



ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF CHILDREN AND FAMILY SERVICES

Parent Notification of Changes In Out-Of-Home Placement

I. NOTIFICATION TO PARENT(S):

Parent's Name _____

Child's Name _____

Parent's Address _____

This is to notify you the above named child (check one) will be/ has been moved to a: (check correct box)

New Foster Home New Facility New School Move Date _____

Comments: *explain reason(s) for move*

II. Specific Reason Justifying the Change of Placement Without Advance Notice:

III. Basis for the Recommended School Change and How it Serves the Child's Best Interest:

IV. Notification of other changes in the case:

Change in Family Service Worker: FSW's Name _____

FSW's Address _____

Effective Date: _____ Phone Number _____

Child left care Child is deceased Date _____

Parental rights terminated Date _____

Child age 16-19 (not in school) Date left school _____

Foster child gave birth Infant's name _____ Date of birth _____

Foster child ran away (requires telephone or in-person notification within 2 hours and follow-up written notice)

V. SIGNATURES:

Family Service Worker Name

DCFS Supervisor Name

Family Service Worker – (Signature)

DCFS Supervisor – (Signature)

Date Signed

Date Signed

Date of Notification

INSTRUCTIONS

CFS-300

Parent Notification of Changes in Out-of-Home Placement

PURPOSE: To notify a child's parents (if appropriate) that the child will be/has been moved to a different foster home or to another type of facility. Routinely, written notice shall be sent **two (2) weeks** prior to the proposed change. After an emergency change of placement, notification shall be made within **twenty-four (24) hours**. The parent(s) shall be notified of the specific reasons why a placement change was made without advance notice. The form also provides a place for any comments the Family Service Worker (FSW) may want to convey to the parents in writing.

Note: Parents are NOT entitled to the foster parents' address and phone number, unless otherwise specified.

COMPLETION:

1. **Section I.** is for information that will go to the parent(s).
 - (a) Write or type in both parents' names (if there are two);
 - (b) Write or type the child's name (all the names if there is more than one);
 - (c) Write or type the parent's address;
 - (d) Check one: "will be" or "has been"
 - (e) Check either "New Foster Home", "New School" or "New Facility";
 - (f) Write or type the date the child's placement was changed (format - mm/dd/yyyy);
 - (g) Write or type any comments the FSW considers appropriate for the child's parents.
2. **Section II.** Is used to justify the change of placement without advance notice. If the change of placement was done without advance notice, type or write the reason justifying the lack of advance notice.
3. **Section III.** Use this section to document specific information concerning changes in the child's school. Include documentation that individuals who are directly involved in the care, custody, and education of foster children worked together to ensure continuity of educational services for the child.
4. **Section IV.** Use this section to make notification to parents of other changes in the case.
 - (a) Each check box requires that some additional information be typed or written in (e.g. name, address, telephone, or date);
5. **Section V.** Is for the FSW and Supervisor's names, signatures and dates.
 - (a) The FSW should write or type his/her name and the name of his/her supervisor and **sign and** date the form.
 - (b) The FSW's Supervisor should review the completed form and sign and date the form.
 - (c) Type or write the date of the notification.

ROUTING:

1. The FSW shall send the signed and dated form to his/her supervisor for review and signature.
2. The Supervisor shall review and sign the form and return the completed form to the FSW for routing to the parents.



ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF CHILDREN AND FAMILY SERVICES

Attorney-Ad-Litem, Court Appointed Special Advocate and Child
Notification of Changes In Out-Of-Home Placement

I. NOTIFICATION TO ATTORNEY AD LITEM / COURT APPOINTED SPECIAL ADVOCATES:

Parent's Name _____ Child's Name _____

Parent's Address _____

This is to notify you the above named child (check one) [] will be/ [] has been moved to a: (check correct box)

[] New Foster Home [] New Facility [] New School Move Date _____

Comments:

[Empty box for comments]

Name of Foster Family or Facility _____ Telephone _____

Address of Foster Family or Facility _____

II. REASON(S) FOR THE MOVE:

[] Change in Family Service Worker: FSW's Name _____

FSW's Address _____

Effective Date: _____ Telephone _____

[] Child left care [] Child is deceased Date _____

[] Parental rights terminated Date _____

[] Placed for Adoption Date _____

[] Child age 16-19 (not in school) Date left school _____

[] Foster child gave birth Infant's name _____ Date of birth _____

Placement address _____

Specific Reason Justifying the Change of Placement Without Advance Notice:

[Empty box for specific reason]

