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 DSHS Consent Form signed by parent(s))

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:** _____@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: _____ **E-mail:** _____

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.

1. Therapist Name: _____
Agency: _____
Mailing Address: _____
_____
Email: _____
Tel. No.: _____

2. Psychiatrist Name: _____
Agency: _____
Mailing Address: _____
_____
Email: _____
Tel. No.: _____

F. Required Referral Attachments (most recent)

☐ ISSP
☐ Release of information (FCAP release form) signed by DCFS SW and youth (if age 13 or older)
☐ DSHS consent form (signed by parent(s) 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: _____

Evaluator: _____