



CHILD WELFARE COMMUNICATION

PART A: Please complete one form for each child for whom assistance is requested.

Please select program: ☐ Relative Caregiver Program (RCP) ☐ Non-Relative Caregiver Financial Assistance (NCFA)

Please select Open or Closed Dependency Case: ☐ Open ☐ Closed

Date: _____ Region/Circuit: _____ Case Number: _____

Child's Name: _____ DOB: _____

Child's SSN: _____ FSFN Child ID: _____

Caregiver's Name: _____ Phone Number: _____

Caregiver's SSN: _____ FSFN Provider ID: _____

Address: _____

PART B: Child's Information (To be completed by Lead Agency/Contracted Provider)

Date Child Adjudicated Dependent: _____

Date Unified Home Study Completed in FSFN (Excludes Emergency UHS): _____

Date Court Approved Placement: _____

Does the child have a Child Placement Agreement (CPA): ☐ Yes ☐ No

PART C: Complete only for RCP when the child in Part "B" above is a half-sibling who is not related to the caregiver.

Name of the child in the placement who is related to the Caregiver: _____

DOB: _____ SSN: _____

Date Child Adjudicated Dependent: _____ Date Unified Home Study Completed in FSFN: _____

Date Court Approved Placement: _____ FSFN Child ID: _____

☐ Check if this child who is related to the caregiver has a Relative Caregiver Program payment or application.

PART D: Request to END a Placement with a Caregiver receiving NCFA.

Please submit this section to: hqw.nonrelative.caregiver@myflfamilies.com

Placement End Date: _____ Placement End Time: _____

Please select one of the below:

☐ Ending Purpose: Admin Change Within Removal Epsd End Reason: _____

☐ Ending Purpose: Discharge from Removal Epsd End Reason: _____

☐ Ending Purpose: Placement Change w/in Removal Epsd End Reason: _____

PART E: Request to End or Assess Relative Caregiver Program Payment.

Please select one of the following reasons:

☐ Child moved out of state. ☐ Child is adopted. ☐ Permanent Guardianship Achieved (Assess)

☐ Child is no longer placed with caregiver. ☐ Child turned 18.

☐ Caregiver has become licensed. License Begin Date: _____

PART F: Information of staff completing form and affirming accuracy.

Name (Print): _____ Date: _____

Phone: _____ Lead Agency: _____

Other Comments: _____

Signature: _____

CBC/Contracted Provider, please submit this form (except for section D) to the following email addresses based on your Region:

Southeast: SER.CIC.Inbox@myflfamilies.com

Northwest: NWR.CIC@myflfamilies.com

Northeast: NER.RELATIVE.CAREGIVER@myflfamilies.com

Central: CNR.D13ESS.CIC@myflfamilies.com

SunCoast: SCR.CIC.RCG@myflfamilies.com

Southern: SNR.RelativeCaregiverForms@myflfamilies.com