A close-up of a logo

Description automatically generated with low confidenceIowa 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  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 |

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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 |