not applicable. Space is provided for comments on those features/standards that are not in compliance.

	Compliance	Non Compliance	N/A
<b>I. HOME</b>			
A. Screened windows			
B. Screened fireplaces			
C. Screened heaters			
D. Well lighted			
E. Comfortably heated/cooled			
F. Adequate ventilation			
G. Exits available			
H. All heaters vented			
I. Smoke detector standard met			
1. Proper placement and number			
2. Operational			
J. Fire extinguisher standard met			
1. Proper placement			
2. Operational			
K. Cleanliness and sanitation			
L. Mobile Home Standards met			
1. Aluminum plate attached (indicate conformity to 1974 National Mobile Home Construction and Safety Standard Act)			
2. Complies with anchor/tie down require- ment of <u>Code of Alabama 1975,</u> (Section 24-5-30 thru 24-5-34)			
<b>II. GROUNDS</b>			
A. Free of abandoned cars/household appliances			
B. Free of exposed lumber with nails			
C. Covered wells/cisterns			
<b>III. SAFEGUARDS</b>			
A. Guns/explosives secured			
B. Household cleansers/chemicals, poisons/drugs secured			
C. Non-skid rugs			
D. Banisters/Bars			
1. Stairs			
2. Outside steps			
3. Bathroom			
E. Rubber mats/strips in bathtub/shower			
F. Emergency plan developed			
G. Swimming pool standard met			
1. Use supervised by person(s) trained in CPR and Basic Water safety			
2. Otherwise, inaccessible to clients			
I. Animal/pet safety standard met			
1. Animal posing threat inaccessible			
2. Certificate of rabies vaccination for pets			

Comments: \_\_\_\_\_



**Section VII: Worker's Assessment (Strengths and Weakness of prospective provider(s), type of client to be considered for placement, etc.)**

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

**Section VIII: Disposition**

Application DENIED: Date \_\_\_\_\_ Reason \_\_\_\_\_  
Written Notice to Applicant(s) \_\_\_\_\_

Approved: Date \_\_\_\_\_ Number of Clients \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Limitations or Handicaps \_\_\_\_\_

Name(s), Address and Social Security Number(s) to Office of Program Operations, Adult Services Division, for General Liability Trust Fund:  
Date \_\_\_\_\_

**REAPPROVAL DUE** \_\_\_\_\_

Worker's Signature \_\_\_\_\_ Date \_\_\_\_\_

AS REPORT OF PHYSICIAN'S EXAMINATION FOR DAY CARE/FOSTER CARE

ALABAMA DEPARTMENT OF HUMAN RESOURCES
REPORT OF PHYSICIAN'S EXAMINATION FOR
DAY CARE/FOSTER CARE FOR ADULTS

Name \_\_\_\_\_ Date of birth \_\_\_\_\_
Address \_\_\_\_\_ Case No. \_\_\_\_\_
Worker \_\_\_\_\_

TO PHYSICIAN:

// Day care for adults is for older or disabled persons who need care during the day, because they either live alone and cannot manage entirely on their own or because family members/caretakers need to be relieved of some of the responsibility for their care in order to avoid institutionalization, thus extending the length of time they are able to live in the community.

// Foster care for adults is for people who, because of physical, mental or emotional limitations, are unable to live independently in the community and who need and desire the support and security of family living.

This examination and recommendation are needed to help determine whether care in day care and/or a foster home setting is appropriate for this person at this time. If you do not feel it would be suitable for this person to participate, please explain. If you have questions about the program or the appropriateness of it for this person, please do not hesitate to call me.

IF PAYMENT IS AUTHORIZED below, a statement showing name of person examined, date of service, service provided and amount of charge must be submitted in duplicate with the original signed.

Payment to maximum of \$10.00 is authorized/is not authorized. (Strike out one)

The \_\_\_\_\_ County Department of Human Resources
By \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

I authorize the physician or medical facility to furnish a complete report of my examination to the Department of Human Resources.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

PHYSICIAN'S STATEMENT

- 1. General state of health: Good \_\_\_ Poor \_\_\_ Very Poor \_\_\_
2. Does this patient have any condition that might be harmful to others? Yes \_\_\_ No \_\_\_ If yes, please explain
3. Is the patient under treatment? Yes \_\_\_ No \_\_\_ If so, for what condition?
4. Is the patient on medication? Yes \_\_\_ No \_\_\_ Can he take it without help? Yes \_\_\_ No \_\_\_
5. Does the patient need a special diet? Yes \_\_\_ No \_\_\_ If so, what type?
6. If a day-to-day health routine is necessary, please write instructions here:

7. When should the patient have the next check-up? \_\_\_\_\_
8. Is the patient able to care for his personal needs, such as shaving and bathing, with little or no assistance? Yes \_\_\_\_\_ No \_\_\_\_\_
9. What specific help will he need from others? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Can suitable care be given in day care and/or foster home (not nursing home)? Yes \_\_\_\_\_ No \_\_\_\_\_
11. Is the patient free of communicable diseases including T.B.? Yes \_\_\_\_\_  
No \_\_\_\_\_

I understand that payment can be made for this examination only if services are provided in compliance with the Civil Rights Act of 1964.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

AS APPLICATION TO PROVIDE FC

County \_\_\_\_\_  
Case No: \_\_\_\_\_

ALABAMA DEPARTMENT OF HUMAN RESOURCES  
APPLICATION TO PROVIDE FOSTER CARE FOR ADULTS

Initial Application \_\_\_\_\_ Renewal Application \_\_\_\_\_ (check one)

Applicant \_\_\_\_\_  
Last Name First MI DOB Race SSN Education

Applicant \_\_\_\_\_  
Last Name First MI DOB Race SSN Education

Your Social Security Number is required by the Departmental Administrative Rules in order to provide individual identification, a mechanism for matching criminal records information and an identification for purposes of Title XIX and Title XX contract and client services.

Address \_\_\_\_\_

Directions for Reaching Home \_\_\_\_\_

Telephone Number \_\_\_\_\_ Religious Preference \_\_\_\_\_

Applicant's Income Source Employer \_\_\_\_\_  
Applicant's Income Source Employer \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Other Household Members

Name Age Relationship Occupation or School grade

REASON FOR YOUR INTEREST IN PROVIDING FOSTER CARE FOR ADULTS \_\_\_\_\_

TRAINING/EXPERIENCE IN CARING FOR ADULTS \_\_\_\_\_

ADULTS FOR WHOM YOU WISH TO CARE: No. \_\_\_\_\_ Sex \_\_\_\_\_ No. of Bedrooms \_\_\_\_\_ Bathrooms \_\_\_\_\_

Have you or any member of your household been arrested, charged or convicted of a criminal offense? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate WHEN, WHERE, and the NATURE of the offense

Have you or any member of your household been investigated for suspected abuse, neglect or exploitation of a child or an adult? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate WHEN, WHERE, and the NATURE of the offense

REFERENCES: Please list three persons not related to you whom you have known for at least two years.

Name Address Phone Number

FOSTER HOME AGREEMENT

I (or We) agree, if approved to provide foster care for adults:

1. To accept only persons referred by the County Department of Human Resources.
2. To allow the representative of the County Department of Human Resources to visit my home any reasonable time and to provide the opportunity for the worker to interview the person in foster care in private, upon request.
3. To observe and share information about the well-being of the person in foster care with the DHR worker and to report any unusual sickness, accident or disturbing behavior to the DHR worker.
4. To accept the supervision of the County Department of Human Resources and to cooperate with the DHR worker in following suggestions and recommendations regarding the health and well-being of the person in foster care.
5. To accept the DHR worker's decision to remove the person from foster care when, in the worker's opinion, such removal is indicated.
6. To give to each person in foster care in my home the opportunity to go to the church of his/her choice if he/she wishes to do so.
7. To treat each person in foster care in my home as a member of the family.
8. To maintain good physical standards in my home, giving consideration to safety, light, heat, ventilation, cleanliness and sanitation, and to comply with local regulations concerning these matters.
9. To adhere to the Minimum Standards for Foster Homes for Adults.
10. To report to the County Department of Human Resources any change of address, or household composition or any serious or continued illness in my family.
11. To participate in training activities recommended or provided by the Department of Human Resources.
12. To notify the DHR worker before taking the person in foster care out of the county or state.
13. To give the DHR worker two weeks notice if I desire that other plans be made for the person in foster care or if I decide to relinquish my approval.

\_\_\_\_\_  
Signature of Applicant

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

Date \_\_\_\_\_

# REPORT OF ADOPTION

ALABAMA

## REPORT OF ADOPTION

**INSTRUCTIONS:** Parts I and II of this report must be completed by the petitioners, their attorney, or the Court. If the child was placed by a licensed child-placing agency or the State Department of Human Resources, information about 1) the natural parents, 2) place of birth of the child, and 3) birth certificate number may be omitted. This information is to be furnished to the State Registrar by the agency which placed the child. Within ten (10) days after the final decree of adoption has been made, the Clerk of the Court shall make his certification in Part III, affix his official seal, and forward this report with the final decree of adoption to the State Registrar, Center for Health Statistics, P. O. Box 5625, Montgomery, Alabama 36103-5625. If the child was born in Alabama a new certificate listing the child's new name and adoptive parents will be prepared. The fee to prepare this new birth certificate is \$20.00 payable to the Alabama State Board of Health. This fee also includes on certified copy of the new certificate. If the adopted child was not born in Alabama, the State Registrar will forward the certified copy of the final decree of adoption and the report of adoption to the proper official in the state of birth. The fee to forward the final decree of adoption and report of adoption to the proper official in the state of birth is \$10.00 payable to the Alabama State Board of Health. To obtain a certified copy of this birth certificate, contact the state of birth.

**PART I INFORMATION ABOUT CHILD (To Identify Original Birth Certificate)**

NOTE: If the official birth certificate number is entered, the names of the father and mother may be omitted.

Full Name of Child at Birth			Birth Certificate Number
First	Middle	Last	
Place of Birth	City-Town or Location	State and Country of Birth	Date of Birth
			Sex
Full Maiden Name of Natural Mother			Race
First	Middle	Last	
Full Name of Legal Father			Race
First	Middle	Last	

**PART II INFORMATION AFTER ADOPTION (For New Birth Certificate)**

Full Name of Child After Adoption			
First	Middle	Last	
FATHER - Full Name			Race
First	Middle	Last	
Father's State of Birth	(if not in U.S.A. name country)	Father's Date of Birth	Father (Check One)
			Adoptive <input type="checkbox"/> Natural <input type="checkbox"/>
MOTHER - Maiden Last Name	Mother's Legal Name	First	Race
		Middle	
		Last	
Mother's Date of Birth	Mother's State of Birth	(if not in U.S.A. name country)	Mother's Usual Residence - State
Mother's Residence - County	Mother's Residence - City or Town and Zip Code		
Mother's Residence - Street Address (if rural, give location)	Mother's Residence - Inside City Limits (specify Yes or No)	Mother (Check One)	
		Adoptive <input type="checkbox"/> Natural <input type="checkbox"/>	
Mailing Address of Adoptive Parents			
Name and Full Address of Attorney Or Agency Representative		Phone Number	Title

**PART III CERTIFICATION OF CLERK OF COURT**

Must be properly signed, dated and sealed

Name of Court _____	For City, County of _____
I hereby certify that the adoption as set forth above was made final in this Court by decree dated _____	
And bear No. _____	
(Seal)	Signature _____
	Title _____
	By _____

**CHILD DESIRED**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Note any particular characteristics of a child that have special significance for the prospective adoptive parents and state reasons. (NOTE Matching of physical characteristics is not a routine criteria in selecting adoptive parents for a particular child.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Age Range of Child Desired: \_\_\_\_\_

3. Sex of Child Desired: \_\_\_\_\_

4. Mixed Racial Heritage	Acceptable	Willing To Discuss	Not Acceptable
A. Black / White	_____	_____	_____
B. Asian / Black	_____	_____	_____
C. Asian / White	_____	_____	_____
D. Hispanic / Black	_____	_____	_____
E. Hispanic / White	_____	_____	_____
5. Number of Children			
A. One Child	_____	_____	_____
B. Sibling group of two	_____	_____	_____
C. Sibling group of three or more	_____	_____	_____
5. Age of Children in Sibling Group			
A. Pre-schoolers	_____	_____	_____
B. Pre-schooler (s) and infant(s)	_____	_____	_____
C. Pre-schooler (s) and school aged	_____	_____	_____
7. Birth Marks			
A. On the body	_____	_____	_____
B. Facial	_____	_____	_____
8. Medical and Physical Problems			
A. Has a slight limp	_____	_____	_____
B. Needs leg braces	_____	_____	_____
C. Cerebral Palsy	_____	_____	_____
D. Cystic Fibrosis	_____	_____	_____
E. Spina Bifida	_____	_____	_____
F. Hare Lip and / or Cleft Palate	_____	_____	_____
G. Has a missing limb	_____	_____	_____
H. Has Kidney problems which may require surgery or Dialysis	_____	_____	_____
I. HIV Positive (without AIDS Symptoms)	_____	_____	_____
J. AIDS or ARC (Aids Related Complex)	_____	_____	_____

Controlled by medication

- B. Seizure disorder not controlled but child has seizures  
Infrequently

10. Blood Disorders

- A. Has a blood disorder that requires frequent transfusions and hospitalization
- B. Blood disorder – life span is limited
- C. Sickle Cell Anemia
- D. Sickle Cell Trait

11. Heart Conditions

- A. Has a heart murmur, activity not curtailed
- B. Heart Murmur, vigorous activity curtailed
- C. May require open heart surgery at a later date but at placement just has to be watched
- D. Definitely will require open heart surgery

12. Visual Impairment

- A. Has sight in both eyes but vision is limited
- B. Has sight in only one eye
- C. Is blind but surgery may give partial sight

13. Hearing Impairment

- A. Has hearing problem with only partial hearing and surgery may Help
- B. Has hearing problem with partial hearing but surgery will not help
- C. Has hearing in only one ear

14. Speech Problems

- A. Has severe speech problem
- B. Speech therapy needed

15. Diabetic Conditions

- A. Borderline diabetic, dietary control necessary
- B. Juvenile Diabetes, requiring daily injections

- B. Encopresis (soiling)
- C. Sexual Acting Out
- D. Sexual Abuse History
- E. Child will need periodic therapy because of emotional problems
- F. Child will need continuous therapy because of emotional problems
- G. Post Traumatic Stress Disorder
- H. Oppositional Defiant Disorder
- I. Child has prescription psychotropic medication

17. Learning Impairments

- A. Attention Deficit Disorder
- B. Attention Deficit Disorder with Hyperactivity
- C. Dyslexia
- D. Learning disabilities, child has difficulty in certain areas rather than with overall capabilities
- E. Slow learner; child's intellectual development is somewhat delayed; may need to repeat a grade
- F. Educable retarded, will require special classes in school, but will be able to work in competitive employment in the community
- G. Trainable retarded, will need special classes in school and will generally be able to work in sheltered employment
- H. Severely retarded, needs training for self help skills and will never be self sufficient as an adult
- I. Downs Syndrome
- J. Autism

