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| ATTENTION: This is an electronic form in FamLink. This Word version must only be used when FamLink is not available. | | | | | | | | | | | | | | | | | |
| State_Seal3 | DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)  **Visit Plan** | | | | | | | | | | | | DATE | | VISIT PLAN ID | | |
| REFERRING CA WORKER’S NAME | | | | | | | | | | | | | PHONE NUMBER (AND AREA CODE) | | | | |
| DCYF STAFF E-MAIL | | | | DSHS OFFICE | | | | | | | | | FAX NUMBER (AND AREA CODE) | | | | |
| DCYF SUPERVISOR’S NAME | | | | | | | | | | | | | PHONE NUMBER (AND AREA CODE) | | | | |
| **Visit Type** | | | | | | | | | | | | | | | | |
| **Visit Type:**  Parent / child visit Sibling visit**Method:**  In person  Electronic  In person and electronic**Transportation:**  With transportation  Without transportation  Transportation only**Provider Type:**  Contracted  Relative / suitable adult caregiver  Foster parent  Case aide / intern Volunteer  Other Preferred Provider: **Reason for Plan / Referral**:  Initial  Re-referral - parent no showed or missed three (3) consecutive visits Re-referral - provider dropped  Update- Changes to visit location, frequency, duration or level of supervision Re-authorization – all supervised visits every three (3) months | | | | | | | | | | | | | | | | |
| **Level of Supervision** | | | | | | | | | | | | | | | | |
| **Unsupervised**The parent is the primary caregiver and is able to demonstrate the willingness and ability to safely care for the child for the duration of the visit.Any safety threats must be managed through the development of a safety plan if indicated. **Monitored**a. Be ON SITE for the duration of the visit;b. Conduct periodic checks where they are able to both see and hear the parent-child interaction;c. Be readily available for intervention as needed. **Supervised**a. Be within direct line of sight and sound of the child and all parties to the visit at all times during the visit.b. Visit service worker must accompany the parent and all children to the restroom if one needs to use the toilet.c. Sibling visits are supervised unless otherwise directed by the DCYF worker. **Explain why visits cannot be unsupervised.** **Describe all resources explored prior to selecting contracted supervision and transportation support and explain why a non-contracted provider cannot be used.** | | | | | | | | | | | | | | | | |
| **Frequency and Duration** | | | | | | | | | | | | | | | | |
| How many visits per week/month?  times per How long should each visit last?  hours  Overnight visits approved as of (date)  Is time for visit negotiable?  Yes  No; please provide required day and time for visit(s):    Court ordered as follows: | | | | | | | | | | | | | | | | |
| **Children Participating in Visits** | | | | | | | | | | | | | | | | |
| CHILD’S NAME / PERSON ID | | | CASE ID | | | ORIGINAL PLACEMENT DATE (OPD) | | | AGE | | GENDER | | | CHILD’S WEIGHT (NECESSARY FOR CAR SEAT SELECTION) | | KNOWN ALLERGIES (IF YES, DETAIL IN CASE SPECIFIC INSTRUCTIONS BELOW) |
|  | | |  | | |  | | |  | |  | | |  | | Yes  No  Unknown |
|  | | |  | | |  | | |  | |  | | |  | | Yes  No  Unknown |
|  | | |  | | |  | | |  | |  | | |  | | Yes  No  Unknown |
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|  | | |  | | |  | | |  | |  | | |  | | Yes  No  Unknown |
| **Parent / Guardian Participating in Visits** | | | | | | | | | | | | | | | | |
| NAME | | EMAIL | | | | | PHONE NUMBER | | | | | PRIMARY LANGUAGE | | | | INTERPRETER NEEDED |
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| **Other Approved Visit Participants** | | | | | | | | | | | | | | | | |
| NAME | | | | | RELATIONSHIP | | | | | | PHONE NUMBER | | | | | |
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| **Acceptable Visit Locations** | | | | | | | | | | | | | | | | |
| Visits should occur in the least restrictive environment. DSHS offices should be reserved for high risk families. | | | | | | | | | | | | | | | | |
| LOCATION NAME | | | | | | | | ADDRESS | | | | | | | | |
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| **Visit Specific Instructions** | | | | | | | | | | | | | | | | |
| **Identify any special conditions / restrictions for visits regarding child health and safety information including:**   * Developmental needs, allergies, medical needs, dietary restrictions, etc. * Expected behaviors of parents during visits including visit rules regarding canceling visits, rescheduling visits, arrival time, etc. * Specify whether the visit participants are allowed to go outside during a visit. * If the visit / contact is an electronic visit (Skype, Face Time, Prison Video Visit), provide specific information regarding the use of the computer or other media device. * If the visit is occurring in a Correctional Facility, provide information for obtaining permission to accompany the child(ren) by visiting DOC website at <http://www.doc.wa.gov> and selecting “Family and Friends” tab. | | | | | | | | | | | | | | | | |
| CASE WORKER’S SIGNATURE DATE | | | | | | | | | | PARENT’S SIGNATURE DATE | | | | | | |
| PARENT’S SIGNATURE DATE | | | | | | | | | | PARENT’S SIGNATURE DATE | | | | | | |