**NON-CONTRACTED PROVIDER WAIVER RENEWAL FORM**

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| **Agency’s Information** | | | |
| Agency’s SHINES Resource ID: |  | Agency’s contact person: |  |
| Agency’s name: |  | Site’s unit name or number: |  |
| Agency’s billing address: |  | Licensed capacity: |  |
| Agency’s site address: |  | Date of last agency inspection: |  |
| Home type: | Child Caring Institution  Child Placing Agency  Personal Care Home    Nursing Services  Community Living Arrangement  Drug Abuse Treatment Center  DBHDD Host Home  Other | Any citations? If so, what where the concerns: |  |
| License type: | Residential Child Care (RCC)  Department of Behavioral Health and Developmental Disability (DBHDD)  Department of Community Health (DCH)  None |
| Requested per diem: |  | Date previous waiver expired: |  |

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| **If placement is in a Non-Contracted CPA:** | | | |
| Name of foster parent(s): |  | SHINES ID number: |  |
| Full address of foster home: |  | Results of CPS screenings for all members 18 and over: |  |
| List all household members (with ages) occupying the residence: |  | Is/Are the child(ren) being placed under 12 years old? | Yes  No |
| Date of the last home inspection by the Child Placing Agency: |  | Number of home visits county plans to make monthly? |  |
| Justification for the per diem (if higher than a contracted RBWO rate): | *Please include any services the placement provider will utilize as well as any specific actions the provider will be taking that are above and beyond what is considered usual services for RBWO providers.* | | |
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| **Child Specific Questions:** | | | | | |
| Child’s Name: |  | Child’s DOB: |  | County of Origin: |  |

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| Child’s current behavior(s) and need(s) and what services are being provided? |
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| What have been the placement efforts to transition youth into a contracted RBWO placement within the last 90 days? |
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| Why is the child/youth still currently placed with a Non-Contracted Provider? |
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| County Case Manager Printed Name |  | County Case Manager Signature |  | Date |
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| County CM’s Supervisor Printed Name |  | County CM’s Supervisor Signature |  | Date |
|  |  |  |  |  |
| County Director Printed Name |  | County Director Signature |  | Date |
|  |  |  |  |  |
| Provider Director Printed Name |  | Provider Director Signature |  | Date |