18. Availability of Background on Child

- A. No background on child available (Foundling)
- B. Background on one parent only

**HEALTH AND SOCIAL FACTORS IN BACKGROUND OF PARENTS OF CHILD**

	Acceptable	Willing To Discuss	Not Acceptable
<b>9. Social Factors of Parents of Child</b>			
A. Alcoholism	_____	_____	_____
B. Prostitution	_____	_____	_____
C. Criminal Record	_____	_____	_____
D. Child born of incestuous relationship	_____	_____	_____
E. Child born of regular drug abuse	_____	_____	_____
F. Drug addiction	_____	_____	_____
G. Drug experimentation	_____	_____	_____
<b>10. Mental History</b>			
A. Mental illness in child's parent (s)	_____	_____	_____
B. Isolated case of mental illness in family	_____	_____	_____
C. Pattern of mental illness in family	_____	_____	_____
D. Mental retardation in child's parent(s)	_____	_____	_____
E. Isolated instance of mental retardation in family	_____	_____	_____
F. Pattern of retardation in family	_____	_____	_____
G. Isolated instance of slow learner	_____	_____	_____
<b>11. Medical Background of Child's Family</b>			
A. Venereal Disease	_____	_____	_____
B. Hemophilia	_____	_____	_____
C. Tuberculosis	_____	_____	_____
D. Diabetes	_____	_____	_____
E. Moderate allergies	_____	_____	_____
F. Epilepsy	_____	_____	_____
G. Hypertension	_____	_____	_____
H. Cancer	_____	_____	_____
I. Heart disease	_____	_____	_____
<b>22. Ability to Accept Legal Risks</b>			
A. Willingness to accept child where alleged father's rights not considered by court	_____	_____	_____
B. Willingness to accept child during appeal process	_____	_____	_____
Willingness to accept child on foster care basis pending court termination of parents' rights	_____	_____	_____

**CHILD ABUSE/NEGLECT CENTRAL REGISTRY CLEARANCE**  
**ALABAMA DEPARTMENT OF HUMAN RESOURCES**  
**CHILD ABUSE / NEGLECT (CA/N) CENTRAL REGISTRY CLEARANCE**

**PRINT OR TYPE** in black or blue ink. Additional information regarding the CA/N Central Registry is on the back of this form.  
**\*\* See instructions for the address to use when submitting this form. \*\***

Requesting Person or Agency/Organization	<b>Check All That Apply</b>
Mailing Address	<input type="checkbox"/> Child Placing Agency
	<input type="checkbox"/> Residential Child Care Facility
	<input type="checkbox"/> Child Day / Night Care Center
Telephone Number ( )	<input type="checkbox"/> Family Day / Night Care Home
<b>PRINT</b> Requestor's Name	<input type="checkbox"/> Exempt Child Day Care Center
Requestor Signature Date	<input type="checkbox"/> Medicaid Rehab. Provider DHR Vendor
Witness Signature Date	<input type="checkbox"/> Other (Please Specify)

The person whose name and identifying information, printed or typed below, will provide **unsupervised care and supervision of children** as an  employee  volunteer  other. This person's specific job/role is or will be:

\_\_\_\_\_

Name \_\_\_\_\_ Sex  Male  Female Race \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Last First Middle

Current Mailing Address \_\_\_\_\_

Alias, Maiden & Prior Married Name(s) \_\_\_\_\_

Name & DOB of Spouse & Former Spouse(s) \_\_\_\_\_

Name & DOB of Children / Stepchildren \_\_\_\_\_

Alabama counties where person has lived and/or worked \_\_\_\_\_

**Attach additional pages as needed to provide all information requested above.**

**To be completed by person being cleared**

I authorize the Alabama Department of Human Resources to release information contained in the Child Abuse / Neglect Central Registry about me to the above named person/agency/organization. I hereby waive any right to any review or hearing to which I may otherwise be entitled. I further release the Department of Human Resources, its officers, and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

**To be completed by DHR**

A search of the Alabama Child Abuse / Neglect Central Registry has been completed with the information provided to determine if the person identified above has been named as being responsible for child abuse or neglect in Alabama. DHR releases only that information which is necessary to discover or prevent child abuse / neglect.

- Substantiated report (i.e., indicated) located. See attached information.  
 Type Report:  Physical Abuse  Neglect  Sexual Abuse  Mental Abuse / Neglect
- No report or no substantiated (i.e., indicated) report located.
- Request Denied \_\_\_\_\_
- Other \_\_\_\_\_

Office of Child Protective Services \_\_\_\_\_ Date Completed \_\_\_\_\_

**CHECKLIST FOR DHR ADOPTION HOME STUDY**  
**CHECKLIST FOR DHR ADOPTION HOME STUDY**

**FORMS**

- Application, DHR-FCS-704 (signed & dated)
- Financial, DHR-FCS-706 (checked for accuracy & discussed with applicants)
- Relative Forms (for both applicants)
- Medicals for:
  - Husband
  - Wife
  - Children in the Home
  - Others in the Home
- Child Desired (checked with accuracy and discussed with applicants)
- GPS Profile, Roadwork, Strengths/Needs Worksheets

**VERIFICATIONS**

- Current / former marriages
- Divorces / Death of former spouses
- Criminal history suitability letter on all household members age 18 years and older
- CA/N Central Registry clearances on all household members age 14 years and older
- Pet vaccinations
- First Aid/CPR (if applicable)

**ORIGINAL NARRATIVE RECORDING**

- First consultation (joint interview if married couple)
- Individual interview with husband
- Individual interview with wife
- Second consultation (child centered)
- Interview with other household members (including other children of the applicants)
- References
  - Minister
  - Relative of husband
  - Relative of wife
  - Husband's employer
  - Wife's employer
  - Friend(s)
- Home visit / Minimum requirements for adoptive home met
- Documentation of participation in GPS "12 Skills for Successful Foster & Adoptive Parenting"
- Diagnosis, Evaluation and Recommendation of Applicants for Adoption

**OTHER**

- Recent color photograph
- Written autobiographies by applicant(s)

## CHECKLIST FOR INDEPENDENT ADOPTION HOME STUDY

### CHECKLIST FOR INDEPENDENT ADOPTION HOME STUDY

#### FORMS

- Financial, DHR-FCS-706 (checked for accuracy & discussed with applicants)
- Relative forms (for both applicants)
- Current Medicals for
  - Husband
  - Wife
  - Children in Home
  - Others in Home
  - Adoptee
- Medical History of Child (DHR-FSC-1748)
- Medical History of Child's Biological Parents (DHR-FCS-1749)

#### VERIFICATIONS

- Current marriage
- All former marriages
- All former divorces
- Deaths of former spouses
- Criminal history check letters on applicants and all household members age 18 and older
- Consents of all parties required to consent
- Adoptee's birth certificate
- Verify any third parties involvement in arranging placement
- Verification of fees and charges
- CA/N Central Registry Clearance on all household members age 14 years and older
- Pet Vaccinations
- First Aid/CPR verifications (if applicable)

#### ORIGINAL NARRATIVE RECORDING

- Joint (if couple) interview with petitioners
- Individual interview with husband
- Individual interview with wife
- Interview with other household members (including other children of the petitioners)
- References
  - Minister
  - Relative of husband
  - Relative of wife
  - Husband's employer
  - Wife's employer
  - Friend(s)
  - Observation of adoptee (within 45 days of placement)
  - Interview with birth mother
  - Interview with birth father and/or legal father
  - Home visit (within 45 days of placement)
  - Documentation of circumstances of the placement
  - Summary sheets - Identifying Information (1767) & Non-Identifying Information (1768)

## CHECKLIST FOR FC RECORDS SUBMITTED TO ADOPTION

### CHECKLIST FOR FOSTER CARE RECORDS SUBMITTED TO OFFICE OF ADOPTION

#### Complete Record (Original)

- White narrative (up-to-date)
- All legal documents and court reports
- Blue narrative (if available) since court child has been in foster care
- Face Sheet (PSD 213)
- Last Individualized Service Plan

#### Verifications

- Child's birth certificate
- All marriages and divorces of child's parents

#### Information on Child

- Birth medicals (if born in Alabama or if can be obtained from other states)
- Developmental information
- School information (IQ tests, IEPs, report cards, behaviors, grade level, etc.)
- Current medical
- Previous medical reports from any physicians who have treated the child since entering foster care including records of hospitalizations, Crippled Children's reports, Medicaid screening
- Physical description
- Adjustment to foster care
- Narrative of child's understanding of adoption, attitude toward adoption etc.
- Narrative of child's relationship with siblings, biological parents, other relatives
- Psychological evaluations, D & E reports, counseling reports
- Narrative of child's behavior, habits, personality, experiences
- Immunization record
- Sickle cell test on all children of black heritage
- Recent color photograph

#### Information on Biological Family

Unless otherwise specified below, the items must be covered on the child's mother, legal or alleged father, grandparents, siblings of the child, aunts and uncles, and other extended family members

- Physical Description
- Prenatal care received by mother
- Information about personalities, attitudes, experiences, talents
- Information on drug or alcohol usage, including type and extent of drug usage
- Educational levels, individual Special Education placements
- Marital history
- For involuntary placements, complete discussion with both parents on understanding of adoption
- Complete health histories on both parents, including mental illness, mental retardation
- Health history on other family members (illnesses, dates, causes of death, inheritable diseases)
- Criminal history (charges, convictions, time served, other punishment)
- Employment (history, type work)
- Parents' Social Security numbers
- Psychological, if indicated, and description of level of functioning
- Parents' dates of birth

**ADOPTION MEDICAL HISTORY**

**MEDICAL HISTORY OF CHILD TO BE PLACED FOR ADOPTION\***

**I. BIRTH INFORMATION**

Name of Child \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

Other Birth Statistics: \_\_\_\_\_

Describe any birth complications and/or treatments (Attach medical reports with official documentation).

**II. IMMUNIZATION RECORD:** (Attach copy of record if available. If unavailable, list dates and types of immunizations and source of information).

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

**III. DATE OF MOST RECENT PHYSICAL EXAMINATION** (Attach Copy)

**IV. LIST DATES AND DESCRIBE ANY CHILDHOOD ILLNESSES, MEDICAL CONDITIONS AND TREATMENTS FOR MENTAL, PHYSICAL, AND EMOTIONAL PROBLEMS.** (Attach records or official summaries of any hospitalizations, treatments, evaluations, consultations, and/or records of any physician who has treated the child – delete identifying information on the child and biological parents, but do not delete the names/addresses of health care providers).

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

**V. DESCRIBE ANY MEDICATIONS CURRENTLY BEING GIVEN THE CHILD OR PRESCRIBED IN THE PAST.**

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>DATE GIVEN</u>	<u>PURPOSE</u>
_____	_____	_____	_____
_____	_____	_____	_____

**VI. DESCRIBE AND DATE ANY OTHER MEDICAL PROCEDURE OR HISTORY NOT LISTED ABOVE** (Attach copies of records or official summaries):

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

**VII. DESCRIBE ANY RECOMMENDATIONS FOR MEDICAL TREATMENT OR EVALUATIONS WHICH REMAIN PENDING AND NOTE THE SOURCE OF THE RECOMMENDATION**

\* The medical information described on this sheet and attachments is as accurate as can be determined by the Department of Human Resources. There may be additional medical information on the child unknown or unavailable to the Department of Human Resources.

I certify that on the date noted below, a copy of this medical history on \_\_\_\_\_ was given to the prospective adoptive parents. (Child's Name)

\_\_\_\_\_  
(Adoptive Parents' Names)

Signature of DHR Representative \_\_\_\_\_ Date \_\_\_\_\_

I certify that on the date noted below, I received a copy of this medical history on \_\_\_\_\_ (Child's Name)

Adoptive Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Adoptive Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY OF BIOLOGICAL PARENT

## MEDICAL HISTORY OF BIOLOGICAL PARENT OF CHILD TO BE PLACED FOR ADOPTION

Father       Mother

I. **HISTORY OF MENTAL ILLNESS** (Include dates, diagnoses, treatment and attach any available reports):  
\_\_\_\_\_  
\_\_\_\_\_

II. **HISTORY OF MENTAL RETARDATION** (Include dates, diagnoses, treatments, and attach any available reports):  
\_\_\_\_\_  
\_\_\_\_\_

III. **HISTORY OF DRUG OR ALCOHOL ABUSE** (Include dates, diagnoses, treatments, and attach any available reports):  
\_\_\_\_\_  
\_\_\_\_\_

IV. **LIST DATES AND DESCRIBE ANY ILLNESSES, MEDICAL CONDITIONS, AND TREATMENTS FOR PHYSICAL, MENTAL OR EMOTIONAL PROBLEMS** (Include dates, diagnoses, treatment and attach any available reports):  
\_\_\_\_\_

V. **DESCRIBE ANY MEDICATION TAKEN BY THE PARENT** (add additional sheet if needed)

Name of Medication	Dosage	Date Taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VI. **DESCRIBE AND DATE ANY OTHER MEDICAL PROCEDURES OR HISTROY NOT LISTED ABOVE** (Attach copies of records or official summaries):  
\_\_\_\_\_  
\_\_\_\_\_

VII. **DESCRIBE ANY RECOMMENDATIONS FOR MEDICAL TREATMENT OR EVALUATIONS WHICH REMAIN PENDING AND NOTE THE SOURCE OF THE RECOMMENDATIONS:**  
\_\_\_\_\_  
\_\_\_\_\_

VIII. **DESCRIBE THE MEDICAL HISTORIES OF OTHER FAMILY MEMBERS** child's siblings, grandparents, aunts, uncles, **INCLUDING DATES AND CAUSES OF DEATHS, DESCRIPTIONS OF ILLNESSES AND TREATMENT PERTAINING TO PHYSICAL, MENTAL OR EMOTIONAL PROBLEMS, AND HEREDITARY CONDITIONS** (Attach additional sheets as needed):

Relative: \_\_\_\_\_  
Medical History: \_\_\_\_\_

Relative: \_\_\_\_\_  
Medical History: \_\_\_\_\_

Relative: \_\_\_\_\_  
Medical History: \_\_\_\_\_

**NOTE:** The medical information described on this sheet and attachments are as accurate as can be determined by the Department of Human Resources. There may be additional medical information on the child's biological parent(s) unknown or unavailable to the Department of Human Resources.

I certify that on the date noted below, a copy of the medical history on the biological parent of \_\_\_\_\_  
(Name of Child)

\_\_\_\_\_  
(Name of Adoptive Parents)

Signature of Representative of Department of Human Resources \_\_\_\_\_ Date \_\_\_\_\_

Signature of Adoptive Parent \_\_\_\_\_ Date \_\_\_\_\_

Signature of Adoptive Parent \_\_\_\_\_ Date \_\_\_\_\_

**ADOPTION REPORT OF RELEASE OF CHILD FROM HOSPITAL**  
**REPORT OF RELEASE OF CHILD FROM HOSPITAL FOR ADOPTION**

\_\_\_\_\_  
Date

**TO:** \_\_\_\_\_ COUNTY DEPARTMENT OF HUMAN RESOURCES

**FROM:** \_\_\_\_\_  
(Name of Hospital)

\_\_\_\_\_  
(Address)

**CONTACT PERSON AT HOSPITAL:** \_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

In accordance with the Code of Alabama, 1975, §§ 26-10A-15(b), you are hereby advised that the child whose name is listed below was released from this hospital within the preceding forty-eight (48) hours to the agency or individual listed below, who is not the child's natural parent, for the purpose of adoption.