Basis for the Recommended School Change and How it Serves the Child's Best Interest:

(IF THE CHANGE IS SCHOOL RELATED, NOTIFY THE CHILD TOO)

[Empty box for basis for school change]

III. SIGNATURES:

Family Service Worker Name _____

DCFS Supervisor Name _____

Family Service Worker - (Signature) _____

DCFS Supervisor - (Signature) _____

Date Signed _____

Date Signed _____

Date of Notification _____



**Arkansas Department Of Health and Human Services
Division of Children & Family Services
Child Maltreatment Assessment Determination Notification**

CHRIS Referral # _____ **County:** _____

To: (Name) _____
(Address) _____

From:(Name/Agency) _____
(Occupation) _____
(Address) _____

Date: _____ **Certified Mail #:** _____

Re: Notice of Child Maltreatment Assessment Determination

Child(ren) Involved:

On _____ the Division of Children & Family Services, or Crimes Against Children Division, received an allegation of suspected child maltreatment involving you and/or your child(ren) or a child(ren) whose care you have been entrusted with. The allegation stated that the incident occurred on or about the following date: _____ and time: _____. This letter is to inform you of the assessment determination of suspected maltreatment using the standard of a preponderance of the evidence.

- The evidence does not support the allegation of Child Maltreatment.
- The evidence supports the allegation of Child Maltreatment and _____ was/were named as the offender(s). Circumstances indicate that a Protective Services case should be opened for your family.
- The evidence supports the allegation of Child Maltreatment and _____ was/were named as the offender(s). Circumstances do not indicate that a Protective Services case should be opened for your family.

You may obtain a copy of your report by sending a written, notarized request to Arkansas Department of Health & Human Services, Division of Children and Family Services, Central Registry Unit, P.O. Box 1437, (Slot S566), Little Rock, Arkansas 72203-1437. The request must give your name and address and the names of the child(ren) involved. Include a \$10.00 check or money order made out to the Department of Health and Human Services (DHHS).

Per A.C.A § 12-12-506(g) the Department may disclose a true investigative determination of any offender when the offender is engaged in child-related activities or employment and the Department has determined that children under the care of the offender are at risk of maltreatment by the offender. If you have been named as the offender of a true report, your name will be placed in the Arkansas Child Maltreatment Central Registry.

Your employment may be adversely effected if your name is placed in the Central Registry. If you disagree with the assessment determination and your name being placed in the Registry, you may request an administrative hearing within thirty (30) days of receipt of the restricted certified mail notification. If the offender was a juvenile (10-17 years old) at the time of the act or omission, this matter has been referred for an automatic administrative hearing. The juvenile offender can decline the automatic hearing by submitting a written waiver.

The administrative hearing may take place in person if requested in writing by the petitioner or the petitioner's attorney within thirty (30) days from the date that the petitioner receives this notification. The hearing officer may conduct the hearing by video teleconference in lieu of an in-person hearing. If neither party requests that the hearing be conducted in person, then the hearing shall be conducted telephonically.

Mail your notarized request for an administrative hearing or your written waiver of the automatic hearing, along with a copy of this letter, to: Appeals and Hearings Officer, Slot N401, P. O. Box 1437, Little Rock, AR 72203, and copy your request to the Investigator named above.

INSTRUCTIONS

CFS-312A

CHILD MALTREATMENT ASSESSMENT DETERMINATION NOTIFICATION

NOTE: Do not use this form if the notification involves an **Underaged Juvenile Aggressor**. Use a CFS-312B.

Purpose: To inform the alleged victim(s) and offender(s) of the outcome of the Child Maltreatment Assessment. Staff from the Division of Children and Family Services (DCFS) and the Crimes Against Children Division (CACD) will use the CFS-312a for notification purposes. This letter is to be mailed if the Child Maltreatment Assessment is found true or unsubstantiated.

Completion:

- Insert the CHRIS Referral number and the county name;
- The form is to be addressed appropriately to the addressee(s);
- Insert the sender's name, select the correct organization, insert the sender's occupation and insert the local DCFS office address;
- Insert the date and the certified mail number;
- Identify the child(ren) involved;
- Insert the date of the allegation AND the date & time of the alleged incident (pick a.m. or p.m.);
- Check the box of the proper assessment determination (outcome);
- Insert the worker's name, occupation and phone number;
- Signed by the worker's supervisor.

NOTE: The identified county will be responsible for preparing the investigative file and defending the determination. The county for DCFS is the county where the child lives. The county for CACD is the county of occurrence.

