DDD-1371AFORPF (10-05)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

CHILD PLACEMENT SUMMARY/AGREEMENT

Clear The Form

CHILD'S NAME *(Last, First, M.I.)*	HEALTH PLAN ☐ CMDP ☐ ALTCS	ASSISTS NO.

CASE MANAGER'S NAME	PHONE NO. ( )	SUPERVISOR'S NAME	PHONE NO. ( )

PROVIDER INFORMATION

THERAPIST'S NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
RBHA CASE MANAGER'S NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
CHILD CARE PROVIDER'S NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
CHILD'S ATTORNEY NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
CASA	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
PROBATION OFFICER'S NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
MEDICAL PROVIDER'S NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
DENTIST'S NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
SURROGATE PARENT'S NAME	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )
OTHER	ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO. ( )

WHO SHALL *NOT* VISIT

NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP

WHO SHALL VISIT

NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP

VISITATION ARRANGEMENT	VISITATION ARRANGEMENT

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program of activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-6825; TTY/TTD Services: 7-1-1.

Clear The Form

FAMILY INFORMATION

MOTHER'S NAME			CITY/STATE
FATHER'S NAME			CITY/STATE
OTHER		RELATIONSHIP	CITY/STATE

SIBLING	CITY/STATE	RESIDES WITH	AGE	PHONE NO.
SIBLING	CITY/STATE	RESIDES WITH	AGE	PHONE NO. ( )
SIBLING	CITY/STATE	RESIDES WITH	AGE	PHONE NO. ( )
SIBLING	CITY/STATE	RESIDES WITH	AGE	PHONE NO. ( )
SIBLING	CITY/STATE	RESIDES WITH	AGE	PHONE NO. ( )
SIBLING	CITY/STATE	RESIDES WITH	AGE	PHONE NO. ( )

ADDITIONAL INFORMATION

CARE INSTRUCTIONS

MEDICATIONS

ADDITIONAL INFORMATION

SCHEDULED APPOINTMENTS *(Date, Time, Place, Name of Provider)*

MEDICAL

DENTAL

BEHAVIORAL HEALTH

EDUCATIONAL

TRANSPORTATION NEEDS

VISITATION ☐ Current ☐ Projected	FREQUENCY	RESPONSIBLE PARTY	COMMENTS *(If more space is needed, use Additional Information)*
MEDICAL ☐ Current ☐ Projected	FREQUENCY	RESPONSIBLE PARTY	COMMENTS *(If more space is needed, use Additional Information)*
SOCIAL/RECREATIONAL ☐ Current ☐ Projected	FREQUENCY	RESPONSIBLE PARTY	COMMENTS *(If more space is needed, use Additional Information)*
SCHOOL/CHILD CARE ☐ Current ☐ Projected	FREQUENCY	RESPONSIBLE PARTY	COMMENTS *(If more space is needed, use Additional Information)*

ADDITIONAL INFORMATION

NEXT CASE PLAN STAFFING *(Actual or anticipated date)* / TIME / PLACE

NEXT FCRB HEARING DATE / TIME / PLACE

NEXT COURT HEARING DATE / TIME / PLACE

NEXT RC DATE / TIME / PLACE

Clear The Form

AGREEMENT

☐ I have reviewed this document which indicates the child's needs and instructions for care as currently identified, the names of the providers currently working with the child, and the names of individuals who **are** and **are not** authorized to visit the child.
☐ I have been advised of the child's legal status, and current case plan goal.
☐ I understand that the child is being placed in my care on a temporary foster care basis.
☐ I agree to provide care and supervision consistent with the Child Developmental Home Agreement (DD-289) and to:

1. Cooperate with the current case plan;
2. Contact DDD immediately if an unusual incident occurs;
3. Follow discipline practices as stated in Article 9 and the Child Developmental Home Agreement (DD-289);
4. Keep all information provided to me about the child and family confidential, pursuant to ARS § 8-807 and;
5. Return to DES all records pertaining to the child when he/she is removed from my care and complete the requested forms, Child Information Guide (DDD-1370A) and Foster Parent Wrap-Up (Feedback on Services) (DDD-1372A);
6. Other *(if applicable).*

Foster parents are entitled to receive case managers' written reports to the court regarding a child currently in their home or a foster child who resided in their home within the past six months, pursuant to ARS § 8-847. This includes receiving foster parents and shelter care facilities that:

are caring for a child that has been with them for at least 30 days;
have cared for a child for 30 days or more within the last six months.

