**Level of Care (LOC) Redetermination Request**

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| Form  Date: | Name of Requesting Party:  Requesting Party’s Role (Resource Parent, FFA Social Worker, Etc.): | | | |
| Assigned County Social Worker (*if known*): | | | | |
| Child’s Name:       Child’s Birthdate: | | | | |
| Child’s Placement Date: | | | | Child’s Current Level of Care (*if known*): |
| County Home  FFA | | | Foster Family Agency (FFA) Name: | |
| Resource Family Name: | | | | |
| Resource Family Phone Number: | | | | |
| Resource Family Address: | | | | |
| Reason(s) a new Level of Care Protocol Redetermination is needed\*: | | | | |
| Information to Support the above Request for a Level of Care (LOC) Redetermination: | | | | |
| \*Please note – a Level of Care redetermination does not guarantee a change in foster care rate. | | | | |
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