



Partnership for Children
A Collaboration of Youth Homes, Inc. and
Intermountain Children's Home and Services

Referral Application for Foster Care, Home Support Services, Case Management or Group Home Placement

-To expedite the referral process please attach any pertinent psychological evaluations, social history, and releases of information for collateral contacts-

Date: _____

Referring Agency: _____

Contact Person: _____ Phone Number: Work # _____

Cell # _____ Email Address: _____

Address: _____

Name of Child Being Referred: _____ SSN: _____ - _____ - _____

Date of Birth: ____ / ____ / ____ Age: ____ Sex: M / F Height: ____ Weight: ____

Race: _____ Tribal Affiliation (If any): _____

Child's Current Insurance Provider(s): _____

Healthy MT Kids or Healthy MT Kids Plus Medicaid ID #: _____

Child's Current Placement and for how long: _____

Address _____

Placement Contact Person: _____

Phone Number: _____

What services are you interested in? Check all that apply:

<input type="checkbox"/> Family support services	<input type="checkbox"/> Therapeutic Foster Care	<input type="checkbox"/> Group Care
<input type="checkbox"/> Outpatient Therapy	<input type="checkbox"/> CBPR&S	<input type="checkbox"/> Case Management

Briefly describe child's need for care: _____

Briefly describe child's strengths: _____

Who should be considered a part of the child's Treatment Team? (Relevant family members, community supports, therapists, school employees, CFS workers, CASA, CSCT, medication prescribers, physicians, juvenile probation officers, family based services, Missoula Urban Indian Health Center, etc.)

Name	Relation to Child	Contact Information

Who has legal custody of this child? _____

Legal Status? _____

Is Child and Family Services involved? No Yes

If yes: Case Worker's name: _____

Phone number: _____

County: _____

Have parental rights been terminated?

Mother: No Yes Date: _____ Unknown

Father: No Yes Date: _____ Unknown

Please detail the current involvement of the child's parent(s), siblings, and other significant individuals.

Placement History-

Placement (<i>Foster families, group care, residential treatment, hospitalizations</i>)	Type	Duration

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Educational History-

Current School: _____ **Current Grade:** _____

Educational Needs: Can this child attend full-day school? No Yes
Does the child have an IEP? No Yes
Attend regular classroom: No Yes
Full -time Special Education: No Yes

Special Needs or Behaviors-

Is child danger to self? No Yes Unknown
Has child had: a. **Suicidal Gesture:** No Yes Unknown
b. **Suicidal Attempts:** No Yes Unknown
Suicide Risk Assessment: Low Moderate High

Other: Explain: _____

Aggression towards: Self Peers Adults

Please explain: _____

Number of runaways from home: _____ **From placements:** _____

History of fire setting: No Yes Unknown
History of cruelty to animals: No Yes Unknown
History of explosive behaviors: No Yes Unknown
History of sexual acting out: No Yes Unknown

Does this child have a history of involvement with the juvenile justice system? No Yes Unknown

Date of most recent psychological/psychiatric evaluation and name of the person who completed the evaluation:

DSM-V Diagnosis: _____

Are medications currently prescribed? No Yes Unknown

If yes, specify drug, dosage, and length of time on these medications: _____

Name of prescribing physicians(s) and phone number: _____

Please provide any additional information you feel is pertinent: _____

Completed applications may be faxed to (406) 541-5532 or mailed to 2825 Stockyard Rd., Suite A-11,

Missoula, MT 59808



RELEASE OF AND REQUEST FOR INFORMATION

Youth's Name: _____

Partnership for Children may RELEASE information to the following person(s) and/or agencies:

Partnership for Children may OBTAIN information from the following person(s) and/or agencies:

The information to be RELEASED and/or OBTAINED may include:_____

The PURPOSE of the information to be RELEASED and/or OBTAINED may include:_____

I voluntarily allow the above named persons and/or agencies to disclose information to facilitate my appropriate involvement with the Partnership for Children. I understand that this information will not be forwarded by Partnership for Children to anyone other than those participating in my involvement in this program without my written permission. I understand that, if the persons or organizations that I authorize to receive my information are not subject to federal and state health information privacy laws, subsequent disclosure by such person or organization may not be protected by those laws. I understand that I can cancel this authorization, in writing, at any time; this cancellation does not include information that has already been given prior to cancellation. No threat or other coercive measures have induced me to sign this document. I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

Parent/Guardian Name (Please print)

Relationship to Client

Parent/Guardian Signature

Date

Partnership for Children Representative

Date

This release is valid until:_____