Routing: One (1) completed letter addressed to:

- The family of each alleged victim;
- The alleged victim, if 10 years of age or older; and
- The family of each alleged offender, if the offender is a minor (under 18) or
- The offender if 18 or over.
- The Attorney Ad Litem, if the child is in an out-of-home placement.
- The Public Defender if one is assigned.
- The Office of Fair Hearings and Appeals for all juvenile offenders when there is a "True" finding. Fair Hearings and Appeals **must** be sent a copy on all offenders who were under the age of 18 at the time of the incident with a "True" finding.
- The Juvenile Division of Circuit Court if there is a true finding of sexual abuse perpetrated by a child under the jurisdiction of the court.
 - 1) If there is a true finding of child maltreatment, the CFS-312a will be routed to the above named individuals by certified mail, restricted delivery or via process server to the recipient's last known address.
 - 2) Two copies of the CFS-312a will be routed to anyone listed above who has appeal rights.
 - 3) Retain a file copy of each letter mailed.

Posting: Post the date the letter is mailed on the Document Tracking screen in CHRIS.



Arkansas Department Of Health & Human Services Division of Children & Family Services

Child Maltreatment Assessment Determination Notification (UNDERAGED JUVENILE AGGRESSOR)

CHRIS Referral # _____ County: _____

To: _____

From: _____

Agency: _____

Address: _____

Date: _____ Certified Mail #: _____

Re: **Notice of Child Maltreatment Assessment Determination**

Child(ren) Involved:

On _____ the Division of Children and Family Services or Crimes Against Children Division, received an allegation of suspected child maltreatment involving your child(ren). The allegation stated that the incident occurred on or about the following date and time: _____, _____. This letter is to inform you of the assessment determination of suspected maltreatment using the standard of a preponderance of the evidence.

- Unfounded** (unsubstantiated): there is no preponderance of evidence that the abuse occurred.
- Exempt from finding** (under 10 years of age): There is a preponderance of evidence that the sexual abuse occurred AND the child(ren) being assessed ___ less than 10 years old, the child(ren) involved ___ named the Underaged Juvenile _____. A Protective Services case should be opened for your family.
- Exempt from finding** (under 10 years of age): There is a preponderance of evidence that the sexual abuse occurred AND the child(ren) being assessed ___ less than 10 years old. The child(ren) involved ___ named the Underaged Juvenile _____. A Protective Services case **does not** need to be opened for your family.

The parents of an underage juvenile aggressor may obtain a copy of the report by sending a written, notarized request to Arkansas Department of Health & Human Services, Division of Children and Family Services, Central Registry Unit, P.O. Box 1437, (Slot S566), Little Rock, Arkansas 72203-1437. The request must give your child's name and address and the names of the other child(ren) involved. Include a \$10.00 check or money order made out to the Department of Health & Human Services (DHHS).

Your child(ren) ___ been named as an Underaged Juvenile _____. ___ will not be placed in the Arkansas Child Maltreatment Central Registry due to _____. This matter has been referred for an automatic administrative hearing. Only the parent or other person acting on behalf of the underage juvenile aggressor can waive the hearing. The waiver must be in writing. The hearing may be in-person if requested in writing by the petitioner or his/her attorney within thirty (30) days of receipt of the restricted certified mal notification. The hearing officer may conduct the hearing by video conference in-lieu of an in-person hearing. If no one requests an in-person hearing, it will be conducted telephonically. Mail your notarized request for an administrative hearing or your written waiver of the automatic hearing, along with a copy of this letter, to: Appeals and Hearings Officer, Slot N401, P. O. Box 1437, Little Rock, AR 72203, and copy your request to the Investigator named above. See the publication "*Child Protective Services: A Caretaker's Guide*" (PUB-052) for additional information, or call _____, _____ at the phone number _____.

() _____.

This information is available in different formats such as: large print, audiotape, etc. If you need another format, contact the Division's ADA Coordinator at 682-8760 or TDD 682-1442.

INSTRUCTIONS CFS-312B

CHILD MALTREATMENT ASSESSMENT DETERMINATION NOTIFICATION UNDERAGED JUVENILE AGGRESSOR

NOTE: Use this form if the notification involves an Underaged Juvenile Aggressor.

Purpose: To inform the alleged victim(s) and the parents of underage juvenile aggressor(s) of the outcome of the Child Maltreatment Assessment. Staff from the Division of Children and Family Services (DCFS) and the Crimes Against Children Division (CACD) will use the CFS-312B for notification purposes. This letter is to be mailed if the Child Maltreatment Assessment is unfounded or exempt from finding (under 10 years of age).

