Iowa Department of Health and Human Services

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

Date:

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

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| **History of Problematic Sexualized Behavior (PSB)** |

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| 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 [ ]  NoIf yes, explain:       |
| *Check all that apply.*Did the sexualized behavior occur with someone five or more years younger? [ ]  Yes [ ]  NoDid the sexualized behavior occur with someone under 12 years of age? [ ]  Yes [ ]  No |

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| **PSB Services Provided in the Community** |

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| 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:       |

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| **Criminal History** |

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| 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 |

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| **Intellectual Functioning** |

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| Does the youth have an intellectual disability? [ ]  Yes [ ]  No [ ]  Unknown |
| If yes, what was the IQ and date of most recent test?       |

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| **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).
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| Name      | Credential      |
| Clinic Name      |
| Address      |
| Phone Number      | Email Address      | Date TOP Completed by Licensed Practitioner      |

**Attach assessment and written recommendation for residential treatment.**

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| **Other comments:** |

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|       |
| Case Manager/JCO | Date      |

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

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| **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). |

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| **Overall Assessment of Suitability for PSB Foster Group Care** |
| SAM/Chief (or designee) decision: [ ]  Not appropriate [ ]  Appropriate |
| Comments:       |
| SAM/Chief (or designee) Signature | Date      |