## **Extended Placement in a Setting Certified as a Qualified Residential Treatment Program**

Use of form: The information on this form conforms to the requirements of the Family First Prevention Services Act of 2018 and the Wisconsin Department of Children and Families Ongoing Services Standards, when a child or youth is going to remain in a facility certified as a Qualified Residential Treatment Program (QRTP) for more than 12 consecutive months or 18 nonconsecutive months (or, in the case of a child who is younger than 13 years old, for more than 6 consecutive or nonconsecutive months).

The form must be completed by the Child Welfare/Youth Justice Professional and uploaded to the child welfare information system before the child or youth has remained in placement for 12consecutive months or 18 nonconsecutive months (or, in the case of a child who is younger than 13 years old, before 6 consecutive or nonconsecutive months). It is mandatory under the terms of the [Wisconsin Ongoing Service Standards](https://dcf.wisconsin.gov/files/cwportal/policy/pdf/ongoing-services-standards.pdf) [September 2021]. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wis. Stats].

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| eWiSACWIS Case ID | | | | | | | | |
| Child’s Name – (Last, First, Middle) | | | | | | | Child’s Birth Date | |
| QRTP Placement Provider Name | | | | | | | | |
| Name – Parent 1 | | | Name – Parent 2 | | | | | |
| Name — Legal Guardian | | | | | | | | |
| Name — Indian Custodian | | | | | | | | |
| **CASE INFORMATION** | | | | | | | | |
| County/Tribe/Child Placing Agency | | | | Date of Last QRTP Addendum | | | | |
| **CHILD’S ASSESSED LEVEL OF NEED** | | | | | | | | |
| Date of Child and Adolescent Needs and Strengths (CANS) | | | | | | | | |
| Child’s Assessed Level of Need (LON) | | | | | | | | |
| **QUALIFIED RESIDENTIAL TREATMENT PROGRAM OUT-OF-HOME PLACEMENT** | | | | | | | | |
| Describe the reasons why the needs of the child cannot be met by the child’s family or in a licensed foster home: | | | | | | | | |
| Describe why placement in a qualified residential treatment program (QRTP) will provide the most effective and appropriate level of care in the least restrictive environment: | | | | | | | | |
| Describe why placement in a qualified residential treatment program (QRTP) is consistent with the child’s short- and long-term goals: | | | | | | | | |
| Describe the specific treatment or service needs that will be met for the child through continued placement in a qualified residential treatment program (QRTP) and the length of time the child is expected to need the treatment or services: | | | | | | | | |
| Describe the efforts made by the agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, an adoptive parent, or in a foster family home: | | | | | | | | |
| **SIGNATURES** | | | | | | | | |
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|  | | Name - Worker | | |  | | | |
|  | |  | | |  |  | |  |
|  | | **SIGNATURE -** Worker | | |  | Date Signed | |  |
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|  | | Name - Supervisor | | |  |  | | |
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|  | | **SIGNATURE -** Supervisor | | |  | Date Signed | |  |
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|  | I reviewed the evidence and documentation demonstrating a QRTP placement is needed and approve the continued placement of this child in a QRTP. | | | | | | | |
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|  | | Name – Head of Agency | | |  |  | | |
|  | |  | | |  |  | |  |
|  | | **SIGNATURE –** Head of Agency | | |  | Date Signed | |  |