**State of Indiana Department of Child Services - Request to Change Services for DCS Programs**

To: [Name of DCS Regional Coordinator]

Fr: [Name and Title of Chief Executive Officer of Organization]

Re: Request to Change Services for DCS Program

Date: [Date of Submission to Regional Coordinator]

Name of Organization: [Name of Requesting Organization]

Please accept this letter regarding our organizations intent to notify and/or request a change in the provision of services for DCS programs in our service area(s).

***The purpose of this letter is to either:***

1. □ Notify DCS personnel that our organization intends to cease providing the following identified service standards and counties:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Service Standard** |  |  | **County(ies)** |  | **Date Effective** |
| Med-Assessment for MRO | □ |  |  |  |  |
| Homemaker/Parent Aid | □ |  |  |  |  |
| Care Network | □ |  |  |  |  |
| CHINS Parent Support Services | □ |  |  |  |  |
| Parent Education | □ |  |  |  |  |
| Parenting/Family Functioning Assessment | □ |  |  |  |  |
| Sex Offender Treatment | □ |  |  |  |  |
| Visitation Facilitation-Parent/Child/Sibling | □ |  |  |  |  |
| Substance Use Outpatient Treatment | □ |  |  |  |  |
| Home-Based Family-Centered Casework Services | □ |  |  |  |  |
| Home-Based Family-Centered Therapy Services | □ |  |  |  |  |
| Counseling | □ |  |  |  |  |
| Diagnostic & Evaluation Services | □ |  |  |  |  |
| Med-Medication Training and Support | □ |  |  |  |  |
| Med-Child and Adolescent Intensive Resiliency Services (CAIRS) | □ |  |  |  |  |
| Med-Adult Intensive Resiliency Services (AIRS) | □ |  |  |  |  |
| Med-Peer Recovery Services | □ |  |  |  |  |
| Transition From Restrictive Placement | □ |  |  |  |  |
| Residential Substance Use Treatment | □ |  |  |  |  |
| Detoxification Services | □ |  |  |  |  |
| Substance Use Disorder Assessment | □ |  |  |  |  |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. □ Request that the Regional Coordinator allow our organization to add the following services in the identified counties:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Service Standard** |  |  | **County(ies)** |  | **Date Effective** |
| Med-Assessment for MRO | □ |  |  |  |  |
| Homemaker/Parent Aid | □ |  |  |  |  |
| Care Network | □ |  |  |  |  |
| CHINS Parent Support Services | □ |  |  |  |  |
| Parent Education | □ |  |  |  |  |
| Parenting/Family Functioning Assessment | □ |  |  |  |  |
| Sex Offender Treatment | □ |  |  |  |  |
| Visitation Facilitation-Parent/Child/Sibling | □ |  |  |  |  |
| Substance Use Outpatient Treatment | □ |  |  |  |  |
| Home-Based Family-Centered Casework Services | □ |  |  |  |  |
| Home-Based Family-Centered Therapy Services | □ |  |  |  |  |
| Counseling | □ |  |  |  |  |
| Diagnostic & Evaluation Services | □ |  |  |  |  |
| Med-Medication Training and Support | □ |  |  |  |  |
| Med-Child and Adolescent Intensive Resiliency Services (CAIRS) | □ |  |  |  |  |
| Med-Adult Intensive Resiliency Services (AIRS) | □ |  |  |  |  |
| Med-Peer Recovery Services | □ |  |  |  |  |
| Transition From Restrictive Placement | □ |  |  |  |  |
| Residential Substance Use Treatment | □ |  |  |  |  |
| Detoxification Services | □ |  |  |  |  |
| Substance Use Disorder Assessment | □ |  |  |  |  |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Organization Chief Executive Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Organization Chief Executive Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_