**NAME OF CHILD:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**NAME OF BIRTH MOTHER:** \_\_\_\_\_

**ADDRESS OF BIRTH MOTHER:** \_\_\_\_\_

**NAME OF INDIVIDUAL TO WHOM CHILD WAS RELEASED:** \_\_\_\_\_

**RELATIONSHIP TO CHILD IF ANY:** \_\_\_\_\_

**AGENCY AFFILIATION OF INDIVIDUAL (if any):** \_\_\_\_\_

\_\_\_\_\_  
(DHR or Name of Licensed Child Placing Agency)

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

**DATE OF RELEASE OF CHILD FROM HOSPITAL:** \_\_\_\_\_

**DATE PARENT SIGNED AUTHORIZATION FOR RELEASED OF CHILD FROM HOSPITAL:** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

**SUGGESTED PRE-PLACEMENT REPORT TO THE COURT**  
*SUGGESTED PRE-PLACEMENT REPORT TO THE COURT*

*DHR PLACEMENTS*

**PRE-PLACEMENT REPORT TO THE COURT FROM**

THE \_\_\_\_\_ COUNTY DEPARTMENT OF HUMAN RESOURCES

APPLICANT(S) \_\_\_\_\_

The \_\_\_\_\_ County Department of Human Resources has on file a completed pre-placement investigation of the above-named applicants for the adoption of a child, and submits the following findings.

**1. The Biological Parents**

**2. The Child**

**3. The Applicant and Their Home** Verification of marriage of applicants. Verification of any divorces or deaths of prior marital partners. Results of criminal background investigations of applicants. Any orders, judgments or decrees affecting the children of the applicants. All costs and expenses of the applicants related to the adoption (attach on separate sheet if necessary). Any other circumstances relevant to the placement of a child with the applicants. Whether, according to the investigation and reference statements, applicants and their home are suitable for the adoption of a specific child or any child.

A full report of the investigation is on file in the office of the \_\_\_\_\_ County Department of Human Resources.

Dated this the \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

By: \_\_\_\_\_, Director  
\_\_\_\_\_ County Department of Human Resources

SUGGESTED PRE-PLACEMENT REPORT TO THE COURT

INDEPENDENT ADOPTIONS

PRE-PLACEMENT REPORT TO THE COURT FROM

THE \_\_\_\_\_ COUNTY DEPARTMENT OF HUMAN RESOURCES

APPLICANT(S) \_\_\_\_\_

The \_\_\_\_\_ County Department of Human Resources has on file a completed pre-placement investigation of the above-named applicants for the adoption of a child, and submits the following findings.

- The Biological Parents** State whether or not a specific child has been identified for placement, and if so, include the following information. Name(s) and marital status of parent(s); custody status of child and any other judgements or decrees affecting the adoptee, and notation of verification of these orders; why the parent(s) wish to be relieved of care, support and guardianship of the child, and whether or not they have abandoned the child or are otherwise unsuited to have custody of the child; the biological parents' medical histories, physical and mental, (attach Medical History of Biological Parents DHR-FCS-1749) and note that the adoptive parents have been provided a copy of the medical information; and whether placement is being arranged by an unauthorized, unlicensed third party.
- The Child** State whether a specific child has been identified for placement, and if so, include the following information. Child's name, date of birth and notation that birth is verified; child's medical history, physical and mental (attach Child's Medical History DHR-FCS-1748) and note that the adoptive parents have been given a copy of the medical information; blood relationship, if any, to the applicant(s); and describe any property owned by the child.
- The Applicant(s) and Their Home** Verification of the applicants' marriage (if a couple); verification of any prior divorces or deaths of prior marital partners; criminal history suitability letters (when adverse results are received on independent adoption applicants, non-suitability should be reported without specifically stating the content of the results and that the results should be considered by the court and that they will be released to the court upon its order); any orders, judgements or decrees affecting the children of the applicants; all costs and expenses of the applicants related to the adoption (attach on separate sheet if necessary); any other circumstances relevant to the placement of a child with the applicants; whether, according to the investigation and reference statements, the applicants and their home are suitable for the adoption of a specific child or any child.

A full report of the investigation is on file in the office of the \_\_\_\_\_ County Department of Human Resources.

Dated this the \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_.

By: \_\_\_\_\_, Director

\_\_\_\_\_ County Department of Human Resources

Suggested  
DHR FCS 1749

PRE-PLACEMENT REPORT TO THE COURT

APPLICANT(S) \_\_\_\_\_

The \_\_\_\_\_ County Department of Human Resources has on file a completed pre-placement investigation of the above named applicants for the adoption of a child, and submits the following findings:

1. The Natural Parents \_\_\_\_\_

2. The Child \_\_\_\_\_

3. The Applicant and Their Home \_\_\_\_\_

A full report of the investigation is on file in the office of the \_\_\_\_\_ County Department of Human Resources.

Dated this the \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

By \_\_\_\_\_  
Director

\_\_\_\_\_ County Department of Human Resources



B. NATURAL FATHER:

NAME:

ADDRESS ( or last known):

DATE OF BIRTH:

AGE AT BIRTH OD ADOPTEE:

SOCIAL SECURITY NUMBER:

NATIONALITY & ETHNIC BACKGROUND:

RACE:

RELIGION:

EDUCATIONAL LEVEL:

C. LEGAL FATHER:

NAME:

ADDRESS ( or last known):

DATE OF BIRTH:

AGE AT BIRTH OD ADOPTEE:

SOCIAL SECURITY NUMBER:

NATIONALITY & ETHNIC BACKGROUND:

RACE:

RELIGION:

EDUCATIONAL LEVEL:

III. PRE-ADOPTIVE BROTHER/SISTER RELATIONSHIPS

NAME OF SIBLINGS

DATE OF BIRTH

FULL OR HALF SIBLING

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IV.

\_\_\_\_\_  
Name of Person Completing This Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Agency

\_\_\_\_\_  
Address of Agency or Individual

**SUMMARY OF NON-IDENTIFYING INFORMATION**  
**SUMMARY OF NON-IDENTIFYING INFORMATION**

**INSTRUCTIONS:**

In accordance with the Code of Alabama, 1975, §§ 26-10A-31(d) and (g), complete the following information and submit this form to the Office of Adoption, State Department of Human Resources, 50 Ripley Street, Montgomery, Alabama 36130, when the court issues the final decree of adoption. For adoption investigations completed by the Department for children other than those children placed by the Department, this form should be accompanied by the Summary of Identifying Information, DHR-FCS-1767.

**V. HEALTH AND MEDICAL HISTORIES OF ADOPTEE'S NATURAL PARENTS**  
(Attach DHR-FCS-1749 if available)

NATURAL MOTHER:

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NATURAL FATHER:

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**VI. HEALTH AND MEDICAL HISTORY OF THE ADOPTEE** (Attach DHR-FCS-1748, if possible)

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**VII. ADOPTEE'S GENERAL FAMILY BACKGROUND**  
(Include ancestral information, without name reference or geographical designation)

NATURAL MOTHER:

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NATURAL FATHER:

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**IV. PHYSICAL DESCRIPTIONS (of natural family members)**

NATURAL MOTHER:

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NATURAL FATHER:

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**V. LENGTH OF TIME ADOPTEE WAS IN THE CARE AND CUSTODY OF SOMEONE OTHER THAN THE PETITIONER**

DATES

RELATIONSHIP (foster home, birth parent, etc.)

<hr/>	<hr/>

**VI. CIRCUMSTANCES UNDER WHICH CHILD COMES TO BE PLACED FOR ADOPTION**

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**VII.**

Name of Person Completing This Form

Date

Name of Agency

Address of Agency or Individual

# ALABAMA ADOPTION SUBSIDY AGREEMENT

## STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES OFFICE OF ADOPTION

### ALABAMA ADOPTION SUBSIDY AGREEMENT

This adoption subsidy agreement is entered into pursuant to the Alabama Subsidized Adoption Act (Act No. 79-691 Regular Session 1979).

We, \_\_\_\_\_  
Name(s) of Prospective Adoptive Parent(s)

hereby apply for a subsidy for the care of \_\_\_\_\_  
Name of Child

We understand that an annual evaluation of need for continuance of this subsidy will be made and agree to cooperate in furnishing information for recertification.

The State Department of Human Resources, Montgomery Alabama, has certified said child as eligible for a subsidy in the event of adoption. The State Department of Human Resources agrees to pay

\$ \_\_\_\_\_ per month as \_\_\_\_\_  
Amount Type Subsidy

to \_\_\_\_\_  
Name(s) of Prospective Adoptive Parent(s)

\_\_\_\_\_ Address

beginning \_\_\_\_\_  
Date

It is agreed that this subsidy will continue until \_\_\_\_\_  
Date and/or Specific Conditions

#### TERMINATION

Termination will occur with any of the following circumstances.

- A. This agreement will terminate upon the conclusion of the terms of this Agreement.
- B. This Agreement will terminate upon the adoptive parent(s) request.
- C. Adoption assistance payments will terminate when the child reaches the age of 19 years. Adoption assistance may be provided until the child is 21 years of age, if the child remains in high school.
- D. This Agreement will terminate upon the child's death.
- E. This Agreement will terminate upon the death of the parent(s) of the child (one in a single parent family and both in a two-parent family).

- F. This Agreement will terminate at the cessation of legal responsibility of the adoptive parent(s) for the child.
- G. This Agreement will terminate if the agency determines that the child is no longer receiving support from the adoptive parent(s).
- H. This Agreement will terminate if the family fails to participate in the renewal process for adoption assistance.
- I. This agreement will terminate immediately if the child is subsequently determined to be ineligible for adoption assistance.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Prospective Adoptive Father

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Prospective Adoptive Mother

**STATE DEPARTMENT OF HUMAN RESOURCES**

\_\_\_\_\_  
Date

**BY** \_\_\_\_\_  
County Director  
as Agent for the Department of Human Resources

FEDERAL ADOPTION ASSISTANCE AGREEMENT

STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES
OFFICE OF ADOPTION

FEDERAL (IV-E) ADOPTION ASSISTANCE AGREEMENT

The following agreement has been entered into by and between the State Department of Human Resources, Gordon Persons Building, 50 Ripley Street, Montgomery Alabama, hereafter called "the agency" and

Adoptive/Adopting Parent(s) Full Name(s)
Address Telephone Number

hereafter called the "adoptive parent(s)," for the purpose of facilitating the legal adoption of

(Child's First Name) born on (Date of Birth) and to aid the adoptive family in providing proper care for this child.

This document is the

[ ] Initial Agreement The prospective adoptive parent(s) agree that he/she/they intend to adopt (Child's Name) and have signed this document prior to finalization of the adoption for the purpose of receiving adoption assistance payments and/or services for the child under Title XIX and XX from the time of placement.

[ ] Renewal Agreement This is a renewal of the Agreement for (Child's Name) adopted on (Date).

The next renewal date is (Date).

PROVISIONS OF AGREEMENT

I. ASSISTANCE

A. Non-Recurring Adoption Expenses (effective January 1, 1987)

List specific items, cost of each, and attach receipts for payment (total not to exceed \$1000.00).

Four horizontal lines for listing adoption expenses.

B MONTHLY CASH PAYMENT  Yes \$ \_\_\_\_\_  No

The amount of this monthly cash payment (adoption assistance) is based on the needs of the child and the circumstances of the adoptive parent(s) and has been determined by mutual agreement between the adoptive parent(s) and the agency. The amount of the payment does not exceed the foster care maintenance payment for \_\_\_\_\_ if he/she were in a foster family home in the

(Child's Name)  
State of Alabama. Adjustments in cash assistance payments may be made with the concurrence of the adoptive parent(s) based upon changes in the needs of \_\_\_\_\_ or changes in the circumstances of the adoptive family.  
(Child's Name)

C. MEDICAL CARE

1. Medical benefits as provided under Title XIX of the Social Security Act (Medicaid) will be available to \_\_\_\_\_ in accordance with the procedures of the State in which child resides.  
(Child's Name)
2. Cost of meeting medical care for a pre-existing condition will be considered by the State Department of Human Resources if the family's health insurance does not cover the cost.

D. SOCIAL SERVICES

1. Social services, as provided under Title XIX of the Social Security Act, will be available to \_\_\_\_\_ in accordance with the procedures of the state in which child resides.  
(Child's Name)
2. Social services will be provided by the County Department of Human Resources if the child resides in Alabama. If the child resides in another state, the State Department of Human Resources will contact a public social service agency in the state of residence for Title XX services for child.

E. When an adoptive family moves from Alabama to another state, the family should contact, Office of Adoption, State Department of Human Resources, 50 Ripley Street, Montgomery, AL 36130, telephone number (334) 242-9500 to assure that child will receive medical care and adoption assistance, including social services from state of residence.

II. NOTIFICATION OF CHANGE

- A. The adoptive parent(s) will immediately notify the agency, in writing, if they are no longer responsible for the support of the child or are no longer supporting the child.
- B. The agency will notify the adoptive parent(s) in writing of changes in adoption assistance payments resulting from increases or decreases in foster care rates. Adjustments will be made, if requested by the adoptive parent(s) within maximum payment allowed, at the time of renewal of the agreement.
- C. Parent(s) will notify the agency of changes in their address.

### III. ADOPTION RENEWAL AGREEMENT

- A This agreement is renewed annually by the adoptive parent(s) and the state agency.
- B The agency shall notify the adoptive parent(s), in writing, forty five (45) days before the need for renewal and shall supply the adoptive parent(s) with the appropriate forms.
- C A second notice will be sent by certified mail twenty (20) days before renewal if the appropriate forms have not been returned. If the renewal request has not been received from the adoptive parent(s) within five (5) working days after the renewal date, the Agreement will be terminated.

### IV. TERMINATION

Termination will occur based on any of the following circumstances.

- A This agreement will terminate upon the conclusion of the terms of this Agreement.
- B This Agreement will terminate upon the adoptive parent(s) request.
- C Adoption assistance payments will terminate when the child reaches the age of 18 years. Adoption assistance may be provided at the state's option until the child is 21 years of age if the child has a mental or physical handicap that warrants continuation.
- D This Agreement will terminate upon the child's death.
- E This Agreement will terminate upon the death of the parent(s) of the child (one in a single parent family and both in a two-parent family).
- F The Agreement will terminate at the cessation of legal responsibility of the adoptive parent(s) for the child.
- G This Agreement will terminate if the agency determines that the child is no longer receiving support from the adoptive parent(s).
- H This Agreement will terminate if the family fails to participate in the renewal process for adoption assistance.
- I This agreement will terminate immediately if the child is subsequently determined to be ineligible for adoption assistance.

### V. APPEAL

Adoptive parent(s) may appeal the agency's decision to reduce, change or terminate adoption assistance in accordance with rules and procedures of the State's Fair Hearing and Appeal Process. Information may be requested from the State Department of Human Resources, Director of the Family Services Division.

This agreement shall remain in effect regardless of the state in which the adoptive parent(s) are residents at any given time.

This Agreement will expire on the child's 18<sup>th</sup> birthday or \_\_\_\_\_, (Date)

subject to annual renewal, unless termination occurs as a result of one or more of the conditions set forth in section IV. **Termination.**

Effective date for Titles XIX and XX \_\_\_\_\_

Effective date for Adoption Assistance payment \_\_\_\_\_

\*\*\*\*\*

\_\_\_\_\_  
Adoptive Mother's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adoptive Father's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
County Director's Signature  
as Agent for the Department of Human Resources

\_\_\_\_\_  
Date

Date a signed copy of this Agreement was given/sent to the adoptive parent(s) \_\_\_\_\_  
Date

**FEDERAL ADOPTION ASSISTANCE AGREEMENT – NON-RECURRING EXPENSES**

**STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES  
OFFICE OF ADOPTION**

**FEDERAL (IV-E) ADOPTION ASSISTANCE AGREEMENT - NON-RECURRING EXPENSES**

The following agreement has been entered into by and between the State Department of Human Resources, Gordon Persons Building, 50 Ripley Street, Montgomery, Alabama, telephone number (334) 242-9500 hereafter called "the agency" and

\_\_\_\_\_  
Adoptive/Adopting Parent(s) Full Name(s)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

hereafter called the "adoptive parent(s)," for the purpose of facilitating the legal adoption of

\_\_\_\_\_ born on \_\_\_\_\_ and to aid the adoptive  
(Child's First Name) (Date of Birth)  
family in providing proper care for this child.

The prospective adoptive parent(s) agree that he/she/they intend to adopt \_\_\_\_\_  
(Child's Name)

and have signed this document prior to finalization of the adoption for the purpose of receiving adoption assistance payments and/or services for the child under Title XIX and XX from the time of placement.

**PROVISIONS OF AGREEMENT**

**I. ASSISTANCE**

- A. Non-Recurring Adoption Expenses (Effective January 1, 1987). List specific items, cost of each, and attach receipts for payment: (Not to exceed \$1,000.00 total.)

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

**II. TERMINATION**

Termination will occur in any of the following circumstances:

- A. This agreement will terminate upon the conclusion of the terms of this Agreement.  
B. This Agreement will terminate upon the adoptive parent(s) request.  
C. This Agreement will terminate upon the child's death.  
D. This Agreement will terminate upon the death of the parent(s) of the child (one in a single parent family and both in a two-parent family).

- E. The Agreement will terminate at the cessation of legal responsibility of the adoptive parent(s) for the child.
- F. This Agreement will terminate if the agency determines that the child is no longer receiving support from the adoptive parent(s).
- G. This Agreement will terminate if the family fails to participate in the renewal process for adoption assistance.
- H. This agreement will terminate immediately if the child is subsequently determined to be ineligible for adoption assistance.

**III. APPEAL**

Adoptive parent(s) may appeal the agency's decision to reduce, change or terminate adoption assistance in accordance with rules and procedures of the States Fair Hearing and Appeal Process. Information may be requested from the Director, Adult, Child and Family Services Division, State Department of Human Resources.

This agreement shall remain in effect regardless of the State of which the adoptive parent(s) are residents at any given time.

This Agreement will expire on the child's 18<sup>th</sup> birthday or \_\_\_\_\_, (Date)

subject to annual renewal, unless termination occurs as a result of one or more of the conditions set forth in Section IV, Termination.

Effective date for Titles XIX and XX \_\_\_\_\_

Effective date for Adoption Assistance payment \_\_\_\_\_

\*\*\*\*\*

\_\_\_\_\_  
Adoptive Mother's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adoptive Father's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
County Director's Signature  
as agent for the Department of Human Resources

\_\_\_\_\_  
Date

A signed copy of this Agreement was given/sent to the adoptive parent(s) on \_\_\_\_\_  
Date

FEDERAL ADOPTION ASSISTANCE AGREEMENT/SSI

STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES  
OFFICE OF ADOPTION

FEDERAL (IV-E) ADOPTION ASSISTANCE AGREEMENT/SSI

The following agreement has been entered into by and between the State Department of Human Resources, Gordon Persons Building, 50 Ripley Street, Montgomery Alabama, hereafter called "the agency" and

Adoptive/Adopting Parent(s) Full Name(s)

Address

Telephone Number

hereafter called the "adoptive parent(s)," for the purpose of facilitating the legal adoption of

born on and to aid the adoptive family in providing proper care for this child.

Child's First Name

Date of Birth

This document is the

Initial Agreement

The prospective adoptive parent(s) agree that he/she/they intend to adopt (Child's Name) and have signed this document prior to finalization of the adoption for the purpose of receiving federal adoption assistance for the child from the time of placement.

Renewal Agreement

This is a renewal of the Adoption Assistance Agreement for

Child's Name

adopted on Date

The next renewal date is Date

PROVISIONS OF AGREEMENT

I. ASSISTANCE

A. Non-Recurring Adoption Expenses (Effective January 1, 1987)  
List specific items, cost of each, and attach receipts for payment (not to exceed \$1000.00 total).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **ADOPTDN RENEWAL AGREEMENT**

- A This agreement is renewed annually by the adoptive parent(s) and the state agency.
- B The agency shall notify the adoptive parent(s), in writing, forty five (45) days before the need for renewal and shall supply the adoptive parent(s) with the appropriate forms.
- C A second notice will be sent by certified mail twenty (20) days before renewal if the appropriate forms have not been returned. If the renewal request has not been received from the adoptive parent(s) within five (5) working days after the renewal date, the Agreement will be terminated.

### **III. TERMINATION**

Termination will occur based on any of the following circumstances.

- A This Agreement will terminate upon the conclusion of the terms of this Agreement.
- B This Agreement will terminate upon the adoptive parent(s) request.
- C Adoption assistance payments will terminate when the child reaches the age of 18 years. Adoption assistance may be provided at the state's option until the child is 21 years of age if the child has a mental or physical handicap that warrants continuation.
- D This Agreement will terminate upon the child's death.
- E This Agreement will terminate upon the death of the parent(s) of the child (one in a single parent family and both in a two-parent family).
- F The Agreement will terminate at the cessation of legal responsibility of the adoptive parent(s) for the child.
- G This Agreement will terminate if the agency determines that the child is no longer receiving support from the adoptive parent(s).
- H This Agreement will terminate if the family fails to participate in the renewal process for adoption assistance.
- I This agreement will terminate immediately if the child is subsequently determined to be ineligible for adoption assistance.

### **IV. APPEAL**

Adoptive parent(s) may appeal the agency's decision to reduce, change or terminate adoption assistance in accordance with rules and procedures of the State's Fair Hearing and Appeal Process. Information may be requested from the State Department of Human Resources, Director of the Family Services Division.

This agreement shall remain in effect regardless of the state in which the adoptive parent(s) are residents at any given time.

B. Monthly Cash Payment  Yes \$ \_\_\_\_\_  No \*\*

The amount of this monthly cash payment (adoption assistance) is based on the needs of the child and the circumstances of the adoptive parent(s) and has been determined by mutual agreement between the adoptive parent(s) and the agency. The amount of the payment does not exceed the foster care maintenance payment for \_\_\_\_\_ if he/she were in a foster family home in the State of Alabama. Adjustments in cash assistance payments may be made with the concurrence of the adoptive parent(s) based upon changes in the needs of \_\_\_\_\_ or changes in the circumstances of the adoptive family.

\*\* IF SSI BENEFITS ARE REDUCED OR TERMINATED, A MONTHLY PAYMENT WILL BE MADE NOT TO EXCEED THE REGULAR FOSTER CARE BOARD PAYMENT AMOUNT.

C. Medical Care

1. Medical benefits as provided under Title XIX of the Social Security Act (Medicaid) will be available to \_\_\_\_\_ in accordance with the procedures of the state in which the child resides.
2. Costs of meeting medical care for a pre-existing condition will be considered by the State Department of Human Resources if the family's health insurance does not cover the cost.

D. Social Services

1. Social services, as provided under Title XIX of the Social Security Act, will be available to \_\_\_\_\_ in accordance with the procedures of the state in which the child resides.
2. Social services will be provided by the County Department of Human Resources if the child resides in Alabama. If the child resides in another state, the State Department of Human Resources will contact a public social services agency in the state of residence for Title XX services for child.

E. When an adoptive family moves from Alabama to another state, the family should contact, Office of Adoption, State Department of Human Resources, 50 Ripley Street, Montgomery, AL 36130, telephone number (334) 242-9500 to assure that the child will receive medical care and adoption assistance, including social services from the new state of residence.

## II. NOTIFICATION OF CHANGE

- A. The adoptive parent(s) will immediately notify the agency, in writing, if they are no longer responsible for the support of the child or are no longer supporting the child.
- B. The agency will notify the adoptive parent(s) in writing of changes in adoption assistance payments resulting from increases or decreases in foster care rates. Adjustments will be made, if requested by the adoptive parent(s) within maximum payment allowed, at the time of renewal of the agreement.
- C. The adoptive parent(s) will notify the agency of changes of address.

This Agreement will expire on the child's 18<sup>th</sup> birthday or \_\_\_\_\_, and is subject to annual renewal unless termination occurs as a result of one or more of the conditions set forth in section IV. **Termination.**

Effective date for titles XIX and XX \_\_\_\_\_

Effective date for Adoption Assistance payment \_\_\_\_\_

\*\*\* \*\*!\*\*\*\*\*

\_\_\_\_\_  
Adoptive Mother's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adoptive Father's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
County Director  
as Agent for the Department of Human Resources

\_\_\_\_\_  
Date

Date a signed copy of this Agreement was given/sent to the adoptive parents \_\_\_\_\_  
Date

**ADOPTION SUBSIDY AGREEMENT - COUNSELING**

**STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES  
OFFICE OF ADOPTION**

**ADOPTION SUBSIDY AGREEMENT - COUNSELING\***

**This adoption subsidy agreement is entered into pursuant to the Alabama Subsidized Adoption Act (Act No. 79-691 Regular Session 1979).**

We, \_\_\_\_\_,  
Name(s) of Prospective Adoptive Parent(s)

hereby apply for a subsidy for the care of \_\_\_\_\_.  
Name of Child

We understand that an annual evaluation of need for continuance of this subsidy will be made and agree to cooperate in furnishing information for recertification.

The State Department of Human Resources, Montgomery Alabama, has certified said child as eligible for a subsidy in the event of adoption. The State Department of Human Resources agrees to pay

\$ \_\_\_\_\_ per month as \_\_\_\_\_  
Amount Type subsidy

to \_\_\_\_\_  
Name(s) of Prospective Adoptive Parent(s)

\_\_\_\_\_ Address  
beginning \_\_\_\_\_

It is agreed that this subsidy will continue until \_\_\_\_\_  
Date and/or Specific Condition(s)

**TERMINATION**

Termination will occur based on any of the following circumstances.

- A. This agreement will terminate upon the conclusion of the terms of this Agreement.
- B. This Agreement will terminate upon the adoptive parent(s) request.
- C. Adoption assistance payments will terminate when the child reaches the age of 19 years. Adoption assistance may be provided until the child is age 21 years if the child remains in high school.
- D. This Agreement will terminate upon the child's death.
- E. This Agreement will terminate upon the death of the parent(s) of the child (one in a single parent family and both in a two-parent family).
- F. The Agreement will terminate at the cessation of legal responsibility of the adoptive parent(s) for the child.
- G. This Agreement will terminate if the agency determines that the child is no longer receiving support from the adoptive parent(s).

- H. This Agreement will terminate if the family fails to participate in the renewal process for adoption assistance.
- I. This agreement will terminate immediately if the child is subsequently determined to be ineligible for adoption assistance.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Prospective Adoptive Father

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Prospective Adoptive Mother

**STATE DEPARTMENT OF HUMAN RESOURCES**

\_\_\_\_\_  
Date

**BY** \_\_\_\_\_  
County Director  
as Agent for the Department of Human Resources

\* Payment will be made at the Medicaid rate for outpatient counseling services related to preadoptive issues. Payment will be secondary to Medicaid and private insurance. This subsidy does not cover the difference between what Medicaid pays and what may be charged for the service.

**ADOPTION SUBSIDY AGREEMENT - ORTHODONTICS**  
**STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES**  
**OFFICE OF ADOPTION**

**ADOPTION SUBSIDY AGREEMENT - ORTHODONTICS \***

**This adoption subsidy agreement is entered into pursuant to the Alabama Subsidized Adoption Act (Act No. 79-691 Regular Session 1979).**

We, \_\_\_\_\_,  
Name(s) of Prospective Adoptive Parent(s)

hereby apply for a subsidy for the care of \_\_\_\_\_,  
Child's Name

We understand that an annual evaluation of need for continuance of this subsidy will be made and agree to cooperate in furnishing information for recertification.

The State Department of Human Resources, Montgomery Alabama, has certified said child as eligible for a subsidy in the event of adoption. The State Department of Human Resources agrees to pay

\$ \_\_\_\_\_ per month as \_\_\_\_\_  
Amount Type Subsidy

to \_\_\_\_\_  
Name(s) of Prospective Adoptive Parent(s)

\_\_\_\_\_ Address

beginning \_\_\_\_\_  
Date and/or Specific Conditions

It is agreed that this subsidy will continue until the agreed upon treatment has been completed.

**TERMINATION**

Termination will occur based on any of the following circumstances.

- A. This agreement will terminate upon the conclusion of the terms of this Agreement.
- B. This Agreement will terminate upon the adoptive parent(s) request.
- C. Adoption assistance payments will terminate when the child reaches the age of 19. Adoption assistance may be provided until the child is 21 years of age if the child remains in high school.
- D. This Agreement will terminate upon the child's death.
- E. This Agreement will terminate upon the death of the parent(s) of the child (one in a single parent family and both in a two-parent family).
- F. The Agreement will terminate at the cessation of legal responsibility of the adoptive parents) for the child.
- G. This Agreement will terminate if the agency determines that the child is no longer receiving support from the adoptive parent(s).
- H. This Agreement will terminate if the family fails to participate in the renewal process for adoption assistance.

1. This agreement will terminate immediately if the child is subsequently determined to be ineligible for adoption assistance.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Prospective Adoptive Father

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Prospective Adoptive Mother

**STATE DEPARTMENT OF HUMAN RESOURCES**

\_\_\_\_\_  
Date

**BY:** \_\_\_\_\_  
County Director  
as Agent for the Department of Human Resources

\* Orthodontic services can be provided for medical purposes only.

