Alameda County Social Services Agency

Department of Children and Family Services

AB-1299 PRESUMPTIVE TRANSFER REQUEST

Child/Youth Information		
Child/Youth Name:	Child/Youth Date of Birth:	County of Residence:
Date Team agreed to this request:	Name members of the team/relationship to the child/youth:	
Caregiver Contact Information		
Caregiver Name:	Type of Placement: __Relative/NREFM __FFA __STRTP __County FC	Date Placed in County:
Caregiver Address:	Caregiver Phone:	Placed for 6 or more months: (YES/NO)

Assigned Social Worker Contact Information	
Name:	
Phone:	Email:
Child's Attorney Information	
Name:	
Phone:	Email:

Specialized Mental Health Services	
Requesting new services:	Requesting continued services:
Name of Service Provider (if known):	Name of Service Provider:
Summary of services needed:	
Contact Information for individuals with rights to sign consents for treatment	
Name:	
Phone:	Email:
Contact Information for individuals with rights to sign release of information	
Name:	
Phone:	Email: