**OMB NO: 0970-0408
EXPIRATION DATE: xxxxx**

**C3. DCFS Biological Parent Study Contact Form**

*Complete this form when a parent who is the focus of reunification services consents to the release of their contact information.*

|  |
| --- |
|  |
| Evaluation ID |

|  |
| --- |
|  |
| Youth Name |

|  |  |  |
| --- | --- | --- |
| Did the parent agree to release his/her contact information? | * Yes
 | * No
 |
| **Parent Contact Information**  |  |  |
|  Parent Name |  | Relationship to the child if not biological parent |

|  |
| --- |
| Is the parent more comfortable reading in Spanish? |
| * Yes
 | * No
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Phone: |  |  | Alternate Phone: |  |
|  |  |  |  |  |
| Address: |  |  |  |  |
| Apt/Room/Bldg: |  |  |  |  |
| City: |  |  | State: | Zip Code:  |
|  |  |  |  |  |
|  |  |  |  |  |
| Alternate Address: |  |  |  |  |
| Apt/Room/Bldg: |  |  |  |  |
| City: |  |  | State: | Zip Code:  |

|  |  |
| --- | --- |
| **FOR OFFICE USE** |  |
| Staff person who completed this document: |  |
| Date document completed: |   / / |
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