STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Mental Health Questionnaire

You and your RRTS caseworker are making a very important decision together about your family's fostering and/or adopting. Because of this, we will be discussing sensitive subjects to help ensure the safety and well-being of your family and potential foster/adoptive children who may come into your home. This discussion will help us make the best decision for you, your family, and the foster/adoptive children.

Is anyone in the home on psychiatric medication?
☐ Yes ☐ No

Family Member	Diagnosis	Medication	Doctor

Please identify behaviors and triggers related to diagnosis:

Have you or anyone in your household been hospitalized for mental health or substance abuse issues or concerns?

☐ Yes ☐ No
If yes, please explain:

Have you or anyone in your household received individual, group, or marital counseling?
☐ Yes ☐ No
If yes, please explain:

Has anyone in your family received treatment due to drugs or alcohol?
☐ Yes ☐ No
If yes, please explain:

Please note: Documentation may be requested from doctor on ability to be foster and/or adoptive parent if answered YES to any of the above questions.

Family Signature(s):	Date:
	Date:

Prescribing Physician/Therapist Mental Health Statement

This form is to be completed by the prescribing physician and/or therapist.

[Name] plans to provide care to children as a foster or adoptive home or is a household member and has been asked to obtain this statement from their prescribing physician/therapist. Your assistance in verifying there are no concerns with regards to [Name]'s mental health will assist us in completing our evaluation for foster care licensure. Thank you.

Name:

Diagnosis:

Medication(s): (Please include name and dosage)

Counseling received: (Individual/Marital, Current/Past, Frequency, Reason)

Behaviors related to diagnosis:

Hospitalizations: (Dates/Reason):

Prescribing Physician/Therapist Statement

Please check one of the following boxes indicating if you have reservations about the individual providing care to children in foster care or adoption in their home, or a household member, given their diagnosis.

☐ On the basis of my examination of _____, it is my professional
insert individual(s) name(s)

opinion that _____ **would not** prevent approval as a foster and/or
(insert diagnosis)

adoptive home.

☐ The following mental health concerns regarding _____ prevent me
insert individual(s) name(s)

from signing this statement as it is my opinion to **recommend against licensing** as a foster and/or adoptive home.

Please explain:

_____

_____

_____

_____

_____

_____

_____ _____

Prescribing Physician/Therapist Signature Date