

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.

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FOR OFFICE USE

Staff person who completed this document:

Date document completed:

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