CONFLICT RESOLUTION PROCESS
REFERRAL FORM & REVIEW DOCUMENTATION

***Instructions**: This form is to be used in making an initial referral to County Department(s), recording date and outcome of review by county and for making referral to the State Conflict Resolution Team (CRT).*

Identifying Information

1. Name of Person making the referral: _____

   Complete mailing address of person making the referral: _____

   Daytime phone number of person making the referral (include area code): _____

   E-mail address of Person making the referral _____

2. Person making the referral is: ☐ Foster Parent ☐ County Supervisor
   ☐ Social Worker ☐ Foster Parent Liaison
   ☐ Other, please identify role _____

3. Foster parent is approved by_____ County DHR

   Child/sib group involved is in custody of

   _____

4. Children Involved:

Full Name	**Birthdate**	**Full Name**	**Birthdate**

Your complaint deals with:

- □ Problem with communication between line worker and the foster parent – lack of courtesy, respect, professionalism in communication such as failing to return phone calls, failure to listen to concerns, etc.
- □ Lack of responsiveness to requests by the foster parent for assistance in dealing with the children in care
- □ Removal of children without due notice according to applicable policies and standards
- □ Issues of potential safety risks to children
- □ Failure to follow policies
- □ Failure to arrange needed services for the child/foster family
- □ Failure to schedule an ISP as requested
- □ Situations where the foster parent or SDHR has identified trends by county as it relates to appropriate grievance issues
- □ Closure of a home by DHR
- □ Failure to abide by provisions of Foster Parent Bill of Rights. Specify which provisions: _____

  _____

- □ Other _____

5. In a BRIEF PARAGRAPH summarize your complaint (do not simply say, "see attached documentation"). *Attach supporting documentation to this referral form.

_____

_____

_____

_____

Documentation of local review:

Date referral initially made with the local agency:_____

Referral was filed initially with:_____
Name of Person(s)

_____
Position of Person(s)

Referral was _____hand delivered _____sent US mail _____sent via email

If a local review was conducted (meeting held) date of meeting:_____

Briefly describe outcome of meeting:_____

_____

_____

Desired outcome of this conflict resolution:_____

_____

_____ _____
Signature person making the CRT referral Signature local review liaison or meeting facilitator

If resolution was not reached at the local level and a review by the State Conflict Team is desired, person making referral should mail this form to: State of Alabama Department of Human Resources
Gordon Persons Building
Family Services Division, Office of Permanency
ATTN: CRT liaison
50 Ripley Street
Montgomery, Al 36130

Upon the liaison's receipt of this referral form an acknowledgement letter will be sent and requests for records made. State CRT members and others will be notified of referral and notification of next standing meeting date will be provided.