Completion:

- Insert the CHRIS Referral number and the county name.
- Address the form (To:) appropriately.
- Select the "Agency:" from the pick list (DCFS or CACD).
- Insert the local office address and date.
- Insert the certified mail number.
- List the names of all the child(ren) (underaged juvenile aggressors) involved.
- Insert the date the allegation was received.
- Insert the date and time the incident occurred.
- Check the correct assessment determination (outcome).
- If you select either of the "Exempt from finding" determinations, you must select a word for each of the three pick lists: "is **or** are", "was **or** were" and "Aggressor **or** Aggressors".
- In the last paragraph, you must make selections for six pick lists: "has **or** have", Aggressor **or** Aggressors", "his, her **or** their" (twice), "name **or** names", and "age **or** ages". The Family Service Worker or CACD Worker's name, agency and phone number should be inserted.,
- A supervisor must sign the form. Finally, you must select a title from a pick list to go under the supervisor's signature. Select either "DCFS County Supervisor **or** CACD Supervisor".

The identified county will be responsible for preparing the investigative file and defending the determination. The county for DCFS is the county where the child lives. The county for CACD is the county of occurrence.

Routing: One (1) completed letter addressed to:

- The family of each alleged victim;
- The alleged victim, if 10 years of age or older; and
- The family of each underage juvenile aggressor
- The Attorney Ad Litem, if the child is in an out-of-home placement.
- The Public Defender if one is assigned.
- The Juvenile Division of Circuit Court if there is a true finding of sexual abuse perpetrated by a child under the jurisdiction of the court.
- The Office of Fair Hearings and Appeals for all juvenile aggressors, when there is a finding of "Exempt from finding".

If there is an "exempt from finding" determination, the CFS-312b will be routed to the above named individuals by certified mail, restricted delivery or process server to the recipient's last known address.

Two copies of the CFS-312b will be routed to anyone listed above who has appeal rights.

Retain a file copy of each letter mailed.

Posting: Post the date the letter is mailed on the Document Tracking screen in CHRIS.

IN THE CIRCUIT COURT OF _____ COUNTY, ARKANSAS
JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES PLAINTIFF

VS. _____ NO. _____

_____, MOTHER

_____, LEGAL/PUTATIVE FATHER OF:

_____ DOB _____ SEX _____

JUVENILE

DEFENDANTS

CERTIFICATE OF SERVICE

I hereby certify that a copy of a Court Report in the above matter set for hearing on _____ was served on the following persons as outlined below:

- Name
Attorney Ad Litem
(Insert Mail address, Fax# or Email)
- Name (NOTE: If mother does not have counsel, you must send to the mother)
Parent Counsel
(Insert Mail address, Fax# or Email)
- Name (NOTE: If father does not have counsel, you must send to the father)
Parent Counsel
(Insert Mail address, Fax# or Email)
- CASA
(Insert Mail address, Fax# or Email)
- (Any other party to this Action)
(Insert Mail address, Fax# or Email)

Name of DCFS employee

DCFS employee signature

cc: OCC Attorney, Fax # or Email
file

Date

INSTRUCTIONS

CFS-423

Purpose

The CFS-423 “Certificate of Service” is used by DCFS staff in filing court reports with the clerk prior to court hearings. The Certificate of Service establishes that the court report has been distributed to all of the parties or their attorneys and the Court Appointed Special Advocate (CASA), if appointed.

Completion

Submit the court report to OCC staff at least fourteen (14) days prior to the court hearing. OCC will be responsible for filing and distributing the court report and the certificate of service.

The CFS-423 will be completed by DCFS staff if the court report is **not** submitted to Office of Chief Counsel (OCC) at least fourteen (14) days prior to the court hearing. If the court report is not submitted to OCC at least fourteen 14 days prior to the court hearing, then DCFS is responsible for filing and distributing the court report. The Certificate of Service along with the court report must be filed seven (7) business days before the hearing certifying that the court report or permanency planning court report has been distributed to all of the parties or their attorneys and CASA, if appointed.

Routing

The Office of Chief Counsel (OCC) will file and distribute the court reports with the clerk prior to court hearings along with the “Certificate of Service” **only** if requested in a timely manner.

The CFS-423 can be completed and placed on top of the court report when the report is filed with the clerk.

