STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Kim Reynolds
GOVERNOR

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Preplacement Screening for Therapeutic Foster Care (TFC)

Date:

Client Name	Date of Birth	FACS ID	County
Current Living Arrangement (indicate "none" if newly entering)			Legal Status: ☐ CINA ☐
Referring Worker Name	Referring Worker Contact Information		

Intellectual Functioning	
Does the youth have an intellectual disability? If yes, what is the IQ and date of the most recent test?	Yes ☐ No ☐ Unknown Date: IQ:
Does the youth have a diagnosed traumatic brain injury? If yes, explain the event in detail.	☐ Yes ☐ No

Severe Emotional Disturbance Criteria Checklist		
DSM diagnosis:		
Youth presents with substantial limitations in the following areas:		
Self-care (examples include hygiene, feeding): If yes, explain.	☐ Yes	☐ No
Social and family relationships: If yes, explain.	☐ Yes	☐ No
School and work: If yes, explain.	☐ Yes	☐ No
Self-direction: If yes, explain.	☐ Yes	☐ No

History of Behavioral Challenges		
Known history of aggressive or assaultive behaviors?	☐ Yes	☐ No
If yes, provide a brief explanation, including dates and frequency, any injuries, and description of victim's age and other relevant details.		

Known history of suicidal ideations, self-injurious behavior, and/or suicide attempts? ☐ Yes ☐ No If yes, provide a brief explanation, including relevant dates and cite the most recent event.	
Known history of sexualized behavior? ☐ Yes ☐ No If yes, provide a brief explanation, including relevant dates.	

Clinical Services Provided in the Community

What treatment programs or interventions have been accessed on behalf of the youth? Please include programs that refused admission.

List programs or individual treatment designed to address behavior and emotional needs, as well as dates of service. Examples could include BHIS, PMIC, waiver, and other group placements.

What past interventions have been the most successful?

What has been the focus of each of these successes?

Case Manager	Date

STOP: Service Area Manager or designee completes final Review of Placement Criteria, suitability, and approval.

Review of Eligibility Guidelines (Check all that apply.)

All of the following is required for Referral:

☐ Meets criteria for co-occurring mental health diagnosis, SED/Behavioral Health, or autism

☐ Is not able to be safely maintained in a non-specialized family home

☐ Age 8 through 12

☐ Adjudicated Child in Need of Assistance (CINA) (In child welfare system)

☐ Parent or an identified family will participate in the program with the expectation the child will exit therapeutic foster care to permanency in their home

Overall Assessment of Suitability for TFC

Service Area Manager (or designee) Decision:

☐ Not appropriate

☐ Appropriate

Comments

Service Area Manager (or designee) Signature	Date

Referral Process
Upon completing of this form, including Service Area Manager (or designee) signoff, attach Form 470-5508 Family Foster Care Referral and send to foster-adopt@fouroaks.org. Referrals for TFC should be made 30 days in advance of the actual placement for planning and team coordination.