



**THERAPEUTIC FOSTER CARE (TFC)**

Tidewater: 1634 London Blvd, Portsmouth, VA 23704 | Office: 757.393.7200 | Fax: 757.393.7219  
 Richmond: 5516 Falmouth St. Suite 202, Richmond, VA 23230 | 804.358.8737 | Fax: 804.358.8750  
 Roanoke: 6711 Peters Creek Rd. Suite 200, Roanoke, VA 24019 | 540.265.2380 | Fax: 540.265.2318  
 NOVA: 5520 Cherokee Ave. Suite 215 | 703.914.0182 | Fax: 703.914.3955  
[FHCReferrals@healthconnectamerica.com](mailto:FHCReferrals@healthconnectamerica.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 <input type="checkbox"/> Yes <input type="checkbox"/> |
| Psychiatrist/Medication Manager                  | Continue service with the same provider: No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Specialized Physician:                           | Continue service with the same provider: No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Probation Officer                                | Continue service with the same provider: No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Other Services (Mentoring, Reunification, etc.): | Continue service with the same provider: No <input type="checkbox"/> Yes <input type="checkbox"/> |

**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<br>(Prescription/Non-Prescription) | Dosage | Reason for Medication | Frequency/ Instructions for<br>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