DPP-193
(Rev. 8/2020)

**CABINET FOR HEALTH AND FAMILY SERVICES**
**Department for Community Based Services**
**Division of Protection and Permanency**

# ADOPTIVE REVIEW COMMITTEE COMMENTS

Date comments are due to Adoption Services Branch staff: _______________

Child(ren): ___________________________________________________________________________

DOB: ______________________________________KAPE ID#:_________________________________

Adoptive family names and address: _____________________________________________________

___________________________________________________________________________________

State/County: __________________________________________________________________________

Family worker name and contact number: ________________________________________________

Date family/family worker was contacted: _______________________________________________

1. Date home study was reviewed by committee: _______________________________________
2. Names of review committee members: (3 minimum) _________________________________

   ___________________________________________________________________________________
3. Was a family selected for the child(ren)? ☐ Yes ☐ No
4. Noted strengths about adoptive family and reason for selection:
5. Reasons family was not selected for the child(ren):
6. Was the worker for the family contacted during consideration of this home?

   ☐ Yes ☐ No
7. Did the family withdraw interest? ☐ Yes ☐ No Date:______________________

   If yes, on what criteria: ____________________________________________________

8. Date permanency lead confirmed all appropriate documentation is entered into TWIST. _________________

Adoption review committee signatures affirming numbers 1-7:

____________________________________ Date: ___________

____________________________________ Date: ___________

____________________________________ Date: ___________

____________________________________ Date: ___________

____________________________________ Date: ___________