



FOSTER CARE PLACEMENT NOTIFICATION
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CHILDREN AND FAMILY SERVICES-FOSTER CARE
 SFN 630 (12-2023)

- Regular Foster Care
 Emergency 96-Hour Foster Care

Name of Custodial Agency/Human Service Zone		County	
Name of Child		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Residence at Time of Removal		City	State ZIP Code
Name of School		Grade Completed	Expected Graduation Date
Has the child been referred for screening services under Health Tracks? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has the child ever been adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does the family receive a subsidy payment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, administered by? <input type="checkbox"/> NDHHS <input type="checkbox"/> Out-of-State Agency	

Emergency Placement - 96 HOURS OR LESS (no exceptions) - Not applicable to children under the custody of a Tribal Nation

Placement Start Date	Placement Start Time	Placement End Date	Placement End Time
Child placed with agency through: <input type="checkbox"/> No Legal Custody/Shelter Care - STOP! This is not a child in foster care. <input type="checkbox"/> Temporary/Emergency Removal Order <input type="checkbox"/> Law Enforcement Removal			

Internal Use Only:

- This case is an Emergency Placement (96 hours or less) - Eligible for RM match only

PARENT INFORMATION (BIOLOGICAL/ADOPTIVE)

Status of Biological/Adoptive Parents to Each Other <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Single Parent Adoption			
Name of Mother		Date of Birth	Telephone Number
Physical Address		City	State ZIP Code
Name of Father		Date of Birth	Telephone Number
Physical Address		City	State ZIP Code

PLACEMENTS SINCE REMOVAL

First Placement Since Removal		Date Placed	End Date
Address		City	State ZIP Code
<u>Licensed Foster Care Placements:</u> <input type="checkbox"/> Family Foster Care <input type="checkbox"/> Tribal Affidavit Home <input type="checkbox"/> QRTP Approved Level <input type="checkbox"/> Base Level Only <input type="checkbox"/> Level 3 Difficulty <input type="checkbox"/> Level 2 Difficulty <input type="checkbox"/> Emergency Rate (limit 30 days)		<u>Nexus-PATH Level of Care:</u> <input type="checkbox"/> Enhanced Treatment FC <input type="checkbox"/> Therapeutic FC <input type="checkbox"/> Regular FC <input type="checkbox"/> Supervised Independent Living - Accommodated (18+) <input type="checkbox"/> Supervised Independent Living - Supported (18+)	
Non-licensed Foster Care Placement <input type="checkbox"/> Relative <input type="checkbox"/> Medical (PRTF or Hospital) <input type="checkbox"/> Assessment Bed <input type="checkbox"/> Detention Center <input type="checkbox"/> Runaway <input type="checkbox"/> Other (specify):			

Second Placement Since Removal	Date Place	End Date	
Address	City	State	ZIP Code
<u>Licensed Foster Care Placements:</u>		<u>Nexus-PATH Level of Care:</u>	
<input type="checkbox"/> Family Foster Care <input type="checkbox"/> Tribal Affidavit Home <input type="checkbox"/> QRTP Approved Level <input type="checkbox"/> Base Level Only <input type="checkbox"/> Level 3 Difficulty <input type="checkbox"/> Level 2 Difficulty <input type="checkbox"/> Emergency Rate (limit 30 days)		<input type="checkbox"/> Enhanced Treatment FC <input type="checkbox"/> Therapeutic FC <input type="checkbox"/> Regular FC <input type="checkbox"/> Supervised Independent Living - Accommodated (18+) <input type="checkbox"/> Supervised Independent Living - Supported (18+)	
Non-licensed Foster Care Placement			
<input type="checkbox"/> Relative <input type="checkbox"/> Medical (PRTF or Hospital) <input type="checkbox"/> Assessment Bed <input type="checkbox"/> Detention Center <input type="checkbox"/> Runaway <input type="checkbox"/> Other (specify):			

Complete a Notice of Change (SFN 45) for additional placements since removal.

LEGAL

Date Petition/Affidavit Filed for Removal (attach copy)	Court Ordered Removal Date (attach copy of court order)		
If court order does not specify removal date, indicate date of hearing sanctioning removal			Physical Removal Date
If physical removal did not take place on the court ordered date, explain			
As per the court order, whom was the child legally removed from (legal removal home)? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other			If Other, List the Name
Other's Relationship to the Child <input type="checkbox"/> No Relation			Legal Guardian? <input type="checkbox"/> Yes (attach guardianship document) <input type="checkbox"/> No

List all residences where the child lived in the 6 months prior to removal, starting with the residence at the time of removal:

Date From	Date To	Name	
Address	City	State	ZIP Code
Type of Residence <input type="checkbox"/> Detention Center <input type="checkbox"/> Hospital <input type="checkbox"/> Friend/Not Related <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other Relative (specify):			
Date From	Date To	Name	
Address	City	State	ZIP Code
Type of Residence <input type="checkbox"/> Detention Center <input type="checkbox"/> Hospital <input type="checkbox"/> Friend/Not Related <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other Relative (specify):			

ELIGIBILITY MONTH

Important: The information provided on the SFN 641 Title IV-E Title XIX Application Foster Care must be specific to the eligibility month.

Case Manager Signature	Date
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DISTRIBUTION: CFS FCSA Unit Custodial Agency Child Support