## REQUEST FOR INTRA-STATE ASSISTANCE

Please complete the following information. Incomplete/missing information will delay response.

RECEIVING AGENC	CY:		SENDING AGENCY:			
ADDRESS:			SENDING PRIMARY WOR	RKER:		
ATTENTION:			PRIMARY WORKER PHO	NE:		
			PRIMARY WORKER EMA	AIL:		
	og.					
ATTACHMENT						
COURT ORDER	□CASE PLAN	_	NCE ABUSE EVAL	□ IEP		
☐ COURT REPORT	SAFETY ASSESSMENTS	☐ MENTAL	HEALTH/ PSYCHOLOGICAL	☐ OTHER		
	☐ SOCIAL SUMMARY	ASSESSM	ENTS			
SECTION 1. DE						
SECTION 1: RE (SELE	CCT ALL THAT APPLY)					
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	Y HOME VISTS OME, HOME STUDY		☐ FOSTER PLACEMENT (HIGHER LEVEL OF CARE) ☐ FOSTER PLACEMENT (NON-KIN OR FICTIVE KIN)			
☐ RELATIVE	HOME STUDY	☐ COORD	☐ COORDINATE LOCAL SERVICE DELIVERY			
□ADOPTIVE	HOME STUDY	☐ SUPERVISE FAMILY VISITS ☐OTHER:				
		_OTHER:	·			
IIICII DDIODITA	DECLIECT					
HIGH PRIORITY EXPLAIN (PL	REQUEST EASE ATTACH ALL RELE	VANT DOCI	UMENTS)			
2311 23111 ( 1 2		VIII (1 200)				

NEXT COURT DATE CONCERNING THIS REQUEST:

Subject: INTRA-STATE COURTESY SUPERVISION

## **SECTION 2: FAMILY AND CASE INFORMATION**

CASE NAME		
UNITY CASE #	ICWA APPLICABLE Y N	
IF CASE IS APPLICABLE FOR THE INDIAN CHILD WELFARI	E ACT PLEASE PROVIDE THE FOLLOWING INFORMA	ΓΙΟΝ:
TRIBAL AFFILIATION: TRIBAL SOCIAL WORKER: TRIBAL SOCIAL WORKER TELEPHONE # TRIBAL CONTACT ADDRESS:	HAS TRIBE BEEN NOTIFIED OF CUSTODY? TRIBE NOTIFIED OF PLACEMENT CHANGE? TRIBAL MEMBERSHIP CONFIRMED? IS PROPOSE PLACEMENT ICWA COMPLIANT?	Y   N   Y   N   Y   N   Y   N   Y   N
	WHAT SERVICES ARE PROVIDED TO MAINTAIN CULT CONNECTION?	URAL
MOTHER'S INFORMATION		<u>"</u>
MOTHER'S NAME: PHONE: LAST KNOWN ADDRESS:	TERMINATION OF PARENTAL RIGHTS: DATE OF TPR VISITATION PLAN/AGREEMENT ESTABLISHED (IF YES PLEASE EXPLAIN)	□ Y □ N □ Y □ N □ Y □ N
FATHER'S INFORMATION		
FATHER'S NAME: PHONE: LAST KNOWN ADDRESS:	TERMINATION OF PARENTAL RIGHTS: DATE OF TPR VISITATION PLAN/AGREEMENT ESTABLISHED (IF YES PLEASE EXPLAIN)	□ Y □ N □ Y □ N □ Y □ N
REMOVAL CAREGIVERS (IF NOT PARENTS) R	ELATIONSHIP TO CHILD(REN)	
NAME: PHONE: LAST KNOWN ADDRESS:	VISITATION PLAN/AGREEMENT ESTABLISHED (IF YES PLEASE EXPLAIN)	☐ Y ☐N
REMOVAL CAREGIVERS (IF NOT PARENTS)  I	RELATIONSHIP TO CHIL(REN)	
NAME: PHONE: LAST KNOWN ADDRESS:	VISITATION PLAN/AGREEMENT ESTABLISHED (IF YES PLEASE EXPLAIN)	☐ Y ☐N

Subject: INTRA-STATE COURTESY SUPERVISION

## **SECTION 3: CHILD AND PLACEMENT INFORMATION** (attach more sheets if necessary)

ARE ALL CHILDREN TO BE PLACED AT THE SAME LOCATION?  $\ \square$  YES  $\ \square$  NO

