CASE NAME	CASEWORKER

Form must be completed by visitation provider.

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)

Visit Coordination Plan

This form is to be completed by the Contractor within five (5) business days of accepting a referral. The information should reflect conversations with the caseworker, parent, and caregiver conducted during coordination activities. The completed "Visit Coordination Plan" will be sent to the assigned caseworker within two (2) days of completion.

AGENCY NAME	
AGENCY PHONE NUMBER (WITH AREA CODE)	AGENCY EMAIL
DATE REFERRAL RECEIVED ☐ Accepted ☐ Denied	REFERRAL EXPIRATION DATE* (SIX MONTHS FROM REFERRAL DATE) * After this date, visits are not authorized and may not be paid. A new referral must be submitted and must include an Area Administrator's signature to authorize the extension of visits and payment

Conversion to Sibling Visit

Contractor requests permission to convert parent – child visit to sibling visit if parent cancels or no-shows for visit AND at least two siblings who do not reside together are present: ☐ Yes ☐ No

Parent

Indicate times the parent is available for visits:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Are there locations other than those identified in the "Visit Referral" where the parent would be willing, able, and/or interested in visiting?

Does the parent know of any kin (relatives and friends) who might be able to supervise visits or help with transportation? Please note full name and date of birth if known to parent.

Identify any special events or occasions that the parent would like to observe or celebrate. Please be sure to identify dates.

Child

Please document the parent, caseworker, and caregiver's perspective regarding the following needs of the child.

- Daycare, school, and activity schedule:
- Culturally specific needs or considerations:
- Medical conditions including allergies:
- If applicable, sibling relationship dynamics:
- Toileting needs:
- Dietary needs and food sensitivities:
- Communication needs:
- Behavior concerns:

Indicate dates and times the child is available for visits:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

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Why is the child unable to visit on certain days and/or at specific times?

For Children 14 years or older

Has the caseworker noted any specific wishes identified by the child?

Caregiver

Note the caregiver's email and preferred method of contact:

Identify the role the caregiver wishes to play in visits.

- ☐ Provide transportation
- ☐ Invite the parent to attend medical and/or extracurricular activities
- ☐ Willing to supervise visits
- ☐ Provide electronic contact to supplement visits
- ☐ Provide snacks
- ☐ Provide diapers or formula

Details or comments:

Describe the caregiver's contingency plan for cancelled or shortened visits. Please identify at least one alternate contact who can be contacted if the caregiver is not available by phone.

Identify other DCYF approved adults or babysitters who are authorized to sign when the child is returned to the caregiver. Babysitters may include youth age 16 or older who are not currently in foster care and meet requirements set forth in WAC 110-148-1605 as verified by the foster parent.

If you were unable to speak with the caregiver, please explain the circumstances.

Visit Summary and Schedule
Please complete the grid on the following page. The visit schedule must mirror the schedule identified by the caseworker in the Visit Referral, DCYF 15-363, taking into consideration the parent and child's availability. If the parent identified other locations and resources for supervision or transportation, the caseworker must give final approval. 1. Identify each day of the week that a visit is scheduled. 2. Identify the beginning and end time of each visit. 3. Identify the visit location including an address. 4. Note who will be supervising the visit. 5. Identify the child and how they will be transported to the visit. Note where the child will be picked up and the time. 6. Notes where the child will be dropped off. 7. Identify any other possible locations for the visit. 8. Identify other individuals available to supervise or provide transportation. Please include the individual's full name and date of birth when possible (Individuals must have an approved background check and caseworker approval).

Visit Summary and Schedule			
See directions on the previous page. Document caseworker's approval at the bottom of this page.			
Choose day.	VISIT TIME :	VISIT LOCATION	VISIT SUPERVISOR
TRANSPORTATION		PICK-UP TIME / LOCATION	DROP-OFF TIME / LOCATION
OTHER LOCATION OPTIONS		OTHER SUPERVISION / TRANSPORTATION OPTIONS	
Choose day.	VISIT TIME :	VISIT LOCATION	VISIT SUPERVISOR
TRANSPORTATION		PICK-UP TIME / LOCATION	DROP-OFF TIME / LOCATION
OTHER LOCATION OPTIONS		OTHER SUPERVISION / TRANSPORTATION OPTIONS	
Choose day.	VISIT TIME :	VISIT LOCATION	VISIT SUPERVISOR
TRANSPORTATION		PICK-UP TIME / LOCATION	DROP-OFF TIME / LOCATION
OTHER LOCATION OPTIONS		OTHER SUPERVISION / TRANSPORTATION OPTIONS	
Choose day.	VISIT TIME :	VISIT LOCATION	VISIT SUPERVISOR
TRANSPORTATION		PICK-UP TIME / LOCATION	DROP-OFF TIME / LOCATION
OTHER LOCATION OPTIONS		OTHER SUPERVISION / TRANSPORTATION OPTIONS	
Choose day.	VISIT TIME :	VISIT LOCATION	VISIT SUPERVISOR
TRANSPORTATION		PICK-UP TIME / LOCATION	DROP-OFF TIME / LOCATION

OTHER LOCATION OPTIONS	OTHER SUPERVISION / TRANSPORTATION OPTIONS

Support for Visits – Concrete Goods

Identify any concrete goods or supports needed and the reason why each is requested. Please note the cost of the good and identity how long you anticipate the support will be needed.

Check the type of support needed.	Support Guidelines	Describe the cost, purpose, and duration of use for each support requested.
☐ Activity Support Costs that exceed these amounts must be pre-approved by the assigned caseworker and retained in the provider's case file.	$7 per child, per visit, except for special occasions or outings	
☐ Food (snacks / meals)	$2 - $5 per person for snacks $8 - $10 per person for meals	
☐ Transportation Support Consider the distance from the parent's starting location to the visit location and utilize the following as a guide. Upper amounts should only be utilized when visits occur more than three times a week. Costs that exceed these amounts must be pre-approved by the assigned caseworker and retained in the provider's client file.	0 – 20 miles ..... $5 - $25 20 – 50 miles ..... $10 - $30 50 – 100 miles ..... $20 - $40 > 100 miles ..... $25 - $50	

Caseworker approved plan on (date) by: ☐ Email ☐ Phone ☐ In-person

☐ Default (caseworker did not respond within five days of receiving Coordination Report)