



RELATIVE CAREGIVER COMMUNICATION

Fax to
Claire Howzell
561-837-5563

Please complete one form for each child for whom assistance is requested.

PART A: To: _____ Date: _____

Economic Self-Sufficiency Services Program County: _____

Family Safety Program/Contracted Provider District/Region: _____

Child's Name: _____ DOB: _____

SSN: _____ Race: _____ Sex: _____

Relative Caregiver's Name: _____ Phone Number: _____

Address: _____

PART B: Child Being Referred to ESS (To be completed by Family Safety/Contracted Provider staff)

Date Child Adjudicated Dependent: _____ Date Home Study Completed: _____

Date Court Approved Placement: _____

PART C: Completed only when the child in Part "B" above is a half-sibling who is not related to the caregiver.

Name of a **child** in the placement who **is** related to Caregiver: _____ Race: ___ Sex: ___

DOB: _____ SSN: _____ Date Child Adjudicated Dependent: _____

Date Home Study Completed: _____ Date Court Approved Placement: _____

Check if this child who is related to the caregiver has a Relative Caregiver Program payment or application.

PART D: Family Safety/Contracted Provider Counselor to be notified: Completed for all referrals.

Name (Print): _____ Date: _____

Phone: _____ Office Location/Unit: _____

Signature: _____

PART E: To be completed by the Economic Self-Sufficiency Specialist when eligibility status is determined.

Relative Caregiver Payment Approved? Yes No FLORIDA Case #: _____

Payment Begin Date: _____ Payment End Date: _____

Amount of Relative Caregiver Payment: \$ _____

Economic Self-Sufficiency Specialist (Print): _____ Date: _____

Phone: _____ Office Location/Unit: _____

Signature: _____

PART F: Additional comments by ESS or Family Safety. If Relative Caregiver payment denied, include reason.

Part F Completed by: _____ Date: _____