Washington State Department of CHILDREN, YOUTH & FAMILIES

Provider Notification of Family Time/ Sibling Visit Transport Schedule Initial Intake Screening Report

(Completed by Contracted Provider)

Provider will send this form back to the referring DCYF worker to provide details regarding the intake screening and scheduling of the ongoing Family Time/Sibling Visits.

Any changes to the Family Time/Sibling Visits schedule must be approved in advance by the assigned DCYF worker.

Agency Assignment

REFERRAL RECEIVED ☐ Accepted ☐ Denied	REFERRAL EXPIRATION DATE* (SIX MONTHS FROM REFERRAL DATE) * After this date, Family Time/Sibling Visits are not authorized and may not be paid. A new referral must be submitted and must include an Area Administrator's signature to authorize the extension of the Family Time/Sibling Visits and payment.	FAMLINK CASE ID
ONGOING SERVICE START DATE		CASE NAME
AGENCY NAME / PHONE NUMBER (AND AREA CODE) / EMAIL ADDRESS		DATE FAMILY TIME/SIBLING VISIT SCHEDULE SENT ELECTRONICALLY TO DCYF STAFF

Visitation

Contractor shall notify assigned DCYF worker of any changes to the assigned Family Time/Sibling Visits supervisor.

ASSIGNED FAMILY TIME/SIBLING VISIT FACILITATOR	PHONE NUMBER (AREA CODE)	LANGUAGES SPOKEN BY FACILITATOR

ADDRESS / LOCATION WHERE FAMILY TIME/SIBLING VISIT WILL OCCUR (I.E., PARENT HOME, CAREGIVER HOME, COMMUNITY)

FAMILY TIME/SIBLING VISITS WILL BEGIN AT (ENTER TIME OF DAY)	DAY OF WEEK
1. ______	1. ______
2. ______	2. ______
3. ______	3. ______
4. ______	4. ______
5. ______	5. ______
6. ______	6. ______
7. ______	7. ______

Transportation

ASSIGNED TRANSPORTATION FACILITATOR	PHONE NUMBER (AREA CODE)	LANGUAGES SPOKEN BY FACILITATOR

TIME OF PICK-UP	TIME OF DROP-OFF
1. ______	1. ______
2. ______	2. ______
3. ______	3. ______
4. ______	4. ______
5. ______	5. ______
6. ______	6. ______
7. ______	7. ______

Family Time/Sibling Visit Intake Screening
Review the Family Time/Sibling Visit Service Referral for the following information: Medical / dietary needs, communication needs and safety / behavioral concerns, sibling dynamics, or hygiene needs. Documented contact with caregiver to discuss: relevant child specific information (include the child's name), scheduling (availability) and barriers to participation: Comments:
Day and time of intake Family Time/Sibling Visit:
Notifications to/from assigned DCYF Staff
Document any changes to Family Time/Sibling Visits (days and times, location, date, length and duration, level of supervision, change in DCYF worker, etc.) and the date that the change was requested and/or authorized by DCYF staff.

DATE OF CHANGE	PARTY REQUESTING CHANGE
CHANGE MADE	
DATE OF CHANGE	PARTY REQUESTING CHANGE
CHANGE MADE	
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