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: ☐ **STANDARD ASSESSMENT:** ☐

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. CAMIS Person ID:**_____

3. Gender: 0__Female 1__Male **4. DOB :** __ __/__ __/__ __ **5. Race/Ethnicity :** _____

6. SSI: 0 __ No 1 __ Yes **7. Legal Status**_____ _____ (See 2nd page for attachment) **8. Legally free**: 0 __ No 1 __ Yes If Yes, Date:__ __ / __ __ / __ __

9. Mental Health Tier Level:_____ **10. Tier Agency:** _____ **11. Not tiered:** ☐

12. Child's Primary Healthcare Provider
Name: _____
Address: _____
_____
Tel. No.: (_____) _____
Dentist Name _____
Tel. No.: (_____) _____

13. 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: **(home)** _____**(work)** _____
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:	_____	**2. Provider Name:**	_____
Mailing Address:	_____	**Mailing Address:**	_____
	_____		_____
Email:	_____	**Email:**	_____
Tel. No.:	(____)/_____	**Tel. No.:**	(____)_____
Services:	_____	**Services:**	_____

F. Required Referral Attachments (most recent)

__ ISSP
__ Release of information (FCAP release form)
__ Placement and Legal History (CAMIS)
__ Dependency or Shelter Care Order

➔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: __ __ __ __ __ __ __