CHILD NAME: UNITY PERSON # PERMANENCY GOAL DATE OF MOST RECENT REMOVAL			IEI	DOB:  MALE FEMALE  IEP Y N  LEGAL STATUS			
CURRENT SERVICES (i.e. mental heal	lth, substanc	e abuse treatment, P	SR, BST	'etc.)			
NON-COVERED SERVICES:			ANTICIPATED COST:				
SPECIAL NEEDS (i.e. pregnant, medically fragile etc)							
PROPOSED PLACEMENT DATE	P		PROPO	PROPOSED PLACEMENT ADDRESS			
NAME (CAREGIVER)			NAME (2 <sup>ND</sup> CAREGIVER)				
DOB	SSN		DOB	Ì	SSN		
RELATIONSHIP TO CHILD	<u>'</u>		RELAT	TIONSHIP TO CHILD		l	
WORK#	CELL#		WORK		CELL#		
BEST TIME TO CONTACT EMPLOYER :			BEST TIME TO CONTACT EMPLOYER:				
OTHER ADULTS IN HOME (OVER 18)		DOB		SSN	RELATION	NSHIP TO CHILD	
PROPOSED PLACMENT DURATIO	)N·						
APPROVED				DENIED			
PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT							

CHILD NAME:				DOB:			
UNITY PERSON #				□ MALE □ FEMALE			
PERMANENCY GOAL				P  Y N			
DATE OF MOST RECENT REMOV	AL		LE	GAL STATUS			
CURRENT SERVICES (i.e. mental hea	lth, substance	e abuse treatment, PS	SR, BST	etc.)			
,	,		,	,			
NON COMEDED SERVICES			1 4 3	TELCUDATED COST			
NON-COVERED SERVICES:			ANTICIPATED COST:				
SPECIAL NEEDS (i.e. pregnant, medical	ally fragile et	tc.)					
PROPOSED PLACEMENT DATE			PROPOSED PLACEMENT ADDRESS				
NAME (CARROTTER)			NAME	NAME (2 <sup>ND</sup> CAREGIVER)			
NAME (CAREGIVER)	CONT			(2 <sup>ND</sup> CAREGIVER)	GGN	T	
DOB	SSN		DOB		SSN		
RELATIONSHIP TO CHILD				TONSHIP TO CHILD			
WORK#	CELL#		WORK# CELL#				
BEST TIME TO CONTACT EMPLOYER:			BEST TIME TO CONTACT EMPLOYER:				
2251 1442 10 001/11/01 244 20 124			DEST .	Take To convince Emile	121.		
OTHER ADULTS IN HOME (OVER 18)		DOB		SSN	RELATIONSHIP TO CHILD		
PROPOSED PLACMENT DURATIO	N.						
APPROVED					DENIED		
PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT							

PROPOSED PLACMENT DURATION:

Subject: INTRA-STATE COURTESY SUPERVISION **CHILD NAME:** DOB:  $\square$  MALE  $\square$  FEMALE **UNITY PERSON #** IEP Y N PERMANENCY GOAL DATE OF MOST RECENT REMOVAL **LEGAL STATUS** CURRENT SERVICES (i.e. mental health, substance abuse treatment, PSR, BST etc.) NON-COVERED SERVICES: ANTICIPATED COST: SPECIAL NEEDS (i.e. pregnant, medically fragile etc.) PROPOSED PLACEMENT ADDRESS PROPOSED PLACEMENT DATE NAME (2<sup>ND</sup> CAREGIVER) NAME (CAREGIVER) SSN DOB DOB SSN RELATIONSHIP TO CHILD RELATIONSHIP TO CHILD WORK# WORK# CELL# CELL# BEST TIME TO CONTACT EMPLOYER: BEST TIME TO CONTACT EMPLOYER: OTHER ADULTS IN HOME (OVER 18) DOB RELATIONSHIP TO CHILD SSN

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APPROVED	DENIED			
PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT				

Subject: INTRA-STATE COURTESY SUPERVISION

SECTION 4: ASSISTANCE APPROVED DESCRIPTION OF SERVICES TO BE PROVIDED E (CHECK ALL THAT APPLY)	BY RECEIVING AGENCY
☐ COURTESY HOME VISTS ☐ ☐ FOSTER HOME, HOME STUDY ☐ ☐ RELATIVE HOME STUDY ☐ ☐ ADOPTIVE HOME STUDY ☐	FOSTER PLACEMENT (HIGHER LEVEL OF CARE) FOSTER PLACEMENT (NON-KIN OR FICTIVE KIN) COORDINATE LOCAL SERVICE DELIVERY SUPERVISE FAMILY VISITS OTHER:
NAME TELEPHONE EMAIL	SUPERVISOR'S NAME SUPERVISOR'S EMAIL
APPROVING PARTY SIGNATURE:	
NAME: TITLE:	SIGNATURE: DATE: