

State of Connecticut Department of Children and Families
FOSTER CARE LICENSING PLACEMENT WAIVERS REQUEST FORM

DCF-009

12/2021 (Rev.)



<input type="checkbox"/> Licensed Foster Parent <input type="checkbox"/> Prospective Foster Parent <input type="checkbox"/> TFC Family		Licensed Bed Capacity:	Language:	Provider LINK #	
Last Name- Caregiver 1	First Name	E-mail:	Phone:	Race:	Ethnicity:
Last Name—Caregiver 2	First Name	E-mail:	Phone:	Race:	Ethnicity:
Address (# and Street)		Apt.#:	City:	State:	Zip:

Type of Waiver	Check, if Applicable	Approving Authority
Criminal History; Pending Criminal Actions; History of Child Abuse or Neglect: Regulations of CT State Agencies §17a-145-152	<input type="checkbox"/>	Commissioner
Fingerprint Exception: Social Security Act §471(a)(20)(A)	<input type="checkbox"/>	Commissioner
More than one out-of-home care license (DDS and CPA): Regulations of CT State Agencies §17a-145-150	<input type="checkbox"/>	FASU Director
More than one TFC Placement*	<input type="checkbox"/>	TFC & Office Director
Physical Requirements of the Home (Egress, Pools, Lead Paint For Children >6): Regulations of CT State Agencies §17-145-137	<input type="checkbox"/>	CPS PS and FC PS
Telephone: Regulations of CT State Agencies §17-145-138	<input type="checkbox"/>	CPS PS and FC PS
Children's Bedroom, Clothing, Privacy, Egress: Regulations of CT State Agencies §17-145-139	<input type="checkbox"/>	CPS PS and FC PS
More than one out-of-home care license (in-house day care): Regulations of CT State Agencies §17a-145-150	<input type="checkbox"/>	CPS PS and FC PS
Financial Condition: Regulations of CT State Agencies §17a-145-147	<input type="checkbox"/>	CPS PS and FC PS
Food and Water: Regulations of CT State Agencies §17-145-140	<input type="checkbox"/>	CPS PS and FC PS
Animals: Regulations of CT State Agencies §17-145-142	<input type="checkbox"/>	CPS PS and FC PS
Health Standards: Regulations of CT State Agencies §17a-145-143	<input type="checkbox"/>	CPS PS and FC PS
Overcapacity: DCF Policy 24-1	<input type="checkbox"/>	CPS PS and FC PS

*NOTE: For a waiver involving more than one TFC placement, follow the Second Child Waiver procedures issued on February 2020

Please List The Name(s) Of The Children To Be Placed In This Home

LAST NAME	FIRST NAME	GENDER	DOB	RACE	LINK CASE ID
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unk			
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unk			
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unk			
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unk			
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unk			

Please List The Name(s) Of Current Household Members (Children and Adults)

NAME	GENDER	DOB	SPECIFY Relationship to Applicant
	<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		
	<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		
	<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		
	<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		
	<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		

Is this a Day Care Home?: Yes No **If Yes, Please List The Children Receiving Day Care In The Home (below):**

LAST NAME (optional)	FIRST NAME (optional)	GENDER	DOB	Hours
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		
		<input type="checkbox"/> Female / <input type="checkbox"/> Male / <input type="checkbox"/> Unknown		

EXISTING WAIVERS

WAIVER REASON

PLAN TO REDUCE OVERCAPACITY

Empty space for the plan to reduce overcapacity.

LENGTH OF TIME OVERCAPACITY/WAIVER IS GRANTED FOR _____ WEEKS OR Permanent Overcapacity: Yes No

REQUIRED SIGNATURES (as applicable):			
Position	Name	Signature	Date
FC PS			
FC PS			
CPS PS			
CPS PS			
TFC Agency Representative			
Office Director (if unavailable, Assistant Chief or Designee)			
FC or Clinical Program Director			
Statewide Director of Foster Care			
Commissioner (if unavailable, Deputy Commissioner)			

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