THOMPSON
Strengthening Children, Families & Communities

Inquiry Date: _____

Foster Child Referral/Screening Form

Child's name: _____
Age: ____ Gender: _____ Ht._____ Wt._____ Race: _____
Does the race of the foster family matter? ____

Type of Service Needed:
___ Regular FC ___Therapeutic FC ___ Foster/Adopt Placement
MCO:_____
Date Placement needed:_____

Type of family requested (two parent, single parent, stay at home parent, other kids, etc):
_____

Religious Preference:_____Do we need to take this preference into consideration when considering placement?:_____

Diagnosis: _____
_____

Medications: _____
_____

Current Behaviors: _____
_____

Past Behaviors: _____
_____

Child's strengths/hobbies/interests: _____
_____

Current School setting (Day tx, Public, Suspended) Does the child need to remain in that school/setting?: _____
_____

Is there an IEP?_____ Current grade level or last completed? _____
Current/proposed plans for after school time (payment source?): _____
_____
_____

Insurance? Method of payment for Foster Care/ Room & Board: _____
_____

Is the child currently receiving therapy/psychiatry services? Where? How frequent? Will that continue after placement? _____
_____
_____

What is the proposed discharge plan? (ie. length of stay, return home, etc): _____
_____

What family involvement (ie. visitation w/ parents, shared parenting needed, sibling visits, how frequent, etc): _____

How did you hear about Thompson?:

_____

Agency Involvement

Social Worker: _____ Phone #: _____
County: _____ e-mail: _____
Address: _____

Referral Source: _____ Phone #: _____
Agency: _____
Title: _____ e-mail: _____
Address: _____

Other: _____ Phone #: _____

Follow-up contacts:

_____
_____
_____
_____
_____
_____
_____

FOSTER CARE ADMISSION SCREENING:

☐ **Eligible for Admission to:** ☐ Regular FC ☐Therapeutic FC ☐ Foster/Adopt Placement

Projected Admission Date: _____/_____/_____ or ☐ **Add to Waiting List**

☐ **Not Eligible for admission to Foster Care services because:** _____

_____

_____ **Referred to:** _____

Decision based on: _____

_____

_____

AND

Documentation Reviewed: ☐ Application ☐ Comprehensive Clinical Assessment ☐ IEP
☐ Internal Documentation ☐ Psychiatric /Psychological Assessments

Name of Person Screening: _____ **Date of Decision:** _____/_____/_____

Title of Person Screening: _____