## State of Connecticut Department of Children and Families FOSTER CARE LICENSING PLACEMENT WAIVERS REQUEST FORM DCF-009



9/19 (Rev.)

Licensed Foster Parent Prospective Foster Parent	Licensed Bed Capacity:	Language:		Provider LINK	C#
Last Name- Caregiver 1	First Name	E-mail:		Phone:	
Last Name—Caregiver 2	First Name	E-mail:		Phone:	
Address (# and Street)	Apt.#:	City:		State:	Zip:
	Type of Waiver			Check, if Applicable	Approving Authority
Physical Requirements of the Home (Egress, Pools, Lead Paint For Children >6) Foster Care Regulations Section 17-145-137				CPS PS and FASU PS	
Telephone: Foster Care Regulations Section 17-145-138					CPS PS and FASU PS
Children's Bedroom, Clothing, Privacy	v, Egress: Foster Care Regulati	ons Section 17-14	5-139		CPS PS and FASU PS
More than one out-of-home care licen	se (in-house day care): Foster	Care Regulations 8	Section 17a-145-150		CPS PS and FASU PS
Financial Condition: Foster Care Regu	ulations Section 17a-145-147				CPS PS and FASU PS
Food and Water: Foster Care Regulat	ions Section 17-145-140				CPS PS and FASU PS
Animals: Foster Care Regulations Sec	ction 17-145-142				CPS PS and FASU PS
Health Standards: Foster Care Regulations Section 17a-145-143				CPS PS and FASU PS	
More than one out-of-home care license (DDS and CPA): Foster Care Regulations Section 17a-145-150			tion 17a-145-150		FASU Director
Criminal History; Pending Criminal Actions; History of Child Abuse or Neglect: Foster Care Regulations Section 17a-145-152				Commissioner	
Overcapacity: DCF Policy 41-19-2				CPS PS and FASU PS	
More than one TFC Placement*				TFC Director	
*NOTE: For a waiver involving more than one TFC placement, the OD or their designee requesting the waiver shall take the lead to obtain agreement between the two involved Regions and the TFC partner agency. Upon agreement, the OD shall notify the FASU Director and attach the finalized waiver form.					
	Please List The Name(s) Of 1	he Children To B			
LAST NAME	FIRST NAME		NDER Male / 🗌 Unknown	DOB	LINK CASE ID
		Female /	Male / 🗌 Unknown		
			Male / Unknown		
Plea	ase List The Name(S) Of The			Home	
NAME	GENDE		DOB		elationship to Applicant
	🗌 Female / 🗌 Ma	ale / 🗌 Unknown			
Female / Male / Unknown					
🗌 Female / 🗌 Male / 🗌 Unknown					
	🗌 Female / 🗌 Ma	ale / 🗌 Unknown			
🗌 Female / 🗌 Male / 🗌 Unknown					
	🗌 Female / 🗌 Ma	ale / 🗌 Unknown			

DCF-009 FOSTER CARE LICENSING PLACEMENT WAIVERS REQUEST FORM

Is this a Day Care Home?: LAST NAME (optional)	Yes No FIRST NAME (opti	If Yes, Please List The Children Receivi onal) GENDER	ng Day Care In The Home (below): DOB Hours
		Female / Male / Unknown	
	-	Female / Male / Unknown	
		Female / 🗌 Male / 🗌 Unknown	
		EXISTING WAIVERS	
Explain (if you need additional i	room, please attach sheet):		
	FOSTER CARE REG	GULATIONS SECTION 17a-145-137-151	
Explain (if you need additional i	room, please attach sheet):		



Explain (if you need additional room, please attach sheet):

OVERCAPACITY: DCF POLICY 41-19-2 CORE TFC				
Explain (if you need additional room, please attach sheet):				

Explain (if you need additional room, please attach sheet):							
LENGTH OF TIME OVERCAPACITY/WAIVER IS GRANTED FOR WEEKS OR Permanent Overcapacity: Yes No							
Position	REQUIRED SIGNA Name	TURES ( <i>as applicable</i> ): Signature	Date				
FASU PS							
FASU PS							
CPS PS							
CPS PS							
TFC Agency Representative							
Office Director (if unavailable, Assistant Chief or Designee)							
FASU or Clinical Program Director							
Commissioner (if unavailable, Deputy Commissioner)							

NOTE: Any request involving more than one Region requires a discussion between both Regional teams before placement occurs.