Sibling Split Request

This form is to be completed for siblings when there is a request for consideration of them not achieving permanency together.

Date of Review:_____

FACTS Case Number(s):_____

Assigned DCF Staff:_____

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: Parents' Names:

_____

_____

Date of PRT/Relinquishment:

_____

_____

Section 2 Date of out of home placement and reason for removal:

_____

_____

_____

_____

Section 3 Placement history of each sibling, to include attempts at placement of the siblings together:

_____

_____

Section 4 Describe why a split would be in the best interest of the siblings:

Section 5 Describe the interventions that have occurred to address the reasons for sibling split consideration.

Section 6 Describe the impact of siblings staying together or split (Discuss for Each Sibling)

Section 7 Therapeutic input from providers working with the siblings (individually or as a group):

Section 8 Describe the recruitment efforts made for each sibling and for the sibling group

Section 9 Identified Resource for each sibling

Section 10 Plans for continued contact:

Provider Case Manager Signature _____ Date _____

Provider Case Team Supervisor _____ Date _____

Recommendations of the Staffing Committee:

_____

_____

_____

_____

_____

_____

Staffing Committee Signatures:

Name: _____ Date _____

Name: _____ Date _____

Name: _____ Date _____

Name: _____ Date _____

CWCMP Program Director Approval _____ Date _____