| Iowa Department of HUman SErvices Foster GROUP Care Referral |
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| Referral Information |
| Date:       | FGCS Contractor:       | DHS Service Area:       |
| Referring Worker |
| Name:       | Email:       | Phone:       |
| City:        | County:        | Cell Phone:       |
| Referring worker Supervisor Information |
| Supervisor Name:       |
| Email:       | Cell Phone:       |
| FSRP Care Coordinator Information |  |
| Name:        | Email:        | Cell Phone:       |
| FSRP Supervisor:        | Email:        | Cell Phone:       |
| Child Demographics |
| Name:       |
| Date of birth:       | State ID:       | Language:       |
| Male [ ]  Female [ ]  | Does Child Identify as LGBTQ ? Yes [ ]  No [ ]  | Race:        |
| Current Care Setting:       |
| City:       | State:       | Phone Number:       |
| Education |
| School District:       | Current School:       | Grade:       |
| IEP? Yes [ ]  No [ ]  | Behavioral [ ]  Educational [ ]  | Special Education : Yes [ ]  No [ ]  |
| **Mental and Physical Health** |
| Date of last Physical Exam:  | Date of last Dental Exam:  | Date of last Vision Exam:  |
| Medical or Physical Needs Known:       |
| Mental Health Diagnosis (include known alcohol/drug abuse):        |
| Current Medications:       |
| Known Allergies:       |
| Insurance |
| MCO:       | TXIX Number:       | Private Insurance:       | Indian Child Welfare Act (Y/N):       |
| **Court and FTDM/YTDM Meetings** |
| Next Court Date:       | No Contact Order: Yes [ ]  No [ ]  With Whom:       |
| Next FTDM Meeting Date:       | Next YTDM Meeting Date:       |

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| Responsible Parties |
| Parent Name:      Phone:      Address:      Email:       | Parent Name:      Phone:      Address:      Email:       |
| Who Has Custody:       |
| **Child’s Supports** |
| Relative’s Name:      Phone:      Address:      Email:       | Relative’s Name:      Phone:      Address:      Email:       |
| Others who are a support:Name:      Phone:      Address:      Email:       | Others who are a support:Name:      Phone:      Address:      Email:       |
| Guardian ad litem:      Phone Number:      Email:       | Attorney:      Phone Number:      Email:       |
| Child’s Needs & Expected Outcomes |
| Reason for referral:       |
| Specific treatment needs to be addressed:       |
| Plan for family involvement, contacts and frequency:       |
| If not included in the above narrative, identify any risks the child would present to self or others:       |
| Current permanency plan after completion of group care stay:       |
| The information/documents below are to be included with all FGCS referrals. In the “Included” box, place an “X” if the item is attached or an “N/A” if the item is not available or not applicable.  |

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| Included | Referral Items |
|       | Placement Agreement 470-0719 |
|       | 3055 |
|       | DHS Case plan (part A, B, C) |
|       | Social History |
|       | Criminal/Delinquency History |
|       | Treatment History, including indication of previously successful modalities |
|       | Current Services – if not part of DHS Case Plan |
|       | Court Report (most recent) |
|       | FSRP Service Plan/Case Progress Report (most recent) |
|       | Transition Plan (If child is over 14yo) |
|       | IEP/School Behavior Plan |
|       | Any pertinent evaluations or screening tools (substance abuse, mental health, domestic violence, risk, level of care) |
|       | Most recent psychological report |
|       | Most recent psychiatric report |
|       | Court Order |
|       | No Contact order |
| Explanation for items Not Included:       |