IOWA Health and Human Services

# 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:<br>☐ CINA |
| Referring Worker Name | Referring Worker Contact Information | | |

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

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

| **History of Behavioral Challenges** |
|---|
| Known history of aggressive or assaultive behaviors? ☐ Yes ☐ No<br>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<br>If yes, provide a brief explanation, including relevant dates and cite the most recent event. |
| Known history of sexualized behavior? ☐ Yes ☐ No<br>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:<br>☐ Meets criteria for co-occurring mental health diagnosis, SED/Behavioral Health, or autism<br>☐ Is not able to be safely maintained in a non-specialized family home<br>☐ Ages 7 through 17<br>☐ Adjudicated Child in Need of Assistance (CINA) (In child welfare system) |

| **Overall Assessment of Suitability for TFC** |
|---|
| Service Area Manager (or designee) Decision:<br>☐ Not appropriate<br>☐ 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. |