## ADOPTION CHECKLIST FOR FINAL RECORDS

### CHECKLIST FOR FINAL RECORDS FOSTER PARENT ADOPTION

Ward # \_\_\_\_\_

Adoptee \_\_\_\_\_

County \_\_\_\_\_

Resource \_\_\_\_\_

Worker \_\_\_\_\_

#### **Child**

- Original birth certificate (copy, if original not available)
- Original Summary Of Non-Identifying Information (DHR-FCS-1768)
- Child's medical records
  - Record of delivery
  - Immunization records
  - Physician, clinics, hospital records
  - Psychological and developmental evaluations
  - Child's Medical History (DHR-FCS-1748)
- Child's school records
- Blue Sheet (if applicable)
- Biological Parent Medical History (DHR-FCS-1749) \_\_\_\_\_ Mom \_\_\_\_\_ Dad
- Summary of Identifying Information (DHR-FCS-1767)

#### **Legal Documents**

- Initial temporary custody petition, court report and court order
- TPR petition, court report and court order
- Adoptive Home Placement Agreement (DHR-FCS-2130)
- Consent to Adopt (DHR-FCS-643)
- Pre-Placement Report to the Court (DHR-FCS-1751)
- Adoption petition and a copy of the acknowledgement to the court
- Interlocutory Order and a copy of the acknowledgement to the court
- Post Placement Report to the Court (DHR-FCS-621)
- Final Decree of Adoption and county's acknowledgement to the court
- Alabama Report of Adoption (DPH-HS-17)

DHR-FCS-2129

**Federal Adoption Assistance – IV-E**

- Subsidy justification memo
- Federal (IV-E) Adoption Assistance Agreement (DHR-FCS-2123)
- Title IV-E Adoption Assistance Agreement/SSI (DHR-FCS-2125)
- Public assistance record for child, child’s SSI or other income award letter
- Tax Identification Form (W-9)
- Letter to Medicaid
- Medicaid Eligibility form (attached to letter)

**State Adoption Subsidy**

- Checklist for Medicaid eligibility (if applicable)
- Subsidy justification memo
- State Adoption Subsidy Agreement (DHR-FCS-2122)
- Federal Non-Recurring Subsidy Agreement (DHR-FCS-2124)
- Tax Identification Form (W-9)
- Letter to Medicaid
- Medicaid Eligibility form (attached to letter)

**Narrative and Other Documents**

- Last ISP (DHR-FCS-2117) prior to placement
- Original case narrative for birth family
- Psychological and health evaluations on birth family
- Consent to Release of Identifying Information (DHR-FCS-1769) signed by birth parent(s) if available
- Termination Of Parental Rights / Foster Parent Adoption Placement Form (DHR-FCS-2136) if applicable)
- Dictation of placement interview
- Original foster/adoption home study
  - Application to Adopt (DHR-FCS-704)
  - Adoption Financial Statement (DHR-FCS-705)
  - Current Foster Family Home Approval (DIIR-DFC-614)
  - Current Medicals \_\_\_\_\_ Mom \_\_\_\_\_ Dad \_\_\_\_\_ Other
  - CA/N Central Registry Clearance (DHR-FCS-1598) \_\_\_\_\_ Mom \_\_\_\_\_ Dad \_\_\_\_\_ Other
  - Criminal History Suitability Letter \_\_\_\_\_ Mom \_\_\_\_\_ Dad \_\_\_\_\_ Other
  - White Narrative
  - Pink Narrative

**Checked by** \_\_\_\_\_

**Date** \_\_\_\_\_

## TPR ADOPTION PROTOCOL AND CHECKLIST

### TERMINATION OF PARENTAL RIGHTS/FOSTER PARENT ADOPTION PROTOCOL AND CHECKLIST\*

WHEN SUBMITTING CASE MATERIAL TO SDHR'S OFFICE OF ADOPTION (OA), PLEASE DO NOT SEND: BILLS, RECEIPTS, SERVICE AUTHORIZATIONS, CLIENT SIGN-IN SHEETS, INTEROFFICE MEMOS, CORRESPONDENCE OR DUPLICATE COPIES OF CASE MATERIAL.

#### I. PRIOR TO TERMINATION OF PARENTAL RIGHTS (TPR)

- Submits 2 copies of the State File Room Clearance Form for potential state wards to SDHR's Central File Room.
- SDHR OA will return 1 copy of the completed File Room Clearance Form indicating whether there is information on the birth family at the State Office. If so, OA provides, in writing, any pertinent information available from another county.
- When possible, obtain a notarized Consent to Release of Identifying Information from the birth parents. This consent is helpful in the event a request is made by the adoptee after he/she reaches age 19. In some cases, it may be more appropriate to wait until the TPR court hearing or after TPR is accomplished before attempting to obtain this consent.

#### II. AFTER TERMINATION OF PARENTAL RIGHTS (TPR)

- Review the permanent custody court order for correctness and if necessary, consult with the local attorney to seek a corrected order.

**The following information should be contained in the permanent custody order.**

- A statement that an attorney was present who represented the child as guardian ad litem
- A statement that a summons was issued or notice was given to all parties pursuant to law and court rules
- Information regarding who was present at the hearing and who represented them
- A finding of facts or that the allegations of the petition are true or that the petition is sustained, and that no less drastic measures than termination of parental rights exist
- If there has been a previous finding of dependency, the Court does not have to make this finding again
- A finding that the Department has made "reasonable efforts" toward reunification which have failed

**The following information must be contained in the permanent custody order.**

- A firm statement that parental rights have been terminated for any and all parties
  - A statement that permanent custody of the child has been granted to the State Department of Human Resources (NOT the County) and that the Department has the authority to place the child for adoption
- Submit the permanent custody order to SDHR's OA
  - Complete Section I of DHR-FCS-2136 and submit 2 copies to SDHR's OA
  - SDHR's OA returns 1 copy of DHR-FCS-2136 to the County Department with the child's ward number
  - Submit 1 copy of Request To Restrict CA/N Reports On Child In DHR Permanent Custody memo to SDHR's OA
  - Send written notification to SDHR Legal if an appeal is filed and send a copy to SDHR's OA (Appeals are handled by SDHR Legal)

#### III. PRIOR TO ADOPTIVE PLACEMENT

- Review the foster home study and add additional information to convert it to an adoptive home study. This includes, but is not limited to, completing the Application to Adopt, Financial Statement, current medicals and current foster home approval
- Prepare the Non-Identifying Background Summary of Information. Names and locations of birth family members must not be included. The summary should not be on County Department letterhead and the worker's name

## TERMINATION OF PARENTAL RIGHTS/FOSTER PARENT ADOPTION PROTOCOL AND CHECKLIST\*

should be omitted. For FPAs, it is not necessary to include the child's current habits and schedule in the summary since the foster parents should be very aware of the child's current habits and schedule.

### SUBSIDY

Determine if the child meets the definition of "special needs" to establish if adoption subsidy can be approved.

Determine if the child is eligible for IV-E (Federal) subsidy or ACFC (State) Adoption Subsidy. Children are eligible for state subsidy when they meet the special needs criteria, but are ineligible for federal adoption assistance.

The amount of subsidy is the regular board rate or the regular board rate plus the \$50 specialized service fee, if applicable. If a child has private funds (e.g., VA, SSI, Social Security) the amount of subsidy is decreased so that the total is equal to the regular board payment or regular board payment plus the \$50.00 specialized service fee. If private funds exceed the subsidy amount, no money payment is made; however an agreement must be signed with money payment deferred.

Determine the need for Medicaid under the state subsidy program using Medicaid Eligibility for State Adoption Subsidy form if the child is eligible for ACFC (State) Adoption Subsidy.

• If regular board rate subsidy,

County Director approves and signs the Subsidy Agreement

• If above regular board rate, prior approval is required from SDHR's OA

County DHR sends written request and supporting documentation of need to SDHR's OA

If eligible for either ACFC (State) subsidy, a Federal Non-Recurring Expense Agreement is to be completed for non-recurring adoption expenses (e.g., legal expenses) related to the adoption.

Any proposed offer of subsidy above the regular rate plus \$50 specialized service fee requires approval from the Office of Adoption. If there appears to be a need to request an increased subsidy, documentation of the current need for subsidy must be forwarded to the Office of Adoption. The request must include the specific service requested and the proposed costs of the service. Most medical subsidies awarded are for outpatient counseling services at the Medicaid rate or for orthodontics. Documentation for orthodontics must support that orthodontic work is already in progress or is to begin within 90 days and the orthodontics is for medical reasons only. Subsidy is not available for orthodontics for cosmetic reasons and expenses such as day care and tutoring are not considered exceptional expenses.

The County Director or designee approves the plan to offer adoption subsidy prior to the placement interview. Any amount over the regular board payment or the regular board payment plus \$50 specialized service fee requires prior approval from the Office of Adoption.

### COUNTY DHR PREPARES ADOPTIVE PLACEMENT FORMS

Prepare 3 copies (1 for adoptive parents, 1 for County DHR file, and 1 for SDHR's OA) of each of the following:

Adoptive Home Placement Agreement

Child's Medical History (DHR-FCS-1748)

Medical History of Biological Parent of the Child (DHR-FCS-1749) for each biological parent

All birth and medical records for the child with identifying information deleted on both the child and birth family.

Subsidy Agreements, as applicable, and once the necessary approvals have been secured

Consent to Adopt signed by the County Director and notarized. If the child has been in the foster home at least 3 months, the County DHR may give consent at the adoptive placement **or** at a later date if additional supervision is needed. If consent is given at the time of placement, the County DHR may also give the adoptive parents the Pre-Placement Report to the Court **or** file the report with the court. If the county prefers to give the report to the adoptive parents, the adoptive parents will need to take it to their attorney for filing with the Petition to Adopt.

## TERMINATION OF PARENTAL RIGHTS/FOSTER PARENT ADOPTION PROTOCOL AND CHECKLIST\*

### IV. ADOPTIVE PLACEMENT

During the placement interview with the foster/adoptive family, the county worker must review all the following documents, answers any questions, and obtain the required signatures. For all forms reviewed and signed, 1 copy is provided to the foster/adoptive parents, 1 copy is retained in the county files, and 1 copy is for SDHR's OA.

- Non-Identifying Background Summary of Information
- The child's birth and medical records; identifying information, including the last name and address of the child and the entire names and addresses of birth family members **must be deleted**. Do not delete any of the identifying information from the copies for the county files and SDHR's OA.
- Child's Medical History (DHR-FCS-1748)
- Medical History for Biological Parents (DHR-FCS-1749); prior to the adoption hearing, 1 copy of each form must be filed with the Probate Court.
- Adoptive Home Placement Agreement
- Subsidy agreements, if applicable
- Consent to Adopt, if the child has been in the home at least 3 months and the County DHR has elected to give consent at the time of the adoptive placement; the Consent must be signed by the County Director and notarized. Note: The foster/adoptive parents must have the Consent to Adopt before they can file the Petition to Adopt. If consent is given at the time of the adoptive placement, the County DHR may also give the Pre-Placement Report to the Court at the same time **or** the County DHR may file the Report with the Probate Court. If the report has been provided, the foster/adoptive parents must take it to their attorney for filing with the Probate Court along with their Petition to Adopt.

### V. AFTER PLACEMENT (NO SUBSIDY)

- Discharge the child from foster care to adoptive placement on the Child Data Form.
- Terminate the foster care board payment effective the date the Adoptive Home Placement Agreement is signed.
- Record the placement interview on pink colored paper and file it in the adoptive family's record. Include in the case narrative all issues raised during the placement interview, the family's response to those issues, any areas of concern, and details of the conversation regarding the concerns.
- Complete Section II of the DHR-FCS-2136 and submit 2 copies to SDHR's OA.
- SDHR's OA will return 1 copy of the 2136 with the Child's T Number.

UPDATE ACWIS (assistance is available through the CIS Help Desk Hotline, 1-800-429-9508, Option 6)

- Register the foster parents on the ACWIS Adoptive Provider Form
- Initiate the Adoption Tracking Form

### VI. AFTER PLACEMENT (WITH SUBSIDY)

- Discharge the child from foster care to adoptive placement on the Child Data Form.
- Terminates the foster care board payment effective the date the Adoptive Home Placement Agreement is signed. If the child has private earmarked funds (e.g., SS, VA, SSDI), continue to disburse these funds on a monthly basis to the foster/adoptive parents until the adoption is final.
- Record the placement interview on pink colored paper and file it in the adoptive family's record. Include in the case narrative all issues raised during the placement interview, the family's response to those issues, any areas of concern, and details of the conversation regarding the concerns. Also record discussion of the details of the adoption subsidy agreement with the family and their understanding of it.

**TERMINATION OF PARENTAL RIGHTS/FOSTER PARENT ADOPTION PROTOCOL AND CHECKLIST\***

**VI. AFTER PLACEMENT (WITH SUBSIDY) (Cont'd)**

Submit subsidy agreements and documents indicated below to SDHR's OA in time for them to be received by the 18<sup>th</sup> of the month for inclusion on the current month's payroll.

- Complete Sections II and III of the DHR-FCS-2136, have the 2136 signed by the County Director or designee, and submit 2 copies to SDHR's OA. **NOTE:** If the child currently receives SSI, do not complete Section III.
- Attach a subsidy justification memorandum to SDHR's OA specifying:
  - the special needs criteria met by the child;
  - the need for a subsidy for the child;
  - the type of subsidy, amount of payment, and terms of the agreement with the adoptive family;
  - if State subsidy Medicaid is awarded, include the policy basis for the award; and
  - for children with private income, include the original award letter from the appropriate agency.
- Non-Identifying Background Summary of Information
- The original Adoptive Home Placement Agreement signed by the County Director or designee
- The original subsidy agreement(s) signed by the County Director or designee
- A copy of the case narrative (on pink colored paper) for the placement interview
- The original 1099 or W-9 with social security number and signature of the adoptive parent who will be payee

Before SDHR's OA adds the family to the payroll, all documents are reviewed to insure that an award can be made per federal/state regulations and DHR policy. Sufficient documentation is required to support awards being made due to federal and state audit purposes.

- SDHR's OA will return 1 copy of the DHR-FCS-2136 with the child's T Number

**AUTHORIZE MEDICAID FOR CHILD (AS APPROPRIATE)**

- Complete either the Federal or State Adoption Assistance Medicaid Forms
- When federal adoption subsidy is awarded, complete the Federal Adoption Assistance Medicaid form and send it with a cover letter to the Alabama Medicaid Agency, P. O. Box 5624, Montgomery, Alabama 36130-5624 using the child's adoptive name and T number. **Note:** Do not complete this form for a child who is a current SSI recipient. If SSI is terminated after the adoption is finalized, send a copy of the SSI termination notice to SDHR's OA with Section III of the DHR-FCS-2136 completed and signed by the County Director. Send the Federal Adoption Assistance form with a cover letter to the Alabama Medicaid Agency, P.O. Box 5624, Montgomery, AL 36130-5624 using the child's adoptive name and new social security number (or T# if the new SSN is not available).
- When state adoption subsidy is awarded and the child meets the criteria for state subsidy Medicaid, complete the State Adoption Subsidy Medicaid form and send it with a cover letter to the Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36130-5624 using the child's adoptive name and T number.

**NOTE:** The Alabama Medicaid Agency will only issue 1 white paper card to the adoptive parents. After adoption finalization, remind the adoptive parents to make application for a new social security number for the child after receiving the new birth certificate. Also remind the adoptive parents to provide the new social security number, the new adoptive name, and permission to release the SSN to the Alabama Medicaid Agency if the child receives Medicaid through the subsidy program.

**UPDATE ACWIS** (assistance is available through the CIS Help Desk Hotline, 1-800-429-9508, Option 6)

- Register the foster parents on the ACWIS Adoptive Provider Form
- Initiate the Adoption Tracking Form

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## TERMINATION OF PARENTAL RIGHTS/FOSTER PARENT ADOPTION PROTOCOL AND CHECKLIST\*

### VII. ADOPTION LEGAL PROCESS

- Provide the adoptive parents with the Consent to Adopt (**signed by the County Director ONLY** and notarized). If the child has been in the foster home at least 3 months, the County DHR has the option of giving consent at the time of the adoptive placement or at a later date if an additional period of supervision is needed.
- Provide the adoptive parents with the Pre-Placement Report To The Court at the time the Consent to Adopt is given **or** the County DHR can file the report with the Probate Court.
- Adoptive parents file the Petition to Adopt with the Probate Court. (1) The Adoption Petition should be filed within three (3) months of the issuance of the Consent to Adopt. If the Petition to Adopt is not filed within this time frame, the county worker must contact the adoptive family, identify the problem and render assistance. If the placement was made with subsidy, the worker will must notify SDHR's OA as to the expected timeframe for the petition to be filed. (2) The adoptive parents should provide their attorney with the Child's Medical History and the medical history forms for each biological parents (given to them at the time of placement) and the Pre-Placement Report To The Court (if provided at time of placement) to file with the Petition to Adopt **or** the County Department may file the medical history forms and the Pre-Placement Report with the court. Procedures will vary according to individual counties' needs and preferences.
- The County DHR will be served a copy of the Petition to Adopt. The adoptive parent or the adoptive parent's attorney is responsible for this service.
- Acknowledge to the Probate Court that the Petition to Adopt has been received and provide the Probate Court with a certified copy of the child's birth certificate. The original birth certificate should be retrieved from the foster/adoptive parents (or case file). If the birth certificate is retrieved from the foster/adoptive parents, a notarized birth verification statement must be provided to them with the child's adoptive name, if a need for such exists prior to finalization.
- Submit a copy of the Consent to Adopt, the Petition, and acknowledgment to the court to SDHR's OA.
- The Probate Court will issue an Interlocutory Order and send a copy to the County DHR. The Interlocutory Order should state that the Department of Human Resources retains permanent custody pending the Final Decree. There is no need for the Court to waive the one-year residency requirement.
- Acknowledge to the Probate Court that the Interlocutory Order has been received.
- Forward a copy of the Interlocutory Order and acknowledgment to SDHR's OA.
- Make 1 supervisory visit with the adoptive family and child within 45 days of the Interlocutory Order's date
- Submit the Post-Placement Report To The Court within 60 days of receiving the Petition to Adopt.
- The adoption hearing is held, and in most counties, the DHR worker participates in the hearing.

**Note: Subsidy agreements, if applicable, must be signed prior to the adoption's finalization.**

- The Probate Court will issue the Final Decree of Adoption and send a copy to the County DHR.
- Acknowledge to the Probate Court that the Final Decree of Adoption has been received.
- Send Report of Adoption (HS-17) to Adoption Clerk, Center for Health Statistics, Department. of Public Health, P. O. Box 5625, Montgomery, AL 36103-5625.
- Send a copy of the Final Adoption Decree, the acknowledgment to the Probate Court, the HS-17, and the Post-Placement Report to the Court to SDHR's OA.
- Enter the date of the HS-17's completion on ACWIS to discharge the child from Adoption Tracking.

### VIII. AFTER FINALIZATION

- Complete the Summary of Identifying Information (DHR-FCS-1767)
- If the child has been receiving Social Security or VA benefits, notify Social Security or VA of the adoption's finalization with the request that DHR be terminated as payee.
- Disburse any private earmarked funds on hand to the adoptive parents.

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## TERMINATION OF PARENTAL RIGHTS/FOSTER PARENT ADOPTION PROTOCOL AND CHECKLIST

- If the adoptive parents will be making application for Social Security benefits, give them the Social Security Claim Number **ONLY** in order for them to make application.

### IX. COUNTY DHR REMINDS ADOPTIVE PARENTS

- To make application for a new social security number for the child after receiving the new birth certificate.
- To provide the new social security number to the county worker if the child receives Medicaid through the subsidy program and provide permission to release the SSN to the Alabama Medicaid Agency. **NOTE:** The worker must send this information to the Alabama Medicaid Agency so they can issue a permanent card in the child's adoptive name.
- To submit an itemized attorney bill and paid receipt to SDHR's OA if the subsidy award included this as a non-recurring expense. "Itemized" is a listing, by date, the service provided and the fee.
- To make application at the Social Security Administration, in their name and using their income, if the child receives SSI, and to give the county worker a copy of the notice if SSI is terminated.
- To notify the county worker of any termination or reduction of any benefits if the child has been awarded any adoption subsidy.

### X. BENEFITS TERMINATED OR REDUCED AFTER FINALIZATION

- Send a copy of the termination notice and DHR-FCS-2136 with Section III completed and signed by the County Director, and a copy of any other documentation if not already sent, to SDHR's OA.
- If the child's SSI is terminated, send the Federal Adoption Assistance form with a cover letter to the Alabama Medicaid Agency, P. O. Box 5624, Montgomery, AL 36130-5624 using the child's adoptive name and new social security number (or T# if this is not available).

### XI. SEND FINAL RECORDS TO SDHR'S OA USING THE CHECKLIST FOR FINAL RECORDS / FOSTER PARENT ADOPTIONS AS THE COVER SHEET

Documents listed below that were previously submitted to SDHR's OA, do not need to be resubmitted.

- Final Decree, County's acknowledgment to the Court, and IIS-17
- Non-Identifying Background Summary of Information
- Adoptive Home Placement Agreement (NOTE: Not necessary if send previously with subsidy documentation)
- Child's Birth and Medical Records, including record of delivery, immunization record, all physical health and mental health records from physicians, clinics, hospitals, counselors, etc. and psychological and developmental evaluations
- Public Assistance Record for child to support Federal Adoption Subsidy
- Child's Medical History (DHR-FCS-1748)
- Biological Parent (Mother and Father) Medical History Forms (DHR-FCS-1749)
- Summary of Identifying Information (DHR-FCS-1767)
- Original birth family narrative (white narrative recording and blue narrative recording, if available)
- Original foster/adoptive home study
  - Adoption application and financial statement
  - Current foster family home approval
  - Current medicals
  - CA/N Central Registry clearances
  - Criminal history check results
  - White and pink case narrative

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August 2004

FEDERAL ADOPTION SUBSIDY MEDICAID  
FEDERAL ADOPTION SUBSIDY  
MEDICAID

Category \_\_\_\_\_

1. PROVIDER'S NAME: \_\_\_\_\_

2. CHILDREN:

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

3. PARENTS' NAMES AND SOCIAL SECURITY NUMBERS:

FATHER: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

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

MOTHER: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

4. EFFECTIVE DATE OF APPROVAL: \_\_\_\_\_

5. PARENTS' HEALTH INSURANCE COMPANY: \_\_\_\_\_

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

**STATE ADOPTION SUBSIDY MEDICAID**  
**STATE ADOPTION SUBSIDY**  
**MEDICAID**

Category \_\_\_\_\_

1. PROVIDER'S NAME: \_\_\_\_\_

2. CHILDREN:

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

NAME \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NO: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NEW "T" NUMBER: \_\_\_\_\_

\*\*\*\*\*

3. PARENTS' NAMES AND SOCIAL SECURITY NUMBERS:

FATHER: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

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

MOTHER: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

4. EFFECTIVE DATE OF APPROVAL: \_\_\_\_\_

5. PARENTS' HEALTH INSURANCE COMPANY: \_\_\_\_\_

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



## TPR FOSTER PARENT ADOPTION PLACEMENT

### TERMINATION OF PARENTAL RIGHTS / FOSTER PARENT ADOPTION PLACEMENT FORM

**I. TPR INFORMATION** TPR Date \_\_\_\_\_ County \_\_\_\_\_

Child

Birth Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_

County of Residence \_\_\_\_\_ Ward Number (assigned by Office of Adoption) \_\_\_\_\_

Parents

Birth Mother: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Maiden Name \_\_\_\_\_

Birth Father: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Parents' Marital Status At Time Of Child's Birth \_\_\_\_\_

Legal father (check one)  Same as birth father or  Other (enter name on next line)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

\_\_\_\_\_

Worker \_\_\_\_\_ Date Submitted \_\_\_\_\_

\_\_\_\_\_

**II. PLACEMENT/DISRUPTION INFORMATION** Placement Date \_\_\_\_\_

A. Placement Type  Foster Parent Adoption  Non - Foster Parent Adoption

Child's Name After Adoption: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Child's T Number (to be assigned by the Office of Adoption) \_\_\_\_\_

Adoptive Mother: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Adoptive Father: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Adoptive Family Approval Date \_\_\_\_\_ County of Residence \_\_\_\_\_

Placement Worker \_\_\_\_\_ Date Submitted \_\_\_\_\_

B. Date Placement Disrupted \_\_\_\_\_ Worker \_\_\_\_\_ Date Submitted \_\_\_\_\_

\_\_\_\_\_

**III. SUBSIDY INFORMATION**

Type  Federal  State Begin Date \_\_\_\_\_ Amount \$ \_\_\_\_\_

Adoptive Parent: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Subsidy Changes  Change in Amount effective \_\_\_\_\_ to \$ \_\_\_\_\_

Address Change effective \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_

Approved: \_\_\_\_\_

County Director \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**POST PLACEMENT REPORT TO COURT**  
**POST-PLACEMENT REPORT TO COURT**

**PETITION OF** \_\_\_\_\_

**TO ADOPT** \_\_\_\_\_ a minor child.

**REPORT OF** \_\_\_\_\_ **COUNTY DEPARTMENT OF HUMAN RESOURCES**

The \_\_\_\_\_ County Department of Human Resources, acting as the designated agency of the State Department of Human Resources, has verified the allegations of the petition, has made a thorough investigation of the matter and submits the following findings.

1. **The Biological Parents** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. **The Child** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. **The Home of the Petitioner(s)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A full report of the investigation is on file in the office of the \_\_\_\_\_ County Department of Human Resources.

Dated this the \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_.

By: \_\_\_\_\_, Director  
\_\_\_\_\_ County Department of Human Resources

SUGGESTED POST-PLACEMENT REPORT TO THE COURT  
DHR PLACEMENTS

STATE OF ALABAMA PROBATE COURT OF \_\_\_\_\_ COUNTY

PETITION OF \_\_\_\_\_

TO ADOPT \_\_\_\_\_, a minor child.

REPORT OF \_\_\_\_\_ COUNTY DEPARTMENT OF HUMAN RESOURCES

The \_\_\_\_\_ County Department of Human Resources, acting as the designated agency of the State Department of Human Resources, has verified the allegations of the petition, has made a thorough investigation of the matter, and submits the following findings:

- The Natural Parents** Custody of (child's name) was duly awarded to the State Department of Human Resources on (date). Since that time, said child has been in the custody and care of this Department and the Department has had sole responsibility for planning for said child pursuant to the order awarding custody to the Department. On (date), the State Department of human Resources gave consent to the petitioners to adopt said child. The consent was given pursuant to the provisions of Alabama Adoption Code (Act No. 90-554) Section 7. State the medical histories of the natural parents, physical and mental, (attach Medical History of Biological Parents DHR-FCS-1749) and note that the adoptive parents have been provided a copy of the medical history.
- The Child** (Child's name) was born (date) and verification is on file in the State Department of Human Resources. Said child has been in the home of petitioners since (date). During this time, said child has received good care and has made a satisfactory adjustment in the petitioners' home. Medical reports are on file in the State Department of Human Resources and the child's medical history has been given to the petitioners. According to observations of workers of the \_\_\_\_\_ County Department of Human Resources who have gone into the home of petitioners, said child is developing normally, physically and mentally, insofar as can be determined. Child has been observed in the home of the petitioners within forty-five (45) days after placement. State the child's medical history, mental and physical (attach Child's Medical History DHR-FCS-1748) and note that the adoptive parents have been given a copy of the medical information.
- The Home of the Petitioner(s)** Include all information listed on the suggested pre-placement report to the court which was not contained in the actual pre-placement report; update all fees and expenses related to the adoption (attach on separate sheet if necessary), note any changes and obtain any required verifications since the time of the pre-placement investigation and the post-placement; state if a pre-placement investigation was completed and by whom; state that the petitioners have been interviewed in their own home within forty-five (45) days after placement, and if not, describe the reasons why; and verify all allegations of the petition not stated elsewhere in the report. For these reasons, the \_\_\_\_\_ County Department of Human Resources recommends the approval of the adoption of (child's name) by (each petitioner's name).

A full report of the investigation is on file in the office of the \_\_\_\_\_ County Department of Human Resources.

Dated this the \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_.

By: \_\_\_\_\_, Director  
\_\_\_\_\_ County Department of Human Resources

Suggested  
DHR-FCS-621

SUGGESTED POST-PLACEMENT REPORT TO THE COURT  
INDEPENDENT ADOPTIONS

PETITION OF \_\_\_\_\_  
TO ADOPT \_\_\_\_\_, a minor child.  
REPORT FROM \_\_\_\_\_ COUNTY DEPARTMENT OF HUMAN RESOURCES

The \_\_\_\_\_ County Department of Human Resources, acting as the designated agency of the State Department of Human Resources, has verified the allegations of the petition, has made a thorough investigation of the matter and submits the following findings.

1. **The Biological Parents** Include all information listed on the suggested pre-placement report which was not contained in an actual pre-placement report. Note the verification that all consents or relinquishments have been given as required by law.
2. **The Child** Include all information listed on the suggested pre-placement report which was not contained in an actual pre-placement report. State if child has been observed in the home of the petitioners within forty-five (45) days after placement, and if not, why, and describe the condition of the child. If the child was placed with petitioners prior to a pre-placement investigation, note the circumstances leading to placement without an investigation. Include the date that the child was placed in the petitioner's home.
3. **The Home of the Petitioner(s)** Include all information listed on the suggested pre-placement report which was not contained in the actual pre-placement report. Update all fees and expenses related to the adoption and attach a separate sheet if necessary. Note any changes and make any required verifications since the time of the pre-placement investigation and the post-placement. State if a pre-placement investigation was completed and by whom. State whether the petitioners have been interviewed in their own home within forty-five (45) days after placement and if not, describe the reasons why. Verify all allegations of the petition not stated elsewhere in the report. Include that the State the Department of Human Resources' recommendation is that the adoption petition be granted or note any concerns for the court's consideration.

