THERAPEUTIC FOSTER CARE (TFC)

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FHCReferrals@uhsinc.com

APPLICATION FOR PLACEMENT

Demographic Information / Department/Division of Social Service (DSS) Goals

Full Name: Date of Referral/Completion of Referral:

Age: DOB: Sex: SSN:

Race/Ethnicity: Languages:

Referring Agency: Date TFC Placement Needed:

Medicaid Card #: ☐ Insurance Information Requested

Medicaid MCO#: ☐ Insurance Information Requested

Is Youth in DSS Custody: No ☐ Yes ☐ Date Youth came in Custody:

Youth's Permanency Goal: Permanency Target Date:

Reason a TFC placement is requested:

If youth is less than one year old, state brief description of their living situation unless discharged directly from the hospital:

What type of foster home is the Worker requesting for the youth (include racial/ethnic preference):

What type of transportation will the youth require for services (i.e. local or distant family of origin visits, school, work, medical appointments, etc.):

Current/Recent Treatment and Service Providers (If Applicable)

Type of Service	**Name of Service Provider / Agency / Telephone Number**
Current placement	
Therapy (individual, group, or family)	

	Continue service with the same provider: No ☐ Yes ☐
Psychiatrist/Medication Manager	Continue service with the same provider: No ☐ Yes ☐
Specialized Physician:	Continue service with the same provider: No ☐ Yes ☐
Probation Officer	Continue service with the same provider: No ☐ Yes ☐
Other Services (Mentoring, Reunification, etc.):	Continue service with the same provider: No ☐ Yes ☐

Note: We will request your consent to obtain and/or exchange information with providers listed.

Other services requested for youth by Social Worker/Family Service Worker, Family of Origin, Legal Guardian/Custodian:

Emergency Contacts (include family of origin as appropriate)**:**

Name	Address	Phone Number

Biological Family Information

Natural Mother:
Address:
City: State:
Zip Code:
Race/Ethnicity:
Occupation:
Marital Status:
Home Phone:
Cell Phone:

Natural Father:
Address:
City: State:
Zip Code:
Race/Ethnicity:
Occupation:
Marital Status:
Home Phone:
Cell Phone:

List names and ages of siblings (if known):

Is there any reason that the siblings will not be placed together?

1. Are the parents able and willing to participate in TFC services/treatment planning at this time?
   No ☐ Yes ☐
2. Have visits been approved between the child and family of origin? No ☐ Yes ☐ (Outline Below)

Name	Relationship	Address	Phone Number

3. Frequency of visitation: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other: _____
4. If no visitation with the family of origin is approved, please explain:

5. Telephone contact permitted: No ☐ Yes ☐
   If so, with whom (specify supervised or unsupervised):

6. Electronic contact (text, e-mail, social media, etc.) permitted: No ☐ Yes ☐
   If so, with whom:

Cultural/Spiritual/Religious Beliefs:

Strengths of Birth Family:

Needs of Birth Family:

DSM-5 Diagnosis:

Educational Information

Name of Current School/ Daycare/Nursery:

Current Grade: Date Withdrawn:

Educational Setting: Regular Education ☐ Special Education ☐; Category:
Daycare/Nursery ☐ GED ☐ Alternative/Private Day ☐

Youth's adjustment/functioning/performance in School/Daycare/Nursery:

Does child have history of suspensions or disciplinary problems in school? No ☐ Yes ☐
If so, briefly explain:

Medical/Health Information

Health of the youth (general health of youth and any medical concerns):

Are Immunizations current within the last 13 months: No ☐ Yes ☐

Date of Last Physical Exam: Date of Last Dental Exam:

Developmentally Challenged: No ☐ Yes ☐ Medically Comprised: No ☐ Yes ☐

Assistive Technology/Resources: No ☐ Yes ☐

Any history of Allergies, Medication Side Effects/Reactions/Effectiveness (efficacy): No ☐ Yes ☐

Explain any of the above items checked **Yes** *(not explained in the DSM diagnosis)*:

Current Medication Name (Prescription/Non-Prescription)	**Dosage**	**Reason for Medication**	**Frequency/ Instructions for taking Medication**

Presenting Emotional/Behavioral Needs of Youth

Youth's Emotional/Psychological needs and problems (include professional treatment needed):

Youth's Behavior in the home or previous placement:

Youth's Sexual Activity (include any sexually provocative/hypersexual behaviors, sexual orientation/gender identification/gender expression):

Any history of **Sexual Abuse**: No ☐ Yes ☐

Is the youth a Victim: No ☐ Yes ☐ Is the youth a Perpetrator: No ☐ Yes ☐

Describe the Sexual Abuse (Victim or Perpetrator):

Any history of **Physical Abuse**: No ☐ Yes ☐

Is the youth a Victim: No ☐ Yes ☐ Is the youth a Perpetrator: No ☐ Yes ☐

Describe the Physical Abuse (Victim or Perpetrator):

Any legal charges/convictions? No ☐ Unknown at this time ☐ Yes ☐

If yes, when and what are they?

Any history of homicidal ideation/gestures/aggression/gang involvement?
No ☐ Unknown at this time ☐ Yes ☐

If yes, when was the last incident and what happened?

Any history of cruelty to animals? No ☐ Unknown at this time ☐ Yes ☐

If yes, when was the last incident and what happened?

Any history of fire setting? No ☐ Unknown at this time ☐ Yes ☐

If yes, when and what occurred?

Any history of suicidal ideation/gestures? No ☐ Unknown at this time ☐ Yes ☐

If yes, when was the last incident and what happened?

Is there a current Safety Plan? No ☐ Unknown at this time ☐ Yes ☐ (please provide a copy of the safety plan or describe the plan)

Does the youth have a history of substance use (illegal, alcohol, tobacco, prescription, over the counter, etc.)? No ☐ Unknown at this time ☐ Yes ☐ If yes, what substance(s)?

Has the youth participated in any substance use treatment interventions/strategies?
No ☐ Unknown at this time ☐ Yes ☐, describe:

Does the youth normally get along with peers? No ☐ Unknown at this time ☐ Yes ☐

If No, what are the issues with peers?

Does the youth have the capability to follow discharge planning instructions independently?: No ☐
Yes ☐

Does the youth have a history of not following discharge plans and/or not taking medication as ordered during previous treatment/placements?: No ☐ Yes ☐

Does the youth have a history of re-hospitalizations based on non-compliance with medications or other post-hospital instructions? No ☐ Yes ☐

Strengths & Skills

Indicate what strengths, skills, and talents the youth possesses:

Describe the youth's Cultural/Ethnic/Spiritual beliefs:

List the youth's special abilities and/or interests (i.e. video games, bike riding, specific sports, fishing, music/musical instruments, poetry/writing, dancing, singing, reading, arts & crafts, etc.):

Appointments/meetings currently scheduled for the youth (i.e. court, family partnership, medical, therapy):

Referring Worker	Phone Number
First Home Care Representative	First Home Care Supervisor/Manager