

Minnesota Department of **Human Services**

Voluntary Placement Agreement for Treatment: Non-American Indian Child

Minnesota Statutes, Chapter 260D

This is an agreement between the county social service agency and the child's parent(s) when a child must be in foster care to receive necessary treatment for an emotional disturbance or developmental disability or related condition. The Notice of Rights and Responsibilities (DHS-5729) is presented to the parent and youth as part of this agreement.

This agreement is between _____, an agency duly authorized by the state of Minnesota to place children in out-of-home care, (hereinafter called "agency"), and _____ and _____, parent(s) of _____, residing at _____, county of _____, Minnesota.

Placement

As the parent, I maintain (keep) legal custody of my child, and agree to place my child in foster care for the purpose of care and treatment.

The agency agrees to provide or authorize supervision of your child who is placed in a licensed foster care home or licensed residential program.

Planning

As the parent, I agree to participate in the development of the out-of-home placement plan with the agency and keep the agency informed of where I live and how to contact me at all times.

The agency agrees to develop a written out-of-home placement plan with you and your child within 30 days of placement, review the plan as required, and provide you with a copy of the plan.

Services

As the parent, I agree to follow through with my responsibilities in the out-of-home placement plan, participate in treatment, case planning, and keep the agency informed of my child's or my family's needs.

The agency will provide for your child's treatment needs, provide coordinated case management, and other services according to the out-of-home placement plan while your child is in placement.

Visitation

As the parent, I agree to visit and keep in touch with my child as stated in the out-of-home placement plan.

The agency will establish a visitation plan with your child and their siblings that preserves your child's bond with you and their siblings, and assists in keeping the visitation schedule.

Financial

As the parent, if the agency is providing financial support for the placement, I agree to cooperate with a fee assessment, and provide the agency with information about the income, child support, and any other benefits that my child and I receive. I will reimburse the agency for the cost of caring for my child in accordance with a plan agreed upon with the agency. I understand that if I receive Minnesota Family Investment Program (MFIP) and/or child support, this placement will affect the payment from these programs.

The agency will assume financial responsibility for the care of my child, including board, room, clothing, medical care, dental care and other expenses. The agency will provide information used to determine your contribution for your child's care and treatment. This will include information about your child's resources used to contribute to their care.

The agency will receive from the Minnesota Department of Human Services consumer credit reports for foster care youth, ages 14 to 17, and assist youth in interpreting the reports and resolving inaccuracies.

Medical insurance

As the parent, I agree to provide health insurance information to the agency and keep my child enrolled in my health plan. I will turn over to the agency any payment from my insurance company for my child's care when the agency paid the bill. If asked, I will apply for Medical Assistance for my child.

The agency will bill your health insurance, Medical Assistance, or you for medical services. The agency will assist you in applying for Medical Assistance.

Parents' authorization for medical care

As the parent, I agree to arrange and participate in my child's medical care, including mental health care, according to the out-of-home placement plan. In the event of an emergency and I cannot be reached, I authorize the agency to arrange and provide for necessary medical care. I maintain authority to consent to major medical care and procedures.

The agency will develop an out-of-home placement plan with you to determine how you will be informed and involved in the medical care of your child.

Parents' authorization for release of the child's medical and educational records

As the parent, I agree to sign the necessary releases for the agency and facility or foster home to have access to my child's medical and mental health and education records.

The agency will maintain data privacy of this information according to state and federal laws.

Termination of the agreement

As the parent, I agree to terminate the agreement by notifying the agency in writing of my desire to end this agreement, and the date I want my child returned to my home. The agency will return your child to you, or their guardian, no earlier than 72 hours, and no later than 30 days, after written notification is received, unless the agency has concerns about a child's safety or well-being and secures legal authority to continue the placement.

The agency may terminate a voluntary placement agreement with written notice. The written notice would include information about your right to a fair hearing and how to appeal the decision. The scheduled time to return your child home will meet their need for safety and reasonable transition. Unless otherwise agreed to by you and the agency, the child will return home no sooner than 72 hours, and no later than 30 days, after the written notice is received or sent by the agency.

Prior to reunification, you and the agency will engage in transition planning, including establishing a time to return your child home, increased visitation to support the transition, and a plan for what services will be provided and in place upon your child's return home.

Notice for parents

The agency is required to provide a notice of the consequences to you (parent) and to your child of being in voluntary foster care. The information gathered during the time your child is in voluntary placement may be used by the agency to support a petition alleging that your child is in need of protection and services. If a child is in foster care for any reason other than to access treatment related to their emotional or developmental disability or related condition, the agency will need to reassess the voluntary placement. Child in Voluntary Foster Care for Treatment Agreement – Notice to Parent(s) Considering Voluntary Foster Care (DHS-5729) provides you and your child with information in writing and is presented to you (parent) as part of this agreement.

Signatures

I agree to the provisions contained in this voluntary foster care placement agreement. Mine/our and the agency representative's signature below provides the agency legal authority to place your child in foster care.

SIGNATURE OF MOTHER/LEGALCUSTODIAN

SIGNATURE OF AGENCY REPRESENTATIVE

SIGNATURE OF FATHER/LEGAL CUSTODIAN

TITLE OF AGENCY REPRESENTATIVE

DATE OF AGREEMENT

The date this agreement is signed must coincide with the date your child is moved to the foster home or facility. (If only one parent has signed the agreement, the agency must document why the other parent did not sign the agreement.)

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໄປຮອດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawl wadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

This information is available in accessible formats for individuals with disabilities by contacting your county worker. For other information on disability rights and protections to access human services programs, contact the agency's ADA coordinator.