DAN FOX FAMILY CARE PROGRAM
Therapeutic Foster Care Referral

Please submit this application and any additional documents (including a court order indicating custody, clinical assessments, evaluations, a release of information for all providers, IEP, and other pertinent information) our Family Developer via fax (543-0356) or email danfoxreferral@youthhomesmt.org. Once we receive this information, we will contact you and other members of the team to ask additional information as needed. We review referrals every other Monday. Please note that we cannot review referrals for youth who are currently requiring restraints in their placement. **If you have any questions, please call our Family Developer & Services Coordinator at (406) 541-1663.**

In addition to this application, please provide the following:

Document Checklist

☐ Court Order Indicating Custody
☐ Clinical Assessments
☐ Evaluations
☐ Release of Information For All Providers
☐ IEP
☐ Other Pertinent Information

Youth Name:
Date of Birth:
Place of Birth:
Social Security Number:
Sex:
Race:

Person making referral (name, position and contact information):
Legal guardian (name and contact information):
Other team members:
Healthy Montana Kids or Healthy Montana Kids Plus (Medicaid) number:
Who will pay for room and board?

Family Information

Have parents' rights been terminated?
Does the youth need to be adopted?
Issues in family of origin, including psychiatric, chemical dependency, and relationship problems:

Please detail circumstances which led to the youth's removal from home and need for placement in foster care:

Previous removals from parents:

Please describe any visitation plans between the youth, parents, and siblings, if appropriate.

Birth mother name:
Current living situation, contact information, and level of involvement with youth:

Birth father name:
Current living situation, contact information, and level of involvement with youth:

Other parental figure:
Current living situation, contact information, and level of involvement with youth:

Siblings (names, ages and placements):

Other parents or parental figures:
Current living situation, contact information, and level of involvement with youth:

Biological family's strengths:

Resources available to biological family:

Goals for biological family:

Youth Information
Current placement:

Contact person at placement (name and contact information):
Placement date:
Discharge date:
Therapist (name and contact information):

Diagnosis:

Current medications and doses:

Therapeutic progress in current placement:

Previous placements (including dates and reason for discharge):

Description of disruptive or detrimental behaviors:

History of problems in peer relationships:

Delinquent history:

Substance abuse/addiction history:

Medical history and allergies to medications:

Check all risk factors:	Past	Current
☐ Domestic violence	_____	_____
☐ Suicidal ideation	_____	_____
☐ Victim of child abuse	_____	_____
☐ Victim of sexual abuse	_____	_____
☐ Eating disorder	_____	_____
☐ Evidence of psychosis	_____	_____
☐ Threat to others	_____	_____
☐ Other, describe: _____	_____	_____

Please elaborate on "yes" response(s) to risk factors:

School Information
Current school:
Grade:
Special needs (IEP, CSCT, etc.):

Summary of school functioning:

History of school attendance and performance including maladaptive behaviors, suspensions and expulsions:

Reason for Referral

THERAPEUTIC FOSTER CARE CASE PLAN

(This section must be completed by applicant)

Youth Name:

Discharge plan including anticipated length of stay in therapeutic foster care:

Initial case goals for the youth and family:

GOAL 1:

GOAL 2:

GOAL 3:

GOAL 4:

Our program will take the responsibility for carrying out these steps with the family.

DAN FOX FAMILY CARE PROGRAM
Placement Recommendations

Youth Name:

The following section gives you the opportunity to give our placement committee some guidance in its efforts to match your youth with a placement family. Please describe the type of foster/adoptive family that you feel would best meet this youth's placement needs.

Please describe the ideal number and sex of parents in the family with a brief rationale for your choice.

Please describe the ideal number, age range, and sex of siblings in the family with a brief rationale for your choice.

What is the ideal geographic placing area (county/town) for this youth and why?

What services does this youth need to continue?

What new services would you like this youth to access?

Could the youth switch individual or family therapists if necessary?

Could the youth change schools if necessary?

What type of family situation would be inappropriate for this youth? *Please give a brief rationale.*

Do you know of a family that would meet this youth's placement needs? *If so, who?*

What do you think is the ideal speed of transition for this youth from his/her current placement into therapeutic foster care/pre-adoptive placement and why?

Additional comments:

Dan Fox Family Care Program
Youth Homes

RELEASE OF INFORMATION REQUEST

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

Client's Name: _____ Date of Birth: _____
(Last) (First)

I give my permission to Dan Fox Family Care Program to RELEASE/OBTAIN information (circle one or both) to the following person:

Contact Person & Credentials: _____ Agency: _____

Specific information to be released or obtained:

- ❑ History
- ❑ Assessments/Evaluations
- ❑ Recommendations

Records
- ❑ Treatment
- ❑ Diagnosis

- ❑ Progress
- ❑ Exchange of information as needed for treatment planning
- ❑ Other: _____
(Psychotherapy notes require a separate release to be signed)

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dan Fox Family Care Program. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date: _____(Or as otherwise indicated)

Conditions
I further understand that Dan Fox Family Care Program will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

I will be given a copy of this authorization for my records.

_____ _____ _____ _____
Signature of Patient/Client Date Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Check here if patient/client refuses to sign authorization.

_____
Signature of Staff Witness Date

❑ Faxed Copy_____
❑ Mailed Copy_____