Information obtained from the written reports to the court or from participation in the Report and Review Hearing is confidential and shall **not** be released or used except as provided by statute or rule or as permitted by order of the court. A person who knowingly discloses or uses information in violation of this law is guilty of a Class 2 misdemeanor.

☐ If you **do not** wish to receive the case manager's written report to the court about this child, please check this box.

ACUERDO

☐ He revisado este documento el cual contiene las instrucciones actuales para el cuidado del niño(a), los nombres de los proveedores que ahora trabajan con el niño, y los nombres de los individuos que **están** y **no están** autorizados para visitar al niño.
☐ Se me ha informado sobre el estado legal del niño, la tarifa de pago y el objectivo actual del plan del caso.
☐ Entiendo que la colocación del niño bajo mi cuidado es en calidad de cuidado temporal.
☐ Me comprometo a ofrecer cuidado y supervisión que sean compatibles con el Acuerdo de Hogar Temporal para Niños (DD-289) y a:.

1. Cooperar con el plan actual del caso.
2. Comunicar de inmediato a DDD si ocurre algún incidente extraordinario.
3. Practicar la disciplina según dispuesto en el Artículo 9 y el Acuerdo de Hogar Temporal para Niños (DD-289).
4. Mantener en confidencia toda la información que reciba sobre el niño y su familia, conforme a ARS § 8-807; y
5. Devolver al DES todos los archivos relacionados con el niño(a) cuando éste sea removido de mi cuidado, y llenar los formularios necesarios que son la Guía de Información sobre el Niño (DDD-1370A) y el Paquete Final del Niño Temporal (DDD-1372A).
6. Otro *(si es aplicable).*

Los padres temporales tienen derecho a recibir los informes escritos preparados para el tribunal por los gerentes de casos sobre el niño que está actualmente en su hogar, o un niño temporal que ha residido en su hogar en los últimos seis meses, conforme a ARS § 8-847. Esto incluye a padres temporales de admisión y locales para amparo que:

cuidan de un niño quien ha permanecido con ellos durante por lo menos 30 días;
han cuidado de un niño durante 30 o más días dentro de los seis meses más recientes.

La información obtenida de los informes escritos para el tribunal o durante la participación en la Audiencia Informativa y de Revisión es de carácter confidencial y **no podrá ser** divulgada ni utilizada excepto bajo disposición estatutaria o reglamentaria, o mediante una orden del tribunal. Cualquier persona quien a sabiendas viole esta ley divulgando o utilizando tal información será culpable de una infracción de la Clase 2.

☐ Si usted **no desea** recibir el informe escrito para el tribunal por el gerente del caso acerca de este niño(a), marque esta cajita.

OUT-OF-HOME CARE PROVIDER'S NAME *(Please Print)* / NOMBRE DEL PROVEEDOR DE CUIDADO FUERA DEL HOGAR *(En letra de molde)*

OUT-OF-HOME CARE PROVIDER'S SIGNATURE / FIRMA DEL PROVEEDOR DE CUIDADO FUERA DEL HOGAR	DATE / FECHA
Original Signature Required	

CASE MANAGER'S NAME *(Please Print)* / NOMBRE DEL GERENTE DEL CASO *(En letra de molde)*

CASE MANAGER'S SIGNATURE / FIRMA DEL TRABAJADOR(A) DEL CASO	DATE / FECHA
Original Signature Required!	