Sibling Separation Staffing

This form is to be completed every 90 days for siblings who are not placed together, unless a sibling split request has been approved. Distribution: Foster Care Liaison

Date of Review:_____

FACTS Case Number(s):_____

1. Siblings Name _____ DOB: _____
   Referral Date:_____ Current Placement:_____
2. Siblings Name _____ DOB: _____
   Referral Date:_____ Current Placement: _____
3. Siblings Name _____ DOB: _____
   Referral Date:_____ Current Placement:_____
4. Siblings Name _____ DOB: _____
   Referral Date:_____ Current Placement: _____
5. Siblings Name _____ DOB: _____
   Referral Date:_____ Current Placement:_____
6. Siblings Name _____ DOB: _____
   Referral Date:_____ Current Placement: _____

Section 1 Reason for separation:

_____

_____

_____

Section 2 Why separation is in best interest at this time:

_____

_____

_____

Section 3 Actions Taken to date to place siblings together:

_____

_____

_____

Section 4 Impact of siblings staying together or separated – long and short term *(discuss for each sibling)*

_____

_____

_____

Section 5 Recommendations/actions to be taken:

_____

_____

_____

Section 6 List of participants:

_____

_____

_____

CWCMP Case Manager Signature: _____

Date: _____

CWCMP Supervisor Signature: _____

Date: _____