**Local Indian Child Welfare Advisory Committee** **(LICWAC) Referral**

Date:       Region:

Case Worker:  Office:

Case Name:  Case Number:

Date of Placement Care and Authority (PCA): Date of initial Shelter Care (SC):

Briefly summarize why children are in care [17 Safety Threats](https://www.dcyf.wa.gov/sites/default/files/pubs/CWP_0016.pdf):

Mother:  Date of Birth:

Tribal Affiliation

Identity of the Tribe unknown  No Tribal heritage or Indian ancestry

Child Name:  Date of Birth:

Father:  Date of Birth:

Tribal Affiliation

Identity of the Tribe unknown  No Tribal heritage or Indian ancestry

Child Name:  Date of Birth:

Father:  Date of Birth:

Tribal Affiliation

Identity of the Tribe unknown  No Tribal heritage or Indian ancestry

Child Name:  Date of Birth:

Father:  Date of Birth:

Tribal Affiliation

Identity of the Tribe unknown  No Tribal heritage or Indian ancestry

**Individuals to be included in LICWAC: CASA, Attorneys, Providers, caregivers, parents, DCYF staff, Others**

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| --- | --- | --- |
| **Name** | **Phone/email** | **Relationship** |
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Send completed form to your office LICWAC Liaison