| Iowa Department of HUman SErvicesFoster 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: | |