



Clear

# CHILD SERVICE AGREEMENT

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## I. CHILD AND FAMILY INFORMATION

Child's Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Date child placed in care: \_\_\_\_\_ Date child placed in your home: \_\_\_\_\_

Reason(s) child came into care:

### Child's Current Goal

- |                                        |                                                               |                                             |
|----------------------------------------|---------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Reunification | <input type="checkbox"/> Long Term Licensed Custody           | <input type="checkbox"/> Long Term Custody  |
| <input type="checkbox"/> Adoption      | <input type="checkbox"/> Guardianship Pursuant to Chapter 744 | <input type="checkbox"/> Independent Living |

### Licensed Out-of-Home Caregiver

### Biological Family

Licensed Out-of-Home Caregivers' Name:

Licensed Out-of-Home Caregivers' Address:

Phone Number: \_\_\_\_\_

Prior Licensed Out-of-Home Caregiver:

Name: \_\_\_\_\_

Address:

Phone Number: \_\_\_\_\_

Primary Caretaker at time of removal:

If appropriate include the following information:

Address:

Phone Number: \_\_\_\_\_

Include the names and current placement (home, relative, licensed out-of-home caregiver) of siblings:

Brothers:

Sisters:

Is the child allowed contact with siblings: ☐ Yes ☐ No

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### Family Services Counselor

### Department Emergency Contact

Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ If applicable, enter "ext." and extension number for "work" phone only

Pager Number: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Pager Number: \_\_\_\_\_ If applicable, enter "ext." and extension number

If applicable, enter  
"ext." and  
extension number

## Family Services Supervisor

Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Pager Number: \_\_\_\_\_

**II. MEDICAL/PSYCHOLOGICAL INFORMATION**

Child's Medical Doctor: \_\_\_\_\_

Child's Therapist: \_\_\_\_\_ Dates of Scheduled Visits: \_\_\_\_\_

Child's Psychiatrist: \_\_\_\_\_ Dates of Scheduled Visits: \_\_\_\_\_

Medication (Name and Dosage): \_\_\_\_\_

Child's Dentist/Orthodontist: \_\_\_\_\_ Dates of Scheduled Visits: \_\_\_\_\_

Is Child's Resource Record Attached: ☐ YES ☐ NO

Pertinent Medical Information (allergies, injuries, depression, chronic conditions, asthma, diabetic, etc.):

**III. SCHOOL INFORMATION**

Child's Grade: \_\_\_\_\_ Surrogate Parent Name: \_\_\_\_\_

Educational Placement: ☐ Regular ☐ Special Ed (type): \_\_\_\_\_

Date of Last IEP: \_\_\_\_\_

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NEW

FORMER

|                     |                     |
|---------------------|---------------------|
| School:             | School:             |
| Phone No.:          | Phone No.:          |
| Teacher:            | Teacher:            |
| Guidance Counselor: | Guidance Counselor: |

Pertinent School Information (activities, organizations, classroom behaviors/concerns, etc.):

**IV: CHILD'S RESOURCE RECORD**[Go Back To Page 1](#)Child's Resource Record accompanied child to placement: ☐ YES ☐ NO[Go Back To Page 2](#)Child Resource Record Includes: If answered no to any of the below, indicate date to be completed and by whom:

| ITEM                           | YES                      | NO                       | WHO | DATE |
|--------------------------------|--------------------------|--------------------------|-----|------|
| Medical/Psychological Inf.     | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| Immunization Records           | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| Medicaid Card                  | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| School Information/Records     | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| Recent Photograph              | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| Family Information             | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| Family Services Counselor Inf. | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| ESI behavior checklist         | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| Family & Dept. Visit Log       | <input type="checkbox"/> | <input type="checkbox"/> |     |      |
| Critical Incident Log          | <input type="checkbox"/> | <input type="checkbox"/> |     |      |

**V. PAYMENTS**

Monthly Board Rate: \_\_\_\_\_

Subsidy, if Emergency Shelter Home: \_\_\_\_\_

Clothing Allowance Payments:

(a) Payment Amount: \_\_\_\_\_

(b) Approximate Dates of Payments: \_\_\_\_\_

**VI. SIGNATURES**

All information contained in this document is true to the best of our knowledge.

\_\_\_\_\_  
Licensed Out-of-Home Caregiver Signature\_\_\_\_\_  
Date[Go Back To Page 2](#)\_\_\_\_\_  
Licensed Out-of-Home Caregiver Signature\_\_\_\_\_  
Date[Go Back To Page 1](#)\_\_\_\_\_  
Department Representative\_\_\_\_\_  
Date

The Family Service Counselor is to fully complete all information regarding the child and have all parties sign this Service Agreement prior to the child being placed in the Licensed Out-of-Home Caregivers home. If any information is not completed on this Service Agreement, indicate the date to be completed and by whom. One copy of the Service Agreement is to be given to the Licensed Out-of-Home Caregiver, one copy given to the child's Family Service Counselor and the original placed in the Licensed Out-of-Home Caregiver licensing file.