A full report of the investigation is on file in the office of the \_\_\_\_\_ County Department of Human Resources.

A full report of the investigation is on file in the office of the \_\_\_\_\_ County Department of Human Resources.

Dated this the \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_.

By: \_\_\_\_\_, Director  
\_\_\_\_\_ County Department of Human Resources

Suggested  
DHR 1008 6/01

**PHYSICAL EXAMINATION FOR PROSPECTIVE ADOPTIVE PARENT**  
**PHYSICAL EXAMINATION FOR PROSPECTIVE ADOPTIVE PARENT**

This person has made application to the Department of Human Resources for the adoption of a child. It is necessary that a physical examination be made to determine whether or not the applicant's health will permit him/her to care for a child. His/Her present as well as future health should be considered.

The completed form should be returned by the physician directly to the \_\_\_\_\_ County Department of Human Resources.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

**I. GENERAL MEDICAL FINDINGS**

Give a brief history of any disabilities and treatment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_

Respiration \_\_\_\_\_ Blood Pressure \_\_\_\_\_

General Appearance \_\_\_\_\_

Eyes-Vision \_\_\_\_\_

(Record any abnormalities)

Ears-Hearing \_\_\_\_\_

(Record any abnormalities)

Nose, Throat, Sinuses \_\_\_\_\_

(Record any abnormalities)

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Genito-Urinary and Gynecological

Abdomen \_\_\_\_\_

Extremities \_\_\_\_\_

Nervous System \_\_\_\_\_

**II. LABORATORY FINDINGS**

Urinalysis \_\_\_\_\_

Blood Count (if indicated) \_\_\_\_\_

Serology \_\_\_\_\_

Any Special Procedures \_\_\_\_\_

III. On the basis of your knowledge of this person, what is your opinion of the possibility of a child being born to him/her?

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IV. On the basis of your examination and knowledge of this person, do you believe his/her physical, mental and emotional condition is such that he/she is able to take on the care and responsibility of a child?

---

---

Signed \_\_\_\_\_ M.D. Date \_\_\_\_\_

Address \_\_\_\_\_

**AUTHORIZATION**

Dr. \_\_\_\_\_: You are hereby authorized to give the Department of Human Resources all information you have regarding my condition, including the history obtained, findings, and diagnosis.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT OF STATE DHR TO ADOPTION**

**CONSENT OF STATE DEPARTMENT OF HUMAN RESOURCES TO ADOPTION**

STATE OF ALABAMA

\_\_\_\_\_ COUNTY

**KNOW ALL MEN BY THESE PRESENTS**, that the State Department of Human Resources (hereinafter SDHR), the agency holding permanent custody of or to which has been relinquished, the minor child

\_\_\_\_\_ born \_\_\_\_\_, does hereby consent to the adoption of the said minor by \_\_\_\_\_ in order that said minor may have all the privileges which may be accorded him or her by the laws of Alabama upon his or her legal adoption.

SIHR executes this document voluntarily and unequivocally, thereby consenting to the adoption of said minor.

SIHR understands that by signing this document and after entry to the final decree of adoption, it will forfeit all rights and obligations (as provided in *Code of Alabama* 1975, Section 26-10A-18), and understands the consent to the adoption and executes it freely and voluntarily.

SIHR understands that the consent to the adoption may be irrevocable.

SIHR has received a copy of this document.

SIHR hereby requests that the probate judge make all such orders and decrees as may be necessary or proper to legally effectuate said adoption.

Given under my hands at \_\_\_\_\_ o'clock, \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ at

\_\_\_\_\_ (address of filing)

STATE DEPARTMENT OF HUMAN RESOURCES

By: \_\_\_\_\_ (SEAL)  
County Director as Agent for the Department of Human Resources

"I, \_\_\_\_\_, acting as agent for the State Department of Human Resources, sign names to this instrument this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_ and being first duly sworn, do hereby declare to the undersigned authority that I execute it as my free and voluntary act for the purposes therein expressed, and that I am nineteen years of age or older, of sound mind, and under no constraint or undue influence."

STATE DEPARTMENT OF HUMAN RESOURCES

By: \_\_\_\_\_ (SEAL)  
County Director as Agent for the Department of Human Resources

STATE OF ALABAMA

\_\_\_\_\_ COUNTY

Subscribed, sworn to and acknowledged before me by \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

(Signed) \_\_\_\_\_  
Notary Public \_\_\_\_\_ County

I acknowledge receipt of two copies of this document.

\_\_\_\_\_ (SEAL)  
Date \_\_\_\_\_

## APPLICATION TO FOSTER AND/OR ADOPT

STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES

County \_\_\_\_\_

APPLICATION TO FOSTER AND/OR ADOPT

Date Received \_\_\_\_\_

PLEASE PRINT USING BLACK OR BLUE INK AND ATTACH ADDITIONAL PAGES AS NEEDED.

Type Application  Initial or  Reapproval to  Foster  Adopt  Both

**Husband or Single Male Applicant**

**Wife or Single Female Applicant**

<b>Name</b>	Last                      First                      Middle	Maiden                      First                      Middle
<b>Residence</b>	Number                      Street                      Town                      County                      State                      Zip                      Phone Number	
	<input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home    No. of Bedrooms (    ) <input type="checkbox"/> Own <input type="checkbox"/> Rent	
<b>If Married</b>	Date	Place
<b>Birth Date &amp; Place</b>		
<b>U.S. Citizen?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Naturalized</b>	Date                      Serial Number	Date                      Serial Number
<b>Nationality/Descend</b>		
<b>Religious Preference</b>		
<b>Church Affiliation</b>		
<b>Previous Marriage(s) Terminated</b>	Date                      Place	Date                      Place
	How                      Date                      Place	How                      Date                      Place
<b>Physical Description</b>	Hair                      Eye                      Skin Coloring	Hair                      Eye                      Skin Coloring
	Height                      Weight	Height                      Weight
<b>Education</b>	High School	High School
	College                      Other	College                      Other
<b>Employment</b>	Occupation	Occupation
	Employer	Employer
	Address                      Phone Number	Address                      Phone Number
	Length of Present Employment	Length of Present Employment
	Social Security #	Social Security #

Children & Other Household Members	Name	DOB	Grade Completed	Relationship
	1			
	2			
	3			
	4			
Specific Serious or Chronic Illness of Any Household Member	Name	Age When Occurred	Condition/Diagnosis	
	1			
	2			
	3			
	4			
Other Children of Applicant & Where They Live				
Reference	Name	Address	Phone Number	
Minister				
Employer of Supervisor (list for each if both applicants are employed)				
Relatives (if 2 applicant, list for each)				
Friend				
Length of Residence In Alabama		How long do you expect to reside in Alabama?		
Have you applied for a child with any other agency? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," provide the date applied & the agency's name/address				
Date:	Name/Address			
Have you previously fostered/adopted? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where?				
If you have previously adopted, date the Final Decree of Adoption was issued.				
Reasons and/or Motivation to Foster/Adopt				
Child/Children Desired	How Many?	Age(s)	Sex	

**ALL APPLICANTS**

I authorize the Department of Human Resources to release information regarding me contained in the State Central Registry on Child Abuse/Neglect to foster/adoption staff of the Department of Human Resources who may use that information in making decisions related to my application to foster/adopt a child. I further release the Department of Human Resources from all responsibility and liability for the release and use of the information as it pertains to the foster/adoption application process.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**AGREEMENT FOR APPLICANTS SEEKING A FOSTER FAMILY HOME APPROVAL**

We hereby agree to the following if we receive an approval to maintain a foster family home.

1. To accept children only through the State of Alabama Department of Human Resources.
2. To work in partnership with the Department of Human Resources providing care for children and cooperating with said Department in maintaining prescribed standards.
3. To report to the Department of Human Resources any changes of address, sickness in family or changes in family composition, and sickness of or accident to children whom we may receive for care.
4. To allow the representatives of the Department of Human Resources to visit the foster family home whenever desired.
5. To treat the children who we may receive for care as well as we would treat members of our family.
6. To obtain permission of the Department of Human Resources for all visits of the children outside of the State and for visits with the State in excess of three (3) days.
7. That we will work in partnership with the Department of Human Resources, children and their families, and the child and family planning team in developing, implementing, maintaining and evaluating permanency goals for children. Ultimately however, it is the responsibility of the State Department of Human Resources to carry out any and all planning responsibility for children. Placements for children may include returning them to their own homes, a relative's home, transfer to other homes or a facility, adoption or any other planning decisions that must be made in the planning and care for children.
8. That in working with the Department of Human Resources, we will maintain confidentiality to protect the personal and intimate information of everyone in accordance with the Code of Alabama.
9. That we will not file a petition in the court to adopt a child in our home, or take steps toward the adoption of the child, without the **WRITTEN CONSENT** of the State Department of Human Resources.
10. To give the Department of Human Resources adequate notice if we want a child removed from our home.

I have read the above Foster Family Home Agreement, understand it, and will abide by its contents. I certify that the information given on this application is true and correct to the best of my knowledge. I understand that any misrepresentation of information may be grounds for denial of the application or revocation of an approval.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# ADOPTION FINANCIAL STATEMENT

## ADOPTION FINANCIAL STATEMENT

Prepared for: Alabama State Department of Human Resources

Date \_\_\_\_\_

County \_\_\_\_\_

Purpose: **APPLICATION TO ADOPT A CHILD**

(Complete and return original and one copy to the County Department of Human Resources)

Prepared by: \_\_\_\_\_

(Applicants)

		AMOUNT
Husband's Income: (Yearly Gross)	SSN: _____	
Earnings: _____		\$ _____
Other: _____		_____
Wife's Income: (Yearly Gross)	SSN: _____	
Earnings: _____		\$ _____
Other: _____		_____

### ASSETS

Cash in Bank: Current Savings) \_\_\_\_\_

Cash in Bank (Average Checking) \_\_\_\_\_

Stock: (Estimated Value) \_\_\_\_\_

Bonds: (Estimated Value) \_\_\_\_\_

**Automobile**

Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Purchase Price \_\_\_\_\_ Market Value \_\_\_\_\_

**Automobile**

Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Purchase Price \_\_\_\_\_ Market Value \_\_\_\_\_

Life Insurance for Husband: (List Names of Companies)

\_\_\_\_\_

\_\_\_\_\_

(List any other insurance held by wife or husband giving type and company)

\_\_\_\_\_

\_\_\_\_\_

Home \_\_\_\_\_ Date of Purchase \_\_\_\_\_ Purchase Price \_\_\_\_\_ Equity \_\_\_\_\_ Market Value \_\_\_\_\_

Other Assets and estimated value (Itemize)

\_\_\_\_\_

\_\_\_\_\_

Total Assets \$ \_\_\_\_\_

### INDEBTEDNESS

Type	To Whom Owed	For What	Month Payments (or prorated monthly)	Remaining Balance
<b>Personal Loans:</b>				
Installment Accounts: (1)				\$ _____
(Itemize) (2)				_____
(3)				_____
(4)				_____
<b>Real Estate Loans:</b>				
Policy Loan on Life Insurance: _____				
Automobile Loans: _____				
Other: _____				

(Attach additional sheets if needed)

**TOTAL OWED: \$ \_\_\_\_\_**

## MONTHLY EXPENSES

(If not monthly, prorate into monthly amount)

1.	House rent or payment, tax, and insurance		\$
2.	House Upkeep – repairs improvements lawn and garden expense	\$ _____	\$
3.	Groceries (include meals purchased out and any food delivered to the door such as milk)		\$
4.	Utilities: power	\$ _____	
	gas	_____	
	water	_____	
	phone	_____	
	garbage	_____	\$
5.	Clothing		\$
6.	Medical and dental – average		\$
7.	Car expenses: gas	\$ _____	
	tag and tax (use last year's figures)	_____	
	payment	_____	
	upkeep on car	_____	\$
8.	Insurance: life	\$ _____	
	health	_____	
	car	_____	
	household (if not included in 1. above)	_____	
	burial	_____	
	other	_____	\$
9.	Newspaper; magazines; books (estimate)		\$
10.	Recreation and hobbies		\$
11.	Church and charity contributions		\$
12.	Installment Accounts		\$
13.	Club membership dues; professional dues		\$
14.	Savings and / or investments		\$
15.	Other (Specify)		\$
	<b>TOTAL MONTHLY EXPENSES</b>		<b>\$</b>
	Husband's monthly take-home pay	\$ _____	
	Add other monthly net income (specify source)	+ _____	
	<b>Total</b>	\$ _____	
	Total monthly expenses (Subtract)	- _____	
	*Excess	\$ _____	
	Excess should be sufficient to cover needs of expected child)	\$ _____	

**ADOPTION INFORMATION REGARDING IMMEDIATE RELATIVES**

**INFORMATION REGARDING IMMEDIATE RELATIVES**

Give information to the best of your knowledge

Wife

Husband

Date

Father — Name \_\_\_\_\_

Age

Address \_\_\_\_\_

Education \_\_\_\_\_ Employment \_\_\_\_\_

Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

Mother — Name \_\_\_\_\_

Age

Address \_\_\_\_\_

Education \_\_\_\_\_ Employment \_\_\_\_\_

Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

**Brothers and Sisters in chronological order of birth:**

1. Name \_\_\_\_\_

Age

Address \_\_\_\_\_

Education \_\_\_\_\_ Employment \_\_\_\_\_

Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

2. Name \_\_\_\_\_

Age

Address \_\_\_\_\_

Education \_\_\_\_\_ Employment \_\_\_\_\_

Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_  
Education \_\_\_\_\_ Employment \_\_\_\_\_  
Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

4. Name \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
Education \_\_\_\_\_ Employment \_\_\_\_\_  
Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

5. Name \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
Education \_\_\_\_\_ Employment \_\_\_\_\_  
Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

6. Name \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
Education \_\_\_\_\_ Employment \_\_\_\_\_  
Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Skin Coloring \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

If deceased, date and cause of death: \_\_\_\_\_

Attach additional sheets if needed

CPS REPORT OF CAN TO FACILITY



Mrs Jane Q Public  
Chairperson of the board

**MONTGOMERY COUNTY**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



Mrs Janet J. Murphy  
Director

Confidential

{system date}

{ assist – Facility Director’s Name }  
{assist - Address line 1}  
{ assist - Address line2}  
{ assist - Address line 3}

Dear { assist - Title} { assist - Last Name}:

This letter is to notify you that we have received a suspected child abuse/neglect report involving your facility and/or staff person. The specifics of the report are stated in the attachment.

The { assist - county name} County Department of Human Resources is now conducting an assessment, and you will be notified about our findings when the assessment is complete.

We would appreciate your cooperation and assistance in this matter. If you have any questions, please call me at {worker phone #}.

