Name: _____ Record #: _____ Medicaid #: _____

Application for Foster Care

REFERRAL INFORMATION

Referral Agency/Name: _____ Date of Referral: _____

Phone Number: _____ Fax Number: _____

CLIENT'S INFORMATION

Name: _____ Medicaid Number: _____

Date of Birth: _____ Place of Birth: _____ Preferred Name: _____

SSN: _____ *Primary Language: _____ *Gender: ○ Male ○ Female

How many total placements has client had prior to current placement? _____

Current School: _____ Current educational grade level of the client: _____

US Citizenship: ○ Yes ○ No

Race: ○ White ○ African-American ○ Latino ○ American Indian ○ Multiracial ○ Other: _____

Registration Type: ○ Voluntary, Initial ○ New Admission ○ Involuntary, Initial Admit (court ordered)

○ Voluntary, Readmission within Agency ○ Involuntary, Readmission (court ordered)

Legal Status: ○ Adoptions (Parental Rights Terminated) ○ Foster Care ○ Protective Investigations ○ Protective Services

○ Committed Delinquent ○ Probation ○ Voluntary Family Services ○ Delinquent ○ None

Client's family income: $ _____ (annually)

Client's parent's marital status: ○ Married ○ Divorced ○ Separated ○ Single (unmarried)

CLIENT'S BIOLOGICAL/ADOPTIVE PARENT(S)

Father's Name: _____ SSN: _____ DOB: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Race: ○ White ○ African-American ○ Latino ○ American Indian ○ Multiracial ○ Other: _____

Religious or Spiritual Orientation: _____

Name: _____ Record #: _____ Medicaid #: _____

Mother's Name: _____ SSN: _____ DOB: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Race: ○ White ○ African-American ○ Latino ○ American Indian ○ Multiracial ○ Other: _____

Religious or Spiritual Orientation: _____

CLIENT'S LEGAL CUSTODIAN

Agency/Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Is a "Voluntary Placement Agreement" in effect? ○ Yes ○ No If "yes," give expiration date: _____

SIBLINGS AND/OR OTHER SIGNIFICANT RELATIVES

Please provide name, address, and phone number of each person.

CLIENT'S RESIDENCE AT TIME OF REFERRAL

Name: _____

Address: _____ Phone Number: _____

Placement Type: ○ Biological/Relative ○ Agency Placement ○ Shelter ○ Non-relative ○ Foster home ○ Group Home

○ Therapeutic Foster Home ○ Judicial Center ○ Alcohol/Drug Rehabilitation ○ Psychiatric Hospital

○ Residential Treatment Center ○ Developmental Services ○ Other: _____

Name: _____ Record #: _____ Medicaid #: _____

CLIENT'S MEDICAL CONDITIONS

Must include any allergies/diet restrictions or indicate "none known."

Begin Date: _____ End Date: _____ Severity: ○ Mild ○ Moderate ○ Severe

Is this condition life threatening? ○ Yes ○ No Is special care needed? ○ Yes ○ No

Who currently provides the care? _____ Is this the Primary Caretaker? ○ Yes ○ No

Activity Restrictions: _____

Describe special care needed:

HANDICAPS/DISABILITIES

- ○ Autistic
- ○ Other
- ○ Visually Impaired
- ○ Health Impaired
- ○ Multi-Handicapped
- ○ Physically Impaired
- ○ Hearing Impaired
- ○ Blind
- ○ Intellectually Gifted
- ○ None
- ○ Emotionally Disturbed
- ○ Deaf
- ○ Language Impaired
- ○ Speech Impaired
- ○ Developmentally Delayed
- ○ Learning Disabilities
- ○ Traumatic Brain Injury
- ○ Function Delayed

HISTORY & REASON FOR REFERRAL PER REFERRAL SOURCE

Mark "HX" if issue(s) are historical (over 6 months) and "C" if issue(s) are current; Indicate ALL that apply.

