



Florida Network of Youth and Family Services
CINS/FINS Shelter Voluntary
Placement Agreement

Two copies of this form must be signed. The parent/guardian/relative retains one copy
and the shelter retains one copy.



I, \_\_\_\_\_ and I, \_\_\_\_\_, parent(s)/legal guardian(s) of the child(ren)
listed below:

Table with 3 columns: Name of Child, Birth Date of Child, Social Security #

I, voluntarily request that the Florida Department of Juvenile Justice and the CDS Family & Behavioral Health Services, Inc.
(Name of CINS/FINS Agency)
assume responsibility for the placement, care and supervision of my child(ren) while in the shelter. This placement is the
most family-like setting available for my child and it is the shelter located nearest to my home. I believe this request is in
the best interest of my child(ren). I understand that I have the right to request the return of my child(ren) at any time and
that the child will be returned to me unless a court finds that it is not in the best interest of my child to be returned.

This shelter is licensed by the Department of Children and Families in accordance with Section 409.175.F.S. as a child-
caring agency and receives an Annual Quality Assurance Review by the Department of Juvenile Justice.

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As the Parent/Legal Guardian of the child(ren), I also:

\_\_\_\_\_ agree to cooperate with all the rules established by the shelter/agency above that pertain to
(Parent/legal guardian Initials)
the care and safety of my child(ren) and other children and staff in the shelter.

\_\_\_\_\_ understand that I retain the right to have contact with my child(ren) through visits and telephone calls. I
have the responsibility to tell the shelter staff of any change in my address or telephone number, so that I can be reached by
my child or the staff at the shelter.

\_\_\_\_\_ retain the right and responsibility to participate in setting goals for my child and to help in the writing of a
service/case plan for my child(ren). To do this, I understand that I may be asked to attend meetings, keep appointments and
respond to calls and other communications from the shelter. The shelter will do its best to schedule these contacts and
meetings at times that will allow me to be present.

\_\_\_\_\_ agree to provide the shelter with any information that will help the shelter to care for my child. This
includes information about my child's health, school experience, important relationships, etc., both currently and in the past.

\_\_\_\_\_ agree to assume financial responsibility to the extent of my ability to pay in accordance with Child Support
Enforcement as stated in Chapter 409.2561, Florida Statutes.

\_\_\_\_\_ consent to such transportation, medical care and treatment as the shelter may consider necessary for  
(Parent/Legal Guardian Initials)  
the health and welfare of my child(ren). I agree for my child (ren) to be given periodic health examinations, tests,  
immunizing treatments, and hospitalization if needed. In the event of any serious illness or accident, I  
understand that the shelter agrees to make every possible effort to reach me immediately, but if it is impossible to locate  
me, I understand that a court order will be obtained unless treatment is considered an emergency. I have the right to retain  
my own doctor for my child if I provide transportation to the appointment and pay the doctor.

\_\_\_\_\_ understand that this Agreement provides only for temporary placement of my child(ren) and that the length of  
time in the shelter will be based upon the needs of the child and family. Placements will not exceed 30 days, unless a  
longer stay is ordered by the court. I agree to make every possible effort for my child(ren) to return to live with me. I  
understand that it is my responsibility to participate in planning for my child's return home. If this is not possible, I will  
cooperate in making other permanent and safe living arrangements for my child(ren).

\_\_\_\_\_ understand that if there is reason to suspect abuse, neglect or abandonment that CDS Family & Behavioral Health Services, Inc.  
(Name of CINS/FINS Agency)  
is required under state law to report such information to the Department of Children and Families.  
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**My additional rights and responsibilities under the Child and Family In Need of Services (CINS/FINS) law, Chapter 984, F.S., have been explained to me by staff and I have received a brochure/handbook for parents.**

YES       NO

\_\_\_\_\_  
(Parent Initials)

THIS AGREEMENT is entered into on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by

and between \_\_\_\_\_ of \_\_\_\_\_ and CDS Family & Behavioral Health Services, Inc.  
PRINT                                  (Parent's Name)                                  Parent's Address)                                  (Name of CINS/FINS Agency)

Signature \_\_\_\_\_ of Mother    Father    Legal Guardian  
(Please Circle One that Applies)

Signature \_\_\_\_\_ of Mother    Father    Legal Guardian

\_\_\_\_\_  
CINS/FINS Agency Staff Signature

**IF APPLICABLE:**

My next meeting to talk about the plan for my child will be on:

\_\_\_\_\_ At \_\_\_\_\_ At \_\_\_\_\_  
Day and date                                  Time                                  Location