Temporary Emergency Placement Referral Form

Instructions: *To initiate requests for Temporary Emergency Placements across the New York / New Jersey state border, Sending Agency caseworkers or case planners must complete, sign, and e-mail this Temporary Emergency Placement Referral Form, along with all available supporting documents, to the Sending Agency Liaison indicated. The Sending Agency Liaison must then forward these documents to the Sending State ICPC Office, Receiving State ICPC Office, and Receiving Agency Liaison. Please attach information in a separate document if the data field does not provide sufficient space.*

Date:

1. CHILD INFORMATION

A. Child(ren) Recommended for Temporary Emergency Placement

Name	DOB	Race / Ethnicity	Sex	Gender Identity
			M F	
Child's Specific Needs *Diagnoses, IEP, therapy, services*				
			M F	
Child's Specific Needs *Diagnoses, IEP, therapy, services*				
			M F	
Child's Specific Needs *Diagnoses, IEP, therapy, services*				
			M F	
Child's Specific Needs *Diagnoses, IEP, therapy, services*				
			M F	
Child's Specific Needs *Diagnoses, IEP, therapy, services*				

B. Indian Child Welfare Act Eligibility
Yes No *If "yes" for any Child, please explain*

C. Title IV-E Eligibility Yes No Pending

D. Name of Parent(s) or Legal Guardian(s)

E. Address of Parent(s) or Legal Guardian(s)

Agreement by and Among the State of New York Office of Children and Family Services, the City of New York Administration for Children's Services, and the State of New Jersey Department of Children and Families for Temporary Emergency Placements.

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F. Current Status

For each Child, please provide a brief description of the reasons for CPS involvement; legal status (e.g. whether Child is remanded, paroled to a relative under court-ordered supervision, etc…); placement history; and any services currently received. Include any concerns relating to domestic violence, mental health, substance use, orders of protection, restrictions on visiting or contact, and potential safety and protection issues for the Child and Cross-Jurisdictional Resource.

G. Services Required for Specific Needs

Specific needs include, but are not limited to, allergies, dietary concerns, behavioral concerns, IEP classification, developmental status, medical conditions and medications, mental health diagnoses, etc… Please attach: (a) the Sending Agency's plan for meeting the Child's medical and financial needs during the Temporary Emergency Placement; and (b) the preplacement physical with available supporting documentation.

H. Justification for Temporary Emergency Placement Request

Please include a brief explanation of why each Child requires expedited placement prior to the completion of a full ICPC home study.

2. CROSS-JURISDICTIONAL RESOURCE INFORMATION

A. Name:

B. Social Security Number *(if available)*

C. Date of Birth:

D. Sex, Gender Identity:

E. Race, Ethnicity:

F. Relationship to Child:

G. Resource Type Parent Relative Foster Parent

H. Residential Address:

I. County of Residence:

J. Home Phone Number(s):

K. Work Phone Number(s):

L. Cell Phone or Other Number(s):

M. Email Address(es):

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3. CROSS-JURISDICTIONAL RESOURCE HOME INFORMATION

A. Total Number of Rooms in Home:

B. Number of Bedrooms for Child(ren)'s Use: C. Number of Bathrooms for Child(ren)s Use:

D. Members of Household, Including Children, Residing in Home:

Name	DOB	Sex	Gender Identity	Relationship to Resource
		M F		
		M F		
		M F		
		M F		
		M F		

4. SENDING AGENCY INFORMATION

A. Sending Agency Name: B. Phone Number:

B. Email Address: B. Fax Number:

C. Name of Requesting Caseworker / Case Planner: D. Phone Number:

D. Email Address: D. Fax Number:

E. Affidavit Confirming Resource Interest

By my signature, I affirm that I have spoken with the Cross Jurisdictional Resource named above and that he/she/they has/have indicated to me that he/she/they seek(s) to proceed with the Temporary Emergency Placement of the Child(ren) named above.

Case Worker / Case Planner Signature: ______________________________ Date:

F. Name of Requesting Supervisor: G. Phone Number:

G. Email Address: G. Fax Number:

H. Supervisor Signature: ______________________________ Date:

I. Additional Information Relevant to Placement *(e.g. Allergies or Other Health Concerns)*

Sending and Receiving Agency Liaisons

NJ DCF: Monica Nelson and Gayle Williamson: njicpc@dcf.nj.gov with copies to your Area Resource Family Specialist (ARFS), monica.nelson@dcf.nj.gov and gayle.williamson@dcf.nj.gov;

Interstate Main Line: 609-888-7120; Monica Nelson: 609-888-7123; Gayle Williamson: 609-888-7485