

Foster Care Assessment Program Referral Form

Thank you for referring this child to the Foster Care Assessment Program (FCAP). The FCAP provides an assessment of health, education, treatment, and permanency needs to guide DCFS case planning, and up to six months of assistance to collaboratively develop, facilitate and monitor a service plan. FCAP does not provide direct treatment services to children or caregivers, and does not recruit homes or provide home studies. The FCAP evaluator works with DCFS during the assessment process and the planning phase as a consultant.

For more information about this program, talk to your FCAP evaluator or call the FCAP coordinator at 206-744-1600.

REUNIFICATION ASSESSMENT:

(Must include ROI signed by parent)

STANDARD ASSESSMENT:

(Must include ROI signed by youth
if age 13 or older)

FOR OFFICE USE ONLY:

Complete Referral

DCFS Contacted

A. DCFS INFORMATION:

1. Date: _____

2. Caseworker: _____

3. DCFS Office: _____

4. Supervisor: _____

5. Caseworker phone: _____

6. Caseworker email: _____ 300@DSHS.WA.GOV

B. ASSESSMENT NEEDS (what are the assessment questions, what decisions will the assessment impact?):

Permanency:

Well-Being (health, mental health, education, cultural identity, etc.):

C. CHILD INFORMATION:

1. Child's Name: _____ 2. Person ID: _____

3. Gender: 0 Female 1 Male

4. DOB : _____ 5. Race/Ethnicity: _____

6. Legal Status: _____

7. Legally free 0 No 1 Yes

If Yes, Date: _____

8. Child's Primary Healthcare Provider

Name: _____

Address: _____

Tel. No.: _____

Dentist Name: _____

Tel. No.: _____

9. Child's School (current/last)

School Name: _____

Staff Contact: _____

School Address: _____

Email: _____

Tel. No.: _____

D. PLACEMENT INFORMATION:

1. Placement Episode Begin Date: _____

2. Current Placement Begin Date: _____

3. Current Caregiver: _____

Address: _____

Caregiver phone: _____

Email Address: _____

Has caregiver been informed of this referral? Yes No

4. Placement Type

1 Foster care

2 Group care

3 Relative

4 Pre-Adoptive home

5 Other (specify): _____

5. If permanency plan is reunification, then:

* Are the parent(s) informed of the referral? Yes No

* Should they be interviewed? No Yes If so, please provide the following information.

Name(s): _____

Address: _____

Phone: (home) _____ (work) _____

6. GAL/CASA volunteer:

Name: _____

Phone: (home) _____ (work) _____

Email Address: _____

E. Service Provider Information

Primary Service Providers (last six months) Please identify the primary service providers for the child, caregivers or family. Include their address and telephone number. Also note the service provided.

1. Provider Name _____

Mailing Address: _____

Tel. No.: _____

Services: _____

Tel. No.: _____

2. Provider Name: _____

Mailing Address: _____

Email: _____

Tel. No.: _____

Services: _____

F. Required Referral Attachments (most recent)

- ISSP
- Release of information (FCAP release form)
(signed by youth if 13 or older/signed by parent if Reunification Assessment)
- Most recent dependency review court order
- Placement and Legal History (Famlink)

➔Check with your DCFS FCAP liaison or local FCAP provider about where to send completed referrals in your region➔

For more information about the Foster Care Assessment Program, contact the FCAP Coordinator at **206-744-1600** or visit the FCAP website at <http://www.fcaponline.org>

For Local FCAP Office Use Only

Long Distance Case

Date Received: _____

Date Assigned: _____

FCAPID: _____