6. If I (we) plan to move to another state, I (we) will notify the Division of Children and Family Services in Arkansas at least ten (10) days prior to the move.
7. Maintenance and special subsidies as outlined in this Agreement will be payable without regard for my (our) state of residence.
8. If my (our) child is eligible to receive a Medicaid card, I (we) understand that it will be necessary to follow the appropriate procedures as determined by Arkansas or my (our) new resident state in order for Medicaid eligibility to continue.
9. This Agreement is for the benefit of the subject child, his or her parents and the State of Arkansas and is enforceable by any and all of these parties.
10. Adoptive parents may appeal the Division's decision to reduce, change or terminate adoption assistance in accordance with the state's hearing and appeal process.
11. For **special subsidies**, this Agreement will be in effect for no longer than twelve (12) months. If a modification should occur sooner, a new Agreement will be entered.

SUBSIDY NOTE:

Children at high risk for the development of a serious physical, mental, developmental or emotional condition may be considered special needs if documentation of the risk is provided by a medical professional specializing in the area of the condition for which the child is considered at risk, but no subsidy payment will be made without documentation that the child has developed the actual condition. When DHHS accepts that the child has developed the condition, the adoption subsidy shall be retroactive to the date the adoptive parents submitted adequate documentation that the child developed the condition. In order to be eligible for special needs based on developmental delay, documentation must be provided, current within 6 months, attesting to the fact that the child has a delay of 24% or more in two major developmental categories.

12. Certification of Adoption Subsidy Eligibility

The Adoption Support Specialist will forward a cover memo along with the CFS-431 (Notarized Statement on Eligibility for State Subsidy) to the adoptive parents annually. The cover memo will inform the adoptive parents that their local Adoption Specialist will contact them to schedule a visit.

The Adoption Specialist will have annual face-to-face contact with the child or otherwise verify that the child is still with the adoptive family. The Adoption Specialist should make the face-to-face contact a positive experience by exploring any needs for **post-adoption** services. The Adoption Specialist should also inquire as to whether the adoptive parents have added the adoptive child to their medical insurance. If so, the family must complete a DCO-662 (Third Party Resource). The Adoption Specialist is responsible for submitting the completed form to the Medical Services Section of the Division of Medical Services.

I (we) agree to complete and submit, annually, the CFS-431 and CFS-426 (Statement of Income and Resources for Adoption Subsidy) to the DCFS Adoption Services Unit within ten (10) days of receiving notification from the Adoption Specialist.

By:	Director, Division of Children and Family Services	Date
	Adoptive Mother's Signature	Date
	Adoptive Father's Signature	Date

A signed copy of the Adoption Assistance Agreement was given / sent to the Adoptive parent(s) on _____
Date

INSTRUCTIONS

CFS-428A

Adoption Assistance Agreement For State Funded Subsidy Payments

PURPOSE -

To define the parameters for an Adoption Assistance Agreement regarding subsidy payments funded by the state. The form identifies the adoptive parents and child(ren). It establishes the amount of the subsidy and the period it will be in effect. The form also specifies the nature of the problem(s) that justify the subsidy.

COMPLETION -

1. The Adoption Subsidy Coordinator fills out the CFS-428a.
2. Insert the adoptive parent(s) name(s) and address.
3. Insert the adoptive child's full name, social security number and date of birth.
4. Insert the date on which the adoption was finalized.
5. Mark the check box if this is an amendment to a prior agreement AND insert the original date of the adoption.
6. Insert the starting and ending dates for this agreement.
7. At numbered item 1., insert the amount of the monthly subsidy payment AND the number of months the agreement will exist.
8. At numbered item 2., insert a brief justification for the subsidy.
9. Read all the information in numbered items 3. – 12 carefully.
10. The adoptive mother and adoptive father will sign and date the form.
11. The DCFS Director or his/her designee will sign and date the form.
12. The DCFS staff member, who gives or mails a signed copy of the form to the adoptive parents will insert the date the signed copy is mailed or given to the adoptive parents.

ROUTING –

1. Once the DCFS Director or his/her designee signs the form, the Adoption Subsidy Coordinator will retain a copy and send the original to the appropriate Adoption Specialist.
2. The Adoption Specialist will have the adoptive parent(s) sign and date the original.
3. The Adoption Specialist will make two copies of the completed form with all the required signatures and will retain one and give the other copy to the adoptive parent(s).
4. The Adoption Specialist will return the completed original form to the Adoption Subsidy Coordinator.

NOTE: The Adoption Specialist will ensure that the original and all copies are dated with the date when a completed copy was given to the adoptive parents.