



Community Family Supports
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 Edina, MN 55349 St. Cloud, MN 56304
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 FAX: 888-526-2781 FAX: 888-526-2781

*If the referring agency is completing this form, please fax to 888-526-2781.

Private Agency Foster Care Referral Form

Date of Intake _____ Staff Completing Form _____

Child's Name: _____ D.O.B.: _____ Age: _____ Sex: _____

Worker Name: _____ Worker Number: _____

County: _____ MAPCY Rating: _____ Race/Cultural Heritage: _____

Date Placement Needed: _____ Length of Placement: _____

Geographical area preference: Yes No
 If yes, where: _____

Current school: _____ Current grade: _____

Is the child in special education: Yes No
 Briefly describe academic motivation, behavior, attendance etc.: _____

Therapy

Is the child in therapy or will need therapy once in placement? Yes No

Location / frequency: _____

Will the child need transportation to the therapy? Yes No

Medications: _____

Chemical usage: Yes No
 If yes, which substances? _____

Is the child on probation? Yes No Probation Officer Name: _____

If yes, describe the charges: _____
 Make Restitution Community Service

Custody

Type of Placement: Voluntary Court Ordered
 Who currently has custody? _____

Parental rights terminated? Yes No

Permanency Plan: LTFC Reunification Adoption Relative/Other: _____

Family History

Describe parent's relationship/involvement: _____

Describe parenting styles/issues leading to out of home placement: _____

Visitation: Yes No

Frequency: _____

Siblings: Yes No

Number: _____

Story of Child/Presenting Problems

Story of child/pertinent information: _____

Strengths of the child: _____

Desired characteristics of the foster home: _____

Placement History

<i>Dates</i>	<i>Location</i>	<i>Reason for termination</i>
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Presenting Problems:

1. Abuse
 - emotional, by whom _____
 - physical, by whom _____
 - sexual, by whom _____
2. Aggressive
3. Assaultive, how: _____
4. Destruction of property
5. Fetal alcohol syndrome
6. Fire Starter
7. Hyperactive
8. Impulsive-Explosive
9. Social Immaturity
10. Lying
11. Parental neglect
12. Prenatal drug exposure
13. Physical/sexually abusive to younger children
14. Runner. Chronic runner
15. Sexually acting out. How? _____
16. Stealing
17. Pregnant
18. Has small child

Mental Health Diagnosis: _____

19. depressed
20. eating disturbance
21. self esteem problems
22. suicidal/self injurious
23. sleeping disturbance
24. other: _____

Special Needs:

25. PCA required
26. Nursing Care, hours/day: _____
27. Apnea monitor
28. Autistic
29. fragile
30. deaf or hard of hearing
31. MR, IQ: _____
32. Non-verbal
33. physically handicapped, weight: _____
34. seizures
35. sight impaired
36. other: _____

Relationship problems:

37. authority
38. mother
39. father
40. female adult
41. male adult
42. peer, female
43. peer, male
44. poor social skills
45. other: _____