- ○ **Abuse**
  - ○ Victim of Type:
    - ○ Physical
    - ○ Emotional
    - ○ Sexual
    - ○ Neglect
  - ○ Perpetrator of Type:
    - ○ Physical
    - ○ Sexual
- ○ **Anxiety**
  - ○ Excessive Worry
  - ○ Restlessness
  - ○ Autonomic Hyperactivity
  - ○ Hypervigilance
  - ○ Specific Fear: _____
  - ○ Sleep Disturbance
  - ○ Phobia: _____
  - ○ Obsessive/ Compulsive: _____
- ○ **Attention Deficit/ Hyperactivity**
  - ○ Short Attention Span
  - ○ Inattentive

Name: _____ Record #: _____ Medicaid #: _____

- Impulsive
- Easily Distracted
- Failure to Follow through
- Excessive Talking
- Negative Attention Seeking Behaviors
- Risk Taker
- Projecting Blame
- Low Self Esteem
- Poor Social Skills
- Low Frustration Tolerance
- Enuresis
- Encopresis
- Hx of Failure to Thrive
- Fire Setting
- Fire Play
- Gang Association
- Manipulative/Lying
- Learning Disability

Poor Verbal Skills

- Expressive
- Receptive

Eating Disorder

- Self-Induced Vomiting
- Use of Laxatives
- Refusal to Maintain Healthy Weight
- Preoccupation with Body Image
- Irrational Fear of Becoming Overweight

Depression

- Sad/Flat Affect
- Irritability
- Isolative/Withdrawn
- Reduced Appetite
- Sleep Disturbances
- Unresolved Grief
- Feeling Hopeless
- Hygiene Problems
- Inactive/low motivation
- Suicidal Attempt
- Suicidal Ideation
- Suicidal Gestures

Self-Harm

- Cutting
- Burning

Oppositional Defiant

- Hostile Towards Adults
- Temper Tantrums
- Constant Arguing with Adults
- Refusing to Comply
- Blaming Others
- Demanding
- Verbal Aggression/Swearing

Conduct Disorder

- Failure to Comply
- Fighting/Assaultive
- Homicidal
- Intimidation
- Harmful to Animals
- Stealing
- School Maladjustment Truancy
- Conflict with Authority
- Risk Taking
- Blaming Others
- Little/No Remorse
- Destruction of Property

Mood Disruption

Physical/ Medical Issues

Psychotic

- Hallucinations:
  - A
  - V
- Paranoid thinking
- Delusions

Sexually Inappropriate Behavior

- Touching
- Exposing

Post Traumatic Stress

- Decreased concentration
- "Flashbacks"
- Avoidance of Issue
- Vigilance
- Sleep Disturbances
- Recurrent nightmares

Substance Abuse

- Drugs: _____
- Alcohol: _____

Pregnancy

Additional Comments

Name: _____ Record #: _____ Medicaid #: _____

FAMILY CIRCUMSTANCES

- ○ Substance Use/Abuse
- ○ Child Custody Issues
- ○ Incarceration
- ○ Domestic Violence
- ○ Low Intellect of Caretaker
- ○ Lack of Parental Control and/or Supervision
- ○ Financial Issues
- ○ Marital Issues
- ○ Resistant to Treatment
- ○ Single Parent
- ○ Non-English Speaking
- ○ Lack of Knowledge of Child Development and Behavior
- ○ Termination of Parental Rights
- ○ Transportation Issues
- ○ Unemployment
- ○ Threatening Hostile Behaviors
- ○ Family History of Abuse
- ○ Other: _____
- ○ Unwanted Pregnancy
- ○ Ineffective Parenting Skills
- ○ Significant Medical Problems
- ○ Poor Communication/Interactions
- ○ Family History of Neglect

Identify any relevant cultural preferences:

_____

PREVIOUS OUT OF HOME PLACEMENTS

Agency: _____ Address/Phone: _____ Dates Placed: _____

Agency: _____ Address/Phone: _____ Dates Placed: _____

Agency: _____ Address/Phone: _____ Dates Placed: _____

Agency: _____ Address/Phone: _____ Dates Placed: _____

Agency: _____ Address/Phone: _____ Dates Placed: _____

DIAGNOSIS

Name: _____ Record #: _____ Medicaid #: _____

PSYCHOTROPIC AND NON-PSYCHOTROPIC MEDICATIONS

Current Medication: _____ Dose/Frequency: _____

Current Medication: _____ Dose/Frequency: _____

Current Medication: _____ Dose/Frequency: _____

Current Medication: _____ Dose/Frequency: _____

Current Medication: _____ Dose/Frequency: _____

AUTHORIZATION

I submit this application for review in request for foster care services with Family Preservation Community Services.

_____ _____

Parent/Legal Custodian/Authorized Representative Date

_____ _____

Parent/Legal Custodian/Authorized Representative Date

Family Preservation Community Services