**FCAP Referral Form : Comprehensive Assessment**

For more information about this program contact the FCAP referral line at (206) 744-1617, fcap@uw.edu.

**IMPORTANT:** EACH REFERRAL MUST MEET ELIGIBILITY CRITERIA BEFORE IT CAN BE ACCEPTED. PLEASE SEE PAGE 3 OF THIS REFERRAL, DETERMINE WHICH CRITERIA ARE MET AND **CHECK THE APPROPRIATE BOXES** ON PAGE 3.

One child per referral.

Required attachments:

>Court Report

> FCAP Release of Information signed by DCYF caseworker (and signed by youth if 13 or older).

> DSHS consent form 14-012 signed by parent(s), plus FCAP ROI, if reunification is being considered.

**A. DCFS INFORMATION**

1. Date:

2. Caseworker:

3. DCYF Office:

4. Caseworker phone:

5. Caseworker email:

6. Supervisor:

**B. CHILD INFORMATION**

1. Child’s Name:

3. Gender:

3. DOB:

4. DCYF Person ID:

5. DCYF Case ID:

5. Race/Ethnicity:

6. Date child came into care:

7. Number of placements:

8. Legally free?

9. Child’s School (current/most recent):

**C. ASSESSMENT NEEDS**

Questions for FCAP to address re permanency and well-being (physical/mental health, education, cultural identity, etc):

**D. PLACEMENT INFORMATION**

1. Current Caregiver:

 Address:

 Phone:

 Cell:

 Email:

 Has caregiver been informed of this referral?

 **E. PARENTS**

1.Unless parental rights have been terminated, please complete:

 Parent name:

 Address:

 Phone:

 Cell:

 Email:

 Parent name:

 Address:

 Phone:

 Cell:

 Email:

 2. Are the parent(s) informed of the referral?

**F. SERVICE PROVIDER INFORMATION (last six months)**

Please identify the primary service providers for the child, caregivers or family.

1. Provider Name:

Agency:

Address:

 Tel No:

 Email:

 Services provided and for whom::

1. Provider Name:

Agency:

Address:

Tel No:

Email:

Services provided and for whom:

1. Provider Name:

Agency:

Address:

Tel No:

Email:

 Services provided and for whom:

**Comprehensive Assessment Eligibility Criteria:**

Two or more of the following factors must be met. Check all that apply:

\_\_1) Multiple out-of-home placements.

\_\_2) Chronic behavioral, emotional, physical, or educational problems.

\_\_3) More than two years spend in out-of-home care.

\_\_4) Assessments and evaluations have been completed, but recommendations differ as to the service plan delivery and the best treatment and placement options are unknown.

\_\_5) Child or youth is prescribed five or more psychotropic medications or any antipsychotic medications.

\_\_6) Repetitive criminal acts or offenses by the child (including inability to comply with court order, treatment, or with conditions of probation or parole).

\_\_7) The child has been or is returning to care subsequent to a disrupted or dissolved adoption.

 **Reunification is a primary permanency plan but cannot proceed due to:**

\_\_8) One or both parents have made minimal or no progress, or;

\_\_9) Parents have borderline capabilities with regard to caring for an exceptional needs child. An assessment will assist with determining whether the abilities match the needs, or;

\_\_10) A successful reunification is highly unlikely, due to intractable problems with the parents, but grounds for termination are not present, or;

\_\_11) Parents are partially or wholly compliant with services, but concerns remain about their capability.

\_\_12) The family has been the subject of one or more prior dependencies.