MH 745
Revised 4/28/21

SUPPLEMENTAL THERAPEUTIC FOSTER CARE SERVICES (TFCS) ASSESSMENT

I. Client Identifying Information

Name: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female
Ethnicity: _____
Other Systems Currently Involved in: ☐ DCFS ☐ Special Education ☐ Probation ☐ Other: _____

II. TFCS Eligibility

Requested start date for TFCS: _____
LACDMH will make a determination to approve or deny the request within five (5) business days from receipt.

☐ Expedited request needed: standard 5 business day timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning.

Information about other service providers involved (*Must include contacts for each type of provider)*

☐ Foster Family Agency: _____ Phone: _____
FFA Clinician Supervising TFCS: _____ Email: _____
☐ TFCS Parent: _____ Phone: _____
☐ Current Specialty Mental Health Provider Agency: _____
Primary SMHP Clinical Staff: _____ Phone: _____
Email: _____

Date of last Child and Family Team (CFT) Meeting: _____

Copies of clinical records are required for request to be considered. Required documents are:

☐ Child and Family Team Meeting Progress Note
☐ Assessment

III. Target Population *(The following are indicators of the need for TFCS. These indicators are not requirements but service as guidance in order to identify children/youth who may need or benefit from TFCS.)*

Client is receiving, or being considered for one of the following:

- ☐ Wraparound
- ☐ IFCCS
- ☐ FSP
- ☐ ISFC
- ☐ TBS
- ☐ Crisis Stabilization
- ☐ Crisis Intervention

☐ Client is at risk of placement in an STRTP
☐ Client is at risk of psychiatric hospitalization
☐ Client has transitioned from an STRTP or psychiatric hospital within the last six months
☐ Client is at risk of losing current placement.
☐ Client is at risk of losing current school enrollment/placement.
☐ Other circumstances. Please specify: _____

Name: **DMH ID#:**

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IV. TFCS Assessment

1. Identify the behaviors and/or symptoms that jeopardize continuation of the current placement or the specific behaviors and/or symptoms that interfere with the child or youth transitioning to a lower level of care:	
Be sure to include: *Intensity* *Frequency* *Duration* *Where Occurring* *When Occurring*	
2. What other specialty mental health service(s) is client currently receiving? Indicate why child or youth needs TFCS in addition to current service(s):	
Be sure to include: *Services* *Why these services are not sufficient to meet needs* *List other less intensive services that have been attempted, if applicable*	
3. Identify skills and adaptive behaviors that the child or youth is using now to manage the targeted behaviors and/or symptoms and/or is using in other circumstances that could replace the targeted behaviors and/or symptoms:	
Be sure to include: *Replacement Behaviors* *Activities enjoyed* *Strengths of client and family/caregiver* *Available Resources* *Supports* *Interventions that are working*	
4. Identify what changes in behaviors and/or symptoms TFCS is expected to achieve and how the Resource Parent and treatment team will know when these services have been successful and can be reduced or terminated:	
Be sure to include: *Where/when/under what circumstances is the Resource Parent most likely to provide TFCS* *How these strategies will complement/enhance the MH treatment team's interventions*	

V. Referring Provider Contact Information

Contact Name:_____ Contact Email: _____ Contact Phone Number:_____

Signatures

_____ _____ _____ _____

Signature & Discipline | Date | Co-Signature & Discipline (if required) | Date

Name: **DMH ID#:**

Agency: **Provider #:**

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