IOWA HHS

Iowa Department of Health and Human Services

Preplacement Screening for Problematic Sexualized Behavior (PSB) Foster Group Care Services/QRTP

Date:

Client Name	Date of Birth	FACS ID	County
Current Living Arrangement			Legal Status: ☐ CINA ☐ Delinquent ☐ Voluntary
Referring Worker Name and Contact Information			

History of Problematic Sexualized Behavior (PSB)

Date of last problematic sexualized behavior or behaviors:

Describe history of problematic sexualized behavior or behaviors including frequency:

Describe violence or coercion used during a sexual act:

Did the sexualized behavior occur between the youth and someone with a substantive developmental delay?
☐ Yes ☐ No

If yes, explain:

Check all that apply.

Did the sexualized behavior occur with someone five or more years younger? ☐ Yes ☐ No

Did the sexualized behavior occur with someone under 12 years of age? ☐ Yes ☐ No

PSB Services Provided in the Community

Was a PSB treatment program or intervention within the community accessed by the youth?

☐ Yes ☐ No

If yes, list programs or individual treatment designed to address PSB, as well as dates of service, which were accessed by the youth:

Reason for unsuccessful service outcomes (most recent). *Check all that apply.*

☐ Refused

☐ Engaged in additional problematic sexualized behavior after treatment began (repeat PSB)

☐ Other

Comments:

Criminal History

Does the youth have criminal charges related to sexual behavior? ☐ Yes ☐ No

If yes, describe:

Most recent charge:

Date:

Is the youth on the Sex Offender Registry? ☐ Yes ☐ No

Intellectual Functioning

Does the youth have an intellectual disability? ☐ Yes ☐ No ☐ Unknown

If yes, what was the IQ and date of most recent test?

Contact information for a licensed practitioner recommending PSB residential placement:

For this purpose, licensed practitioners are a:

- Psychologist,
- Social worker (LMSW or LISW),
- Marital and family therapist (LMFT), or
- Mental health counselor (LMHC).

Name		Credential
Clinic Name		
Address		
Phone Number	Email Address	Date TOP Completed by Licensed Practitioner

Attach assessment and written recommendation for residential treatment.

Other comments:	
Case Manager/JCO	Date

STOP: SAM/Chief completes final Review of Placement Criteria, suitability, and approval.

Review of Placement Criteria *(Check all that apply.)*

Required for referral:

☐ TOP has been completed by a licensed practitioner.

☐ Licensed practitioner is recommending residential treatment.

Two or more of the following must apply:

☐ Has been served in the community and determined unsuccessful.

☐ Individual has been involved in violence during a sexualized behavior, who cannot at this time be served in the community.

☐ Individual repeatedly engaged in a PSB, who cannot at this time be served in the community.

☐ Sexual act involved a much younger or developmentally younger child (chronological or developmental equivalent of at least five years).

Overall Assessment of Suitability for PSB Foster Group Care

SAM/Chief (or designee) decision: ☐ Not appropriate ☐ Appropriate

Comments:

SAM/Chief (or designee) Signature	Date