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**TREATMENT FOSTER CARE / SHORT-TERM FOSTER CARE ONLINE REFERRAL FORM**

**Please** **email** **any additional information (such as psychological, social history, etc.) or fax to 804.239.1060**

**If you do not get a response from us within one hour during regular business hours (8:30 a.m. to 4:30 p.m.), please call John Jenks, admissions coordinator, 804.310.7572**

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| **Today’s date** |  |
| **Desired placement date** |  |
| **Est. length of placement** |  |
| **Referred to UMFS before?** | **Yes**  |  | **No** |  |
| **If yes, when?**  | **Date** |  | **Service** |  |
| **Past or Current Services provided by UMFS or another Agency?** | **Yes**  |  | **No** |  |
| **If Yes, when?** | **Date**  |  | **Service Provided** |  |
| **Is the child currently in imminent danger or at risk of harming self or others?**  | **Yes** |  | **No** |  |
| **If yes, please provide details of this behavior:** |  |
| **Are there any current safety concerns?** |  | **Yes** |  | **No** |  |
| **If Yes, please describe current safety concerns:** |  |
| **How did you hear about us?** | CSA DirectoryCurrent/Former CustomerEmail NewsletterFAPT TeamNewspaper/Magazine  | ArticleProgram BrochureGuardian NewsletterMobile AdsRadio | Sales PresentationTrainingTV-CommercialUMFS WebsiteVendor fair/trade show |
| **Reason for Referral:** |  |
| **Location preference:** |
| Richmond 🞏 | NOVA 🞏 | Fredericksburg 🞏 | Tidewater 🞏 |  |
| South Central 🞏 | Lynchburg 🞏 | Farmville 🞏 | No Preference 🞏 |  |
| Preferred race of family: |  |
| Restrictions on other children in the home? |  |
| Does single parent or 2-parent home make a difference? If so, give preference: |  |
| Can child be placed with pets? |  |
| **Client Information** |
| **Name** |  |
| **DOB/Age** |  |
| **Gender** | Male Female |
| **Race/Ethnicity** | Am. Indian, Alask. Nat.Asian (Non-Pacific Isl.)Black, African AmericanHispanic, Latino | Pacific IslanderWhite (Non-Hisp/Latino)Multi-Ethnic/RacialOther |
| **Height/Weight** |  |
| **Contact at Current Address** |  |
| **Current Address** |  |
| **Financial Status (include financial assistance & insurance coverage)** |  |
| **Social Insurance # (if available)** |  |
| **Legal Status-legal standing or custody** |  |
| **Freed for Adoption (TPR date)** |  |
| **Permanency Plan** |  |
| **Developmental Level** |  |
| **Primary Language** |  |
| **Cultural Background and Tradition** |  |
| **Cultural Issues Requiring Special Service Provision** |  |
| **Sexual Orientation** |  |
| **Gender Identity and Expression** |  |
| **Immigration/Refugee History and Status** |  |
| **Does the Indian Child Welfare Act Apply?****If so, Tribal Affiliation** |  |
| **VEMAT SCORE** |  |
| **EDUCATION** |
| **Grade** |  |
| **Is Child in Special Ed?** |  |
| **Specific Classroom Needs** |  |
| **Vocational/Independent Living Needs** |  |
| **Parent/Custodian/Referral Source** |
| **Custodian/Agency/DSS**  |  |
| **Parent Name/Worker Name** |  |
| **Address** |  |
| **Worker/Parent Phone-ext** |  |
| **Fax** |  |
| **Email** |  |
| **Supervisor Name/Phone #** |  |
| **Emergency Contacts/Phone (if any)** |  |
| **BEHAVIORS** |
| **Current Behaviors** | **At Home, School, etc.** | **Frequency** | **Description of Behavior** |
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| **Interventions in the past that have been effective in addressing these behaviors** |  |
| **Is child on probation? If Yes, list PO name, contact info and charges.**  |  |
| **Other significant behaviors in child's past not noted above** |  |
| **Is there a current risk for these behaviors? Why or why not?** |  |
| **Is there a history of runaway behavior? If yes, explain** |  |
| **DSM-IV DIAGNOSIS** |
| Axis |  |
| **I** |  |
| **II** |  |
| **III** |  |
| **IV** |  |
| **V** |  |
| **IQ** |  |
| **CURRENT MEDICATIONS** |
| **Medication** | **Dosage** | **Prescribing Physician** | **Frequency** |
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| **Is youth compliant with medications?** | **Yes**  |  | **If no, please explain:** |
| **No** |  |  |
| **Psychiatrist name and phone** |  |
| **MEDICAL/PHYSICAL**  |
| **Allergies** |  |
| **Overall Health** |  |
| **Overall Development** |  |
| **List any emergency health needs, known medical conditions, illnesses, medical care or physical limitations** |  |
| **History of substance abuse?** |  |
| **Is medical/dental follow-up required?** | **Yes**  |  | **If yes, please explain:** |
| **No** |  |  |
| **Does child wear braces?** | **Yes** |  | **If yes, please explain:** |
| **No** |  |  |
| **Nutritional and Dietary Needs** |  |  |  |
| **PLACEMENT HISTORY** |
| **Placement/Service** | **Dates** | **Reason for Move/Termination** |
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| **STRENGTHS/Needs** |
| **What are the client’s strengths, interest, skills and talents?** |  |
| **Other comments/needs** |  |
| **FAMILY Relationships** |
| **Reason removed from birth parents** |  |
| **Parental Involvement?** |  |
| **Mother’s Name** |  |
| **Father’s Name** |  |
| **Are there siblings? Do they need to be placed together?**  |  |
| **Visitation? With whom? Frequency?** |  |
| **Does visitation need to be supervised?** |  |
| **Transportation Requirements (role of DSS, foster parent and UMFS)** |  |
| **Location of Visitation** |  |
| **History of Trauma, Family Violence, Abuse, Neglect or Exploitation in the Family or Child’s Past (including human trafficking)** |  |
| **Other Essential Family Members** |  |
| **Family Support System (formal & informal supports) - Strengths & Resources** |  |
| **Is there a social history available? If yes, please send a copy.** |  |
| **Special Needs or Considerations for Family and their participation in Treatment: (one face to face therapy session with family per month is required if family is the D/C plan)** |  |
| **Any Other Relevant Information Necessary to Provide Services** |  |

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| **Form completed by** | **Name** |  |
| **Date** |  |
| **For more information on UMFS’ programs and services, please visit our** [**website**](http://www.umfs.org) |

**For UMFS use Only**

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| **Form Screened by** | **Name** |  |
| **Date** |  |
| **Screened Recommendations** |  |