

Voluntary Placement Agreement

Use of form: This form is required by section 472(f)(2) of the social security act when a child is voluntarily placed in out-of-home care by a parent or legal guardian. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

I hereby request the _____ to place
Department of Children and Families / County Department

my child _____, born on _____, in a
(First, MI, Last) (mm/dd/yyyy)

foster home, group home, pursuant to s.48.63(1), Wis. Stats., group home, pursuant to s.48.625(1m), Wis. Stats.

Placement dates are from _____ to _____.
(mm/dd/yyyy) (mm/dd/yyyy)

I understand that by signing this document I grant placement and care responsibility of the child to the department listed above.

I understand that the child's placement in a licensed foster home may not exceed 180 days from the date of placement. I understand that the child's placement in a group home, under s.48.63(1), Wis. Stats., may not exceed 15 days from the date of placement. I understand that the child's placement in a group home, under s.48.625(1m), Wis. Stats., may not exceed 180 days from the date of placement.

I understand that I may terminate this agreement at any time and that the child age 12 years of age or older may terminate the agreement relative to his or her placement.

I understand that a permanency plan, pursuant to s.48.63(4) and 48.63(5)(c), Wis. Stats., will be prepared and I will be involved in the development of that plan.

I agree to keep the department informed of any changes in my circumstances, including address, employment and earnings, marital status, health, access to health insurance and plans relative to the child.

I understand that I may be held financially responsible for all, or a portion of, the placement costs that may incur during the child's stay in the foster home or group home placement. I agree to cooperate with the department in determining my portion of the placement costs for the child. If determined to be financially responsible I agree to pay the department for the care of the child in the amount of \$ _____ per week month beginning on _____ (mm/dd/yyyy). Payments are to be made to: _____

located at _____.
(Street, City, State, Zip Code)

I hereby agree that the department may give consent for medical evaluations, necessary inoculations, immunizations or routine medical or health care or treatment for the child. I hereby agree that the department may consent to other necessary medical or health care as prescribed, including but not limited to major medical, psychiatric and surgical treatment for the child if I cannot be located to give my consent.

SIGNATURE – Parent / Guardian

Date Signed

SIGNATURE – Parent / Guardian

Date Signed

SIGNATURE – Department Representative

Date Signed

SIGNATURE – Child (if age 12 or older)

Date Signed