



**UNACCOMPANIED REFUGEE MINOR (URM) PROGRAM
NOTICE OF CHANGE**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF REFUGEE SERVICES
SFN 1083 (8-2024)

Name of Child	Date of Birth
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CHANGE/ADD PLACEMENT Change in Primary Add Secondary Placement

Current Primary Provider	End Date
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Secondary Placement Provider	Start Date	End Date	Provider Type
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New Primary Provider	Start Date	End Date
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Address	City	State	ZIP Code
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<p>Licensed/Certified Foster Care:</p> <input type="checkbox"/> Family Foster Care (State and Tribal) <input type="checkbox"/> QRTP Approved Level <input type="checkbox"/> Base Level Only <input type="checkbox"/> Level 3 Difficulty <input type="checkbox"/> Level 2 Difficulty <input type="checkbox"/> Emergency Rate (limit 30 days)	<p>Nexus-PATH Level of Care:</p> <input type="checkbox"/> Treatment (TFC) <input type="checkbox"/> Emergency (30 days unapproved) <input type="checkbox"/> Base <input type="checkbox"/> Supervised Independent Living - Accommodated (18+) <input type="checkbox"/> Supervised Independent Living - Supported (18+)
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Payment Status of Licensed Foster Care Placement
 Open for Payment No Payment (list reason): _____

Relative providers are not eligible to receive TANF Kinship benefits and foster care payments in the same month

Comments

Other Placement

<input type="checkbox"/> Relative	<input type="checkbox"/> Medical (PRTF or Hospital)	<input type="checkbox"/> Detention Center	<input type="checkbox"/> Pre-Adoptive Placement
<input type="checkbox"/> Trial Home Visit	<input type="checkbox"/> Assessment Bed	<input type="checkbox"/> Runaway	<input type="checkbox"/> Certified Shelter
<input type="checkbox"/> Other (specify): _____			

CLOSING FOSTER CARE

Name of Person Discharged To	Telephone Number	Discharge Date
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Physical Address	City	State	ZIP Code
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Mailing Address (PO Box if applicable)	City	State	ZIP Code
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Relationship
 Mother Father Legal Guardian Other (specify): _____

Reason

<input type="checkbox"/> Discharge from Foster Care Prior to Age 18	<input type="checkbox"/> Aged Out - Discharged From Foster Care at Age 18 or Greater
<input type="checkbox"/> Guardian	<input type="checkbox"/> Child Adopted
<input type="checkbox"/> Subsidized Guardianship	<input type="checkbox"/> Subsidized Adoption <input type="checkbox"/> Private Adoption
<input type="checkbox"/> Non-Subsidized Guardianship	

Date Finalized as per Court Order	State Adoption Took Place
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Other (specify): _____

Worker Name	Agency	Date
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If placed with Nexus-PATH - Nexus-PATH supervisor must complete this section

Nexus PATH Worker	Initials for Approval of Dates	Date
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Distribution:

- HHS URM Administrator
- Case Management Child File