Sincerely,

{assist - name}  
Protective Services Worker

APPROVED:

{assist - name}  
Protective Services Supervisor

**NOTIFICATION TO DA/LEA**



**Mrs Jane Q Public**  
Chairperson of the board

**MONTGOMERY COUNTY**

S. Gordon Persons Building  
50 Ripley Street  
P.O. Box 304000  
Montgomery, Alabama 36130-4000  
Telephone: (334) 242-1310  
Fax: (334) 242-1310



**Mrs Janet J. Murphy**  
Director

**Confidential**

{system date}

(user selected – DA or LEA)  
(assist -Address line 1)  
(assist - Address line 2)  
(assist - Address line 3)

Dear (assist)

Attached is a copy of our completed assessment for the suspected child abuse/neglect report received on { assist - date}.

State law allows the disclosure of suspected child abuse/neglect reports for the purpose of preventing or discovering child abuse and neglect. Our Department protects this information from disclosure to persons who are not strictly authorized to have access per Code of Alabama 1975 Section 26-14-8 (c). The Department has taken the position that attorneys who represent parents or other persons allegedly responsible for abuse/neglect in civil or criminal cases are not entitled to these reports without a court order. Our procedure is to request in camera inspections by the appropriate judge and disclosure of only those portions the judge determines as necessary for release.

Our position and procedures for releasing these records is in keeping with the Alabama Supreme Court decision in the case of Ex parte Alabama Department of Human Resources (in re Patricia Harris V. Liberty National Life Insurance Company), 719 So. 2d 194 (Al., 1998). The Alabama Supreme Court held that section 38-2-6 (8) prohibits the wholesale discovery of DHR records. The Court is required to conduct an in camera inspection of DHR records and release only that information relevant and material to the lawsuit. The case also holds that neither DHR or any person has the ability to waive the prohibition of discovery of DHR records.

The Department of Human Resources takes very seriously the confidentiality statute governing child abuse and neglect records. These records must be kept confidential in order to assure reporters that their identity will be kept confidential.

We are asking, therefore, that written or verbal information from these reports not be furnished by you to defense attorneys or anyone else outside your office. It is with this stipulation that we are disclosing these reports to you and your staff. If you have questions about these policies, please call the State Department of Human Resources Legal Office at 334-242-9330.

Sincerely,

{assist - name}  
County Director

DISPOSITION TO MANDATORY REPORTER

Confidential  
{system date}

{ assist - Reporter }  
{assist - Address line 1}  
{ assist - Address line2}  
{ assist - Address line 3}

Dear { assist - Title} { assist - Last Name}:

**We have completed an assessment of the suspected child abuse/neglect report you made on {received date}. The report was regarding {Person(s) Identified at Risk}.**

- Abuse or neglect occurred. Child will remain in the home with services being provided.
- Abuse or neglect occurred. Child will remain in the home. DHR services will not be provided as the family and family support systems are able to meet the family needs.
- Abuse or neglect occurred. Child placed out of home with services being provided.
- Abuse or neglect did not occur and/or evidence did not substantiate the allegations. However services are being provided as a preventive measure.
- Abuse or neglect did not occur and/or evidence did not substantiate the allegations. No services are being provided.
- Unable to complete the assessment.

[User entered comments.]

**Thank you for your assistance and cooperation in this matter. Please notify our agency if you observe further evidence of abuse or neglect. The information in this letter is confidential, is being provided to you for the purpose of discovering and/or preventing further abuse/neglect, and must be used only for this purpose.**

**If you have any questions or additional concerns, please call me at {worker phone #}.**

Sincerely,

{assist - name}  
Protective Services Worker

APPROVED:

{assist - name}  
Protective Services Supervisor

**DISPOSTION TO PARENT/PRIMARY CAREGIVER**

**Confidential**

{system date}

{ assist - Parent/Primary Caregiver's Name }  
{assist - Address line 1}  
{ assist - Address line2}  
{ assist - Address line 3}

Dear { assist - Title} { assist - Last Name}:

**This letter is to notify you of the disposition of the report received alleging that your child was abused/neglected while in the care of {name of PAR}.**

**The assessment reveals the following:**

Allegation(s)	Allegation Description(s)	Disposition(s)	Location of Incident if Known	Date of Incident If Known
{ }	{ }	{ }	{ }	{ }

**Disposition of Report:        {disposition}**

**The disposition of “Indicated” means that credible evidence reveals the allegations are true. The disposition of “Not Indicated” means that sufficient credible evidence was not found.**

**Thank you for your cooperation and assistance in this matter**

Sincerely,

{assist - name}  
Protective Services Worker

APPROVED:

{assist - name}  
Protective Services Supervisor

**DISPOSTION TO PARENT/REPORTER**

**Confidential**

*{system date}*

*{ assist - Reporter }*  
*{assist - Address line 1}*  
*{ assist - Address line2}*  
*{ assist - Address line 3}*

Dear *{ assist - Title}* *{ assist - Last Name}*:

**The {county name} County Department of Human Resources has completed an assessment on the report you made alleging that your child(ren) had been abused/neglected. The assessment reveals the following:**

<b>Child</b>	<b>Allegation(s)</b>	<b>Allegation Description(s)</b>	<b>Disposition(s)</b>
{ }	{ }	{ }	{ }

**The disposition of “Indicated” means that credible evidence reveals the allegations are true. The disposition of “Not Indicated” means that sufficient credible evidence was not found.**

**Thank you for your cooperation and assistance in this matter**

Sincerely,

*{assist - name}*  
Protective Services Worker

APPROVED:

*{assist - name}*  
Protective Services Supervisor

INDICATED DISPOSITION TO PAR/REQUEST FOR ADMIN REVIEW

Confidential

{Date}

{Person Allegedly Responsible's Name}

{Address line 1}

{Address line 2}

{Address line 3}

Dear: {Title} {Person Allegedly Responsible's Last Name}

The {county name} County Department of Human Resources (DHR) has completed the initial assessment on the suspected child abuse/neglect report that named you as being responsible for the abuse or neglect. Our preliminary decision is we have reasonable cause to believe the report is "Indicated" (true). An "Indicated" finding is used when there is more credible evidence than not, based on the professional judgement of the social worker, that child abuse or neglect has occurred. The initial assessment revealed that:

*(User entered text – describe the incident, timeframe, children involved and basis for the disposition)*

**You have the right to an administrative record review. This means that the county's written report will be reviewed by an independent panel of DHR employees who are not involved in the case. The panel members will review the written report and make a final decision about whether the written report supports the finding. The panel has the authority to overturn the county's decision if the documentation does not support the findings.**

**If you want the decision reviewed by the panel, you must submit your written request to me at the {county name} County Department of Human Resources (address is above) within ten (10) working days from the date of receipt of this letter. You may include any written information that, in your opinion, proves the findings are not true.**

**If we do not receive a written request within the 10 working days, we will consider that you have given up your opportunity for a review. At that time, the preliminary decision will become a final decision, and it will be entered into the Department's Central Registry for Child Abuse/Neglect. This information is for the Department's records only and does NOT refer to any criminal charges. Our records are confidential and may only be released according to State law.**

**If you have questions, please call me at {worker's phone number}.**

Sincerely,

{Name}

Protective Services Worker

APPROVED:

{Name}

Protective Services Supervisor

PSAS0

An

**INDICATED DISPOSTION TO PAR/HEARING REQUEST**

**Confidential**  
*(Current Date)*

*(PAR's Name)*  
*(Address 1)*  
*(Address 2)*  
*(City, State ZIP)*

Dear *(Title) (PAR's Last Name)*:

The *{county name}* Department of Human Resources has completed the assessment on the suspected child abuse/neglect report that named you as being responsible for the abuse or neglect. Our preliminary decision is we have reasonable cause to believe the report is true. The initial assessment revealed that:

[User entered text]

We are offering you the opportunity for a CA/N hearing to allow you to respond to our findings of abuse or neglect. The Department is responsible for providing proof that supports our findings, and this includes presenting witnesses and other evidence.

You have the right to be represented by a lawyer or other person of your choice at the hearing. You may also cross-examine witnesses, present additional information, testify, and present your own witnesses. Also, you may request that we provide you a short and plainly written statement about the findings we will present at the hearing. Actual Department records cannot be provided.

If you want a hearing, you must notify us in writing at the address shown at the top of this letter. We must receive your request within ten (10) working days from the date you receive this letter. If we do not hear from you within this time, we will consider that you have given up your opportunity to a hearing and our decision will become final.

Once the final decision is reached, the information will be entered into the Department's Central Registry on Child Abuse and Neglect as required by Code of Alabama 1975, Section 26-14-8. We will also share our findings with your employer and licensing/certifying agency, and may choose to provide this information to future or prospective employers or licensing/certifying agencies for the protection of children and other vulnerable persons.

If you have any questions, please call me at *{worker phone #}*.

Sincerely,

*{name}*  
Protective Services Worker

APPROVED:

*{name}*  
Protective Services Supervisor  
PSAS0

An Affirmative Action/Equal Opportunity Employer

mm/dd/yyyy

**MEMORANDUM TO SCHEDULE CAN HEARING**

**Memorandum**

*(Current Date)*

To: State Department of Human Resources  
Office of Administrative Hearings  
11 South Union Street, Room 224  
Montgomery, AL 36130-0152

From: Worker's Name: *{Primary Worker for Assessment}*  
Telephone #: *{Worker phone #}*

Re: Request for CA/N Hearing

Person Allegedly Responsible: *{Participant with role of PAR}*  
Case Name: *{Case Name}*  
DHR #: *{DHR #}*

The above named person was provided notice of due process rights on *{date letter generated}*. Enclosed is a copy of the notification letter and the written request for a CA/N hearing.

Enclosure

**MEMORANDUM TO SCHEDULE ADMINISTRATIVE RECORD REVIEW**

**Confidential**  
(Current Date)

To: Family Services Division  
Office of Child Protective Services  
Administrative Record Reviews

From: Worker's Name: {Primary Worker for Assessment}  
Telephone #: {Worker phone #}  
Supervisor's Name: {Supervisor of Primary Worker}  
Telephone #: {Supervisor phone #}

Re: Person Allegedly Responsible {Name of Participant with role of PAR}  
For Abuse/Neglect (PARAN)  
Requesting Administrative Review:

Address for PARAN: {address for PARAN}

Child(ren) "Indicated" {Name of Persons Identified at Risk}  
On Above Named PARAN:

Case Name: {Case Name}  
County Case No: {DHR #}  
Date Report Received: {Earliest Allegation Received Date}

The following checked items are attached.

- Copy of the letter mailed to the PARAN, "Notification of Indicated Disposition " **(Required Attachment)**
- Copy of the PARAN'S Request for an Administrative Record Review **(Required Attachment)**
- Law Enforcement Reports
- Medical reports
- Photographs
- Forensic interviews
- Other information not contained in ASSIST

County Reviewer: {name}  
Telephone Number: {phone # of county reviewer}

**NOT INDICATED DISPOSITION TO PAR**

**Confidential**  
*(Current Date)*

*(PAR's Name)*  
*(Address 1)*  
*(Address 2)*  
*(City, State ZIP)*

Report Received: *{Assist received Date}*  
**Child(ren)'s Name(s):** *{names of Person Id at Risk in allegation with PAR}*

Dear *(Title) (PAR's Last Name)*:

The *{county name}* Department of Human Resources has completed the assessment on the suspected child abuse/neglect report received on the date noted above.

We did not find sufficient evidence to support that you [user entered text].

The finding of "Not Indicated" has been entered into the Department's Central Registry For Child Abuse and Neglect. In accordance with Alabama law, if the Department receives no further reports in the next five (5) years identifying you as being responsible for abuse or neglect, you may request that your name be removed from the Department's Central Registry. If you want your name removed after the five (5) years has passed, you must send a written request to:

State Department of Human Resources  
Family Services Partnership  
Child Abuse/Neglect Central Registry  
50 Ripley Street  
Montgomery, AL 36130

Your written request should include the name of the county that completed the assessment, the date the report was received (as noted above), your full name at the time of the report, and your current name, address and telephone number.

If you have any questions, please call me at *{worker phone #}*.

Sincerely,

*{name}*  
Protective Services Worker

APPROVED:

*{name}*  
Protective Services Supervisor

## INDICATED RECORD REVIEW DECISION

{First Name} {Middle Name} {Last Name} {Suffix}  
Address Line One  
Address Line Two  
City, State, Zip

County Case No:  
Child's Name:  
Report Date:

Dear {Title} {Last Name}:

We have completed our administrative record review on the above noted case. It has been determined that the County Department does have enough credible evidence to support a dispositional finding of "indicated", i.e. true.

This report will be entered into the Department's Central Registry on Child Abuse and Neglect as an "indicated" incident.

Sincerely,

{First Name} {Last Name}  
Administrative CA/N Record Reviewer

Cc: {County Name} County DHR  
County Reviewer

**NOT INDICATED RECORD REVIEW DECISION**

{First Name} {Middle Name} {Last Name} {Suffix}  
Address Line One  
Address Line Two  
City, State, Zip

County Case No:  
Child's Name:  
Report Date:

Dear {Title} {Last Name}:

We have completed our administrative record review on the above noted case. It has been determined there is not sufficient credible evidence documented in the county departments record to support a dispositional finding of "indicated", i.e. true. The disposition on this report will be entered into the Department's Central Registry on Child Abuse and Neglect as "not Indicated, i.e. not true.

During the investigation, the County Department may have identified needs within your family and are providing services to assist your family. You are encouraged to cooperate with the County Department. Please be assured that the Department's primary concern is the welfare of children and families.

In accordance with the law, you may request that your name be removed from the Department's Central Registry on Child Abuse/Neglect after five years, assuming no other reports are received during this time. At the appropriate time you may send your request to:

**State Department of Human Resources  
Division of Family Services  
Central Registry on Child Abuse/Neglect  
50 Ripley Street  
Montgomery, AL 36130**

Please provide identifying information, including your full name at the time of this report, county name, date of report as noted above, your current name, address and telephone number, when you make this request.

Sincerely,

{First Name} {Last Name}  
Administrative CA/N Record Reviewer

Cc: {County Name} County DHR  
County Reviewer

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**REPORT TO LEA FOR INVESTIGATION**

**Confidential**

{system date}

(user selected - police dept or sheriff's office)

(assist – address line 1)

(assist – address line 2)

(assist – address line 3)

RE: Case #: {assist - case number}

Case Name: {assist - case name}

Dear (assist)

Attached for your investigation, pursuant to Code of Alabama, Section 26-14-3 (c), is information reported to the Department of Human Resources as suspected child abuse/neglect. The alleged incident involves discipline or corporal punishment in a school setting.

When your investigation is complete, please attach a copy of your investigation and return this package to us. If your findings indicate abuse/neglect occurred and the above-named person was responsible, this Department must offer a child abuse/neglect hearing before the disposition can be entered into the Department's Central Registry. If a hearing is held, you will be called upon to participate.

This Department will take no further action until we receive notification of your disposition. If you have any questions, please call me at {worker phone #}.

Sincerely,

{assist - name}

Protective Services Worker

APPROVED:

{assist - name}

Protective Services Supervisor