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:

☐ **Family support services** ☐ **Therapeutic Foster Care** ☐ **Group Care**

☐ **Outpatient Therapy** ☐ **CBPR&S** ☐ **Case Management**

Briefly describe child's need for care: ____

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Briefly describe child's strengths: ____

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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.

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<u>Placement History-</u>

Placement *(Foster families, group care, residential treatment, hospitalizations)*	**Type**	**Duration**

<u>Educational History-</u>

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

<u>Special Needs or Behaviors-</u>

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: ____

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Please provide any additional information you feel is pertinent: ______________________________________

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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:______________
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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:____