

PERMISSION TO PLACE AND TREAT CHILD PLACED UNDER VOLUNTARY SERVICES PROGRAM

DCF-449

9/15 (Rev.)



This is an agreement between the Department of Children and Families (DCF) and the parent(s) or guardian(s) of:				
Name of Child:		DOB:	LINK#:	
<p>As legal guardian(s) of the above child, and as a parent(s) who retains all parental rights over said child, I/we request and agree to his/her voluntary placement under the care and supervision of DCF.</p> <p>I/We authorize routine tests and treatment that DCF considers necessary for the proper welfare of my/our child, including psychiatric, medical and dental treatment. I/We also authorize DCF, in my/our absence (after making reasonable but unsuccessful attempts to contact me/us) to authorize emergency treatment, including surgery, to protect the life and well-being of my/our child.</p> <ul style="list-style-type: none"> • visit my/our child as arranged by me/us and the treatment team • actively participate in the case planning for my/our child toward the anticipated goal of reunification with his/her family • actively participate in any/all treatment work/sessions for my/our child, as recommended by the treatment team • notify DCF should I/we plan to remove my/our child from DCF care • provide DCF with information related to my/our child's health and welfare, and authorize the release of all relevant information and reports to DCF and authorize DCF to share information about my/our child with those providing health, education or other services for the welfare of my/our child • keep DCF informed of our current whereabouts and contact information, both for routine and emergency purposes • I/We understand that we may be expected to make financial contributions toward the cost of care for my/our child, if determined capable by the State of Connecticut, Department of Administrative Services Bureau of Collection Services 				
Parental restrictions:				
Parental medical coverage(s):				
<p>The Department of Children and Families will:</p> <ul style="list-style-type: none"> • upon your request, return your child to you within 24 hours, unless an emergency exists • provide care for your child in the least restrictive and most appropriate treatment setting available to DCF • arrange for you to visit with your child • actively participate in the case planning for your child toward the anticipated goal of reunification with his/her family • make arrangements with you for the medical, dental and optical care of your child • notify you when DCF determines that it is appropriate to return your child to you 				
Name of Parent 1/Guardian 1:		Signature of Parent 1/Guardian 1:		Home/Cell #
Address (No. and Street):		City:	State:	Zip:
Name of Parent 2/Guardian 2:		Signature of Parent 2/Guardian 2::		Home/Cell #
Address (No. and Street, <i>if different from above</i>):		City:	State:	Zip:
Name of Social Worker"		Signature of Social Worker:		Home/Cell #
Name of Social Work Supervisor:		Signature of Social Work Supervisor:		Home/Cell #
DCF Office and Address:			Date:	