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