



RESIDENTIAL CHILD CARE DISCHARGE FORM

Purpose: Residential Child Care Providers use this form to request CPS to remove a child from a placement.

Directions: Contractor shall complete and submit this Discharge Notice Form and submit to the Caseworker, Caseworker's chain of command and the State Office Discharge Mailbox at dfpsdischarge@dfps.state.tx.us within the following timeframes:

- For an Emergency Discharge, within 48 hours of deciding to discharge the child
- For a Non-Emergency Discharge, upon deciding to discharge the child

Contractor shall complete and submit this form for any placement change after the child's initial placement; including movement from one foster home to another within the same Child Placing Agency.

CHILD'S INFORMATION

Child's Name	Child's CPS Person ID number	Child's DOB
Type of Discharge Notice (select only one): <input type="checkbox"/> 24 Hour Emergency Discharge Notice <input type="checkbox"/> 10 Day Discharge Notice (GRO providing emergency care services) <input type="checkbox"/> 14 Day Discharge Notice (Non-Emergency) <input type="checkbox"/> 30 Day Discharge Notice (Non-Emergency)		

CONTRACTOR INFORMATION

Contractor Name	Resource ID number	Date Form Completed
Person Completing this Form	Contact Phone Number	
Contracted Service Type: <input type="checkbox"/> BCC - Basic Child Care <input type="checkbox"/> RTC - Residential Treatment Center <input type="checkbox"/> CPA - Child Placing Agency <input type="checkbox"/> SIL - Supervised Independent Living <input type="checkbox"/> TED - Treatment for Emotional Disorders <input type="checkbox"/> IPTP - Intensive Psychiatric Transition Program <input type="checkbox"/> ES - Emergency Shelter <input type="checkbox"/> CSC - Child Specific Contract		

DISCHARGE REASON

Provide reason contractor is requesting discharge (select all that apply):	
<input type="checkbox"/> Achieved therapeutic goals <input type="checkbox"/> Child's behavior <input type="checkbox"/> Caregiver moved <input type="checkbox"/> Change of verification/License type <input type="checkbox"/> Not least restrictive <input type="checkbox"/> Not verified/licensed to serve <input type="checkbox"/> Facility/Home closed/inactive	<input type="checkbox"/> Risk (or actual) abuse/neglect <input type="checkbox"/> Remains in placement, change of CPA <input type="checkbox"/> Service level decreased <input type="checkbox"/> Service level increased <input type="checkbox"/> Child incarcerated <input type="checkbox"/> Child hospitalized

EFFORTS TO PREVENT PLACEMENT DISRUPTION

Indicate efforts made to prevent placement disruption (select all that apply):

- Utilized the YES waiver (or contacted LMHA YES Waiver contact to pursue YES waiver)
- Utilized TCM Rehab services
- Contacted STAR Health Turning Point (for Bexar, Harris & Tarrant counties and Brownwood/Abilene areas only)
- Contacted local mental health authority mobile crisis team
- Utilized STAR Health Service Coordination
- Utilized STAR Health Complex Case Management
- Other (please specify)

RECOMMENDATION

Provide recommendations for future placement. This can include information regarding the child's triggers, what type of placement the child requires, what level of supervision, or special services that may be needed.

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our [privacy policy](#).

SIGNATURES

Contractor Signature Authority:

X

Printed Name:

X

Title:

Date Signed:

FOR DFPS USE ONLY

Resource ID:

Date of Placement:

Date of Notice:

Caregiver Name: