

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES

**COVER SHEET**

**INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN (ICPC)**

This form is for use by New York (NY) local department of social services (LDSS) and voluntary authorized agency (VA) caseworkers when preparing a request for a home study under ICPC Regulations 1, 2, or 7; this replaces the Cover Letter that was previously required. Complete ALL fields, sign, and date the form. Include one copy of this form as the first page of the request packet. If you have questions, contact NY ICPC at [ocfs.sm.NYSICPC@ocfs.ny.gov](mailto:ocfs.sm.NYSICPC@ocfs.ny.gov) or **518-474-9406**.

1. NY Sending Agency:				
2. <b>Child(ren) to be placed:</b> <i>(for sibling group of more than 6 children, provide a second Cover Sheet)</i> <b>Proposed Resource Relationship to Child:</b> <i>Please write in one of the following, or explain if other: Non-Relative, Parent, Step-parent, Grandparent(s), Adult Aunt/Uncle, Adult Sibling, or Other Relation (state which).</i> <b>Child's Current Placement Setting:</b> <i>Please check one of the following, or explain if other: Foster Boarding Home (FBH), Therapeutic Foster Boarding Home (TFBH), Residential Treatment Center (RTC), Parent (Par), Relative-unlicensed (Rel), Other (explain).</i>				
Name	DOB (mm/dd/yyyy)	Proposed Resource Relationship to Child	Child's Current Location (City, State)	Child's Current Placement Setting
	/ /			<input type="checkbox"/> FBH <input type="checkbox"/> TFBH <input type="checkbox"/> RTC <input type="checkbox"/> Par <input type="checkbox"/> Rel <input type="checkbox"/> Other:
	/ /			<input type="checkbox"/> FBH <input type="checkbox"/> TFBH <input type="checkbox"/> RTC <input type="checkbox"/> Par <input type="checkbox"/> Rel <input type="checkbox"/> Other:
	/ /			<input type="checkbox"/> FBH <input type="checkbox"/> TFBH <input type="checkbox"/> RTC <input type="checkbox"/> Par <input type="checkbox"/> Rel <input type="checkbox"/> Other:
	/ /			<input type="checkbox"/> FBH <input type="checkbox"/> TFBH <input type="checkbox"/> RTC <input type="checkbox"/> Par <input type="checkbox"/> Rel <input type="checkbox"/> Other:
	/ /			<input type="checkbox"/> FBH <input type="checkbox"/> TFBH <input type="checkbox"/> RTC <input type="checkbox"/> Par <input type="checkbox"/> Rel <input type="checkbox"/> Other:
	/ /			<input type="checkbox"/> FBH <input type="checkbox"/> TFBH <input type="checkbox"/> RTC <input type="checkbox"/> Par <input type="checkbox"/> Rel <input type="checkbox"/> Other:
3. Date and reason for child(ren)'s removal/remand:        /        /        ,				
4. Proposed Resource				
Name				
Address				
Phone		(        )        -		
5. Type of placement sought <i>(select only one type)</i>				
<b>Regulation 2</b>	<input type="checkbox"/> Foster Care – Relative <input type="checkbox"/> Foster Care – Non-Relative <input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Adoptive <input type="checkbox"/> Parent <input type="checkbox"/> Relative <i>(unlicensed)</i> not permissible in all states, check with NY ICPC			
<b>Regulation 7, Expedited</b>	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <i>(unlicensed)</i> <input type="checkbox"/> Legal Guardian			
<b>Regulation 1, Relocation of Intact Family</b>	<input type="checkbox"/> Foster Care – Relative <input type="checkbox"/> Foster Care – Non-Relative <input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Adoptive <input type="checkbox"/> Parent <input type="checkbox"/> Relative <i>(unlicensed)</i> not permissible in all states, check with NY ICPC			
6. Describe relationship between proposed resource and child(ren). Has there been recent contact/visitation?				
7. List child(ren)'s permanency goal(s) and describe child(ren)'s relationship with parent/guardian from whom child(ren) were removed; note any orders of protection or restrictions on visits.				

8. Note any particular issues/concerns to be addressed in the home study, including any concerns about resource's ability to care for the child(ren).

9. List the status of any documents that are unavailable at the time of submission (e.g., birth certificate, social security card, medical or educational records).

10. Signatures of Caseworker and Supervisor

CASEWORKER'S NAME (TYPE OR PRINT):	(AREA CODE) PHONE: (    )    -
SIGNATURE:	DATE: /       /
SUPERVISOR'S NAME (TYPE OR PRINT):	(AREA CODE) PHONE: (    )    -
SIGNATURE:	DATE: /       /