**Out of State Family Time Referral**

DateVisit Plan Id

Referring DCYF Worker’s Name  Phone Number (And Area Code)

DCYF Staff E-Mail DCYF Office

Fax Number (And Area Code)

DCYF Supervisor’s Name Phone Number (And Area Code)

**Visit Type**

**Visit Type:** [ ]  Parent / child visit[ ]  Sibling visit

**Method:** [ ]  In person [ ]  Electronic [ ]  In person and electronic

**Transportation:** [ ]  With transportation [ ]  Without transportation [ ]  Transportation only

**Provider Type:** [ ]  Contracted

**Reason for Plan / Referral**: [ ]  Initial [ ]  Re-referral - parent no showed or missed three (3) consecutive visits

[ ]  Re-referral - provider dropped [ ]  Update- Changes to visit location, frequency, duration or level of supervision

[ ]  Re-authorization – all supervised visits every three (3) months

**Family Time Levels of Supervision**

[ ]  **Unsupervised**

The parent is the primary caregiver and is able to demonstrate the willingness and ability to safely care for the child for the duration of the visit.

Any safety threats must be managed through the development of a safety plan if indicated.

[ ]  **Monitored**

 a. Be ON SITE for the duration of the visit;

 b. Conduct periodic checks where they are able to both see and hear the parent-child interaction.

 c. Be readily available for intervention as needed.

[ ]  **Supervised**

 a. Be within direct line of sight and sound of the child and all parties to the visit at all times during the visit.

 b. Visit service worker must accompany the parent and all children to the restroom if one needs to use the

 toilet.

 c. Sibling visits are supervised unless otherwise directed by the DCYF worker.

**Explain why visits cannot be unsupervised. Describe all resources explored prior to selecting contracted supervision and transportation support and explain why a non-contracted provider cannot be used**.

**Sibling Visits Levels of Supervision**

[ ]  **Sight and Sound**

Requires the Service Worker to maintain line of sight and sound supervision and be within the immediate vicinity to provide instant intervention to maintain positive interaction and play between siblings.

[ ]  **Sight or Sound**

Requires the Service Worker to maintain line of sight and/or sound supervision dependent upon the developmental needs or behavioral issues of the child(ren) and be available for direct intervention to maintain positive interaction and play between siblings.

[ ]  **Sight**

Requires the Service Worker to maintain line of sight supervision and be available for intervention as needed to maintain positive interaction and play between siblings.

**Frequency and Duration**

How many visits per week/month?  times per How long should each visit last?  hours

Overnight visits approved as of (date)

Is time for visit negotiable?

[ ]  Yes

[ ]  No; please provide required day and time for visit(s)

**Court ordered as follows**:

**Children Participating in Visits**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CHILD’S NAME / PERSON ID** | **CASE ID** | **ORIGINAL PLACEMENT DATE (OPD)** | **AGE** | **GENDER** | **CHILD’S WEIGHT (NECESSARY FOR CAR SEAT SELECTION)** | **KNOWN ALLERGIES (IF YES, DETAIL IN CASE SPECIFIC INSTRUCTIONS BELOW)** |
|  |  |  |  |  |  | [ ]  Yes[ ]  No[ ]  Unknown |
|  |  |  |  |  |  | [ ]  Yes[ ]  No[ ]  Unknown |
|  |  |  |  |  |  | [ ]  Yes[ ]  No[ ]  Unknown |
|  |  |  |  |  |  | [ ]  Yes[ ]  No[ ]  Unknown |
|  |  |  |  |  |  | [ ]  Yes[ ]  No[ ]  Unknown |

**Parent / Guardian Participating in Visits**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **EMAIL** | **PHONE NUMBER** | **PRIMARY LANGUAGE** | **INTERPRETER NEEDED** |
|  |  |  |  | [ ]  |
|  |  |  |  | [ ]  |
|  |  |  |  | [ ]  |
|  |  |  |  | [ ]  |

**Other Approved Visit Participants**

|  |  |  |
| --- | --- | --- |
| **NAME** | **RELATIONSHIP** | **PHONE NUMBER** |
|  |  |  |
|  |  |  |
|  |  |  |

**Acceptable Visit Locations**

Visits should occur in the least restrictive environment.

|  |  |
| --- | --- |
| **LOCATION NAME** | **ADDRESS** |
|  |  |
|  |  |
|  |  |
|  |  |

**Visit Specific Instructions**

**Identify any special conditions / restrictions for visits regarding child health and safety information including:**

* Developmental needs, allergies, medical needs, dietary restrictions, etc.
* Expected behaviors of parents during visits including visit rules regarding canceling visits, rescheduling visits, arrival time, etc.
* Specify whether the visit participants are allowed to go outside during a visit.
* If the visit / contact is an electronic visit (Skype, Face Time, Prison Video Visit), provide specific information regarding the use of the computer or other media device.
* If the visit is occurring in a Correctional Facility, provide information for obtaining permission to accompany the child(ren) by visiting DOC website at <http://www.doc.wa.gov> and selecting “Family and Friends” tab

Case Worker Signature Date

Supervisor Signature Date