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.

Youth Name _____ Evaluation ID _____

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: _____

Burden Statement: *This collection of information is voluntary and will be used to evaluate the Permanency Innovations Initiative. Public reporting burden of the collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Reports Clearance Officer (Attn: OMB/PRA 0970-0355), Office of Planning, Research and Evaluation, Administration for Children and Families, Department of Health and Human Services, 370 L'Enfant Promenade S.W., Washington DC 20447.*

FOR OFFICE USE

Staff person who completed this document: _____

Date document completed: / /