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| **PLACEMENT REFERRAL FORM**  **(Replaces DCFS Forms 709, 6017, and 6090-used for TSC FACILITIES, EMERGENCY PLACEMENT UNIT (EPU), RFH-EPU (14-DAYS))**  **Complete all fields that apply.** | | | | | |
| **TRANSITIONAL SHELTER CARE (TSC) FACILITY:**  New Detention  Nonminor Dependent (NMD)  Replacement  14 day Notice | | | **Accelerated Placement Team** (APT) /**EMERGENCY PLACEMENT UNIT** (EPU) Placement for Child/Youth/NMD who requires temporary placement (FFA-EPU and RFH-EPU) until an appropriate placement is available. Submit the **DCFS 179 and Current PMA to** [EXD-DCFS\_APT@dcfs.lacounty.gov](mailto:EXD-DCFS_APT@dcfs.lacounty.gov)  Placement Support 24/7: (213) 437-9855 | | |
| **Referral Date:** | | | **Referral Number:**       **Primary Language:** | | |
| **Case Date:** | | | **Case Number:** | | |
| **DCFS Child’s Name:**  **Child part of sibling set?**  **Yes**        **# of siblings:** **No** | | | **Date of Birth:**       **Age:** | **Gender:**  **M**  **F**  **Intersex** | |
| ***Sexual Orientation/Gender Identity and Expression (SOGIE)* *Disclaimer:*** ***Engage youth around their SOGIE, before this information is indicated on the form. SOGIE should be asked and not assumed. Per DCFS policy, the youth must consent to this information being shared and can decline to provide information.*** **Different scenarios may arise on a case-by-case basis regarding LGBTQ+ children/NMDs.  For any concerns related to confidentiality prior to the disclosure of SOGIE information, CSWs and SCSWs may conference and/or consult with County Counsel.**  Youth consents to their SOGIE being shared  Youth Declines to their SOGIE being shared  Youth’s preferred pronouns:  Does youth self-identify with respect to sexual orientation?  Yes  No If yes, how does youth self-identify? Choose an item.  Does youth self-identify with respect to gender identity?  Yes  No If yes, how does youth self-identify? Choose an item.  How does youth express their gender? Choose an item. | | | | | |
| **CSW/SCSW/ARA/RA CONTACT INFORMATION** | | | | | |
| **Regional Office:**  Choose an item. | | | | | |
| **CSW Name:** | | | **CSW Phone:** | **CSW Cell Phone:** | |
| **SCSW Name:** | | | **SCSW Phone:** | **SCSW Cell Phone:** | |
| **ARA Name:** | **Phone:** | | **RA Name:** | **RA Phone:** | |
| **Section A** | | | | | |
| List Strengths of Child/ Youth: | | | | | |
| **Description of youth’s mental health needs and level of functioning or the youth’s behaviors/symptoms/developmental factors exhibited that are of concern?:** | | | | | |
| **Is youth connected to Mental Health Services?**  **Yes**  **No** | | | **Therapist Name and Contact Number:**  **Wraparound Provider Name/Number:**  **IFCCS Provider Name/Number:** | | |
| **What psychotropic medication is youth currently taking (include diagnosis medication is addressing)?** | | | **Medication/medical supplies with the youth?**  **Yes**  **No** | | |
| **Is youth connected to a psychiatrist?**  **Yes**  **No** | | | **Psychiatrist Name and Contact Number (if known):** | | |
| **Psychotropic Medication Authorization (PMA) on file?**  **Yes**  **No** | | | | | |
| **Any known medical conditions (include diagnosis if known) :** | | | | | |
| **What non-psychotropic (medical) medications is youth currently taking (if known)?** | | | | | |
| **Regional Center involvement?**  **Yes**  **No**  **None Known**  **If yes, Regional Center Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service Coordinator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **Is the child/youth able to handle his/her/their own allowance and other cash resources?**  **Yes**  **No** | | | | | |
| Reason for Detention/ Replacement: | | | | | |
| Current Placement: | | | Visitation Plan (include with who & Attach visitation plan if any):  Monitored        Unmonitored        Special Instructions | | |
| Case Status:  ER  FR  FM  PP  VFR  NMD | | | Number of Prior Placements: | | |
| Child/Youth is currently enrolled or being referred to the following programs:  IFCCS  Regional Center  Medically Fragile  STRTP  CSEC Unit  ILP Services | | | | | |
| Does the Child/Youth meet STRTP requirements:        Yes  No | | | Previous EPU placements: | Previous STRTP placements: | |
| This Child/Youth is: | | | Concerns of Child/Youth (describe in detail in the comment section) | | |
| Currently in EPU placement  Yes  No | | | Currently on Probation:  Formal  Informal | Mental Health/Behavior Needs | |
| Overstay at the TSC  Yes  No | | | Chronic-Away from Care | Previous Diagnosis: | |
| Identified as CSEC  Yes  No | | | Emotional Abuse  General Neglect | Substance Abuse (list drug of choice) | |
| Is a CSEC Recruiter  Yes  No | | | Sexual Abuse  Physical Abuse | Other *(specify):* | |
| Respite Care  Yes  No | | | Developmental Delay | IEP | |
| Allergies: Yes  No List Allergies: | | | Comments: | | |
| **CORE PRACTICE MODEL INFORMATION** | | | | | |
| **Engagement: Have you talked with youth about placement? What does the youth want?** | | | | | |
| **Teaming: Who is part of the child’s team now? List the names and contact information for any individuals (i.e. formal/informal supports) important to the youth (if known):** | | | | | |
| **Assessment and Planning: What do the youth, family, and other team members see as the youth’s 3 most critical needs?** | | | | | |
| **Section B** | | | | | |
| **Where is youth currently?**  **DCFS Office**  **In Placement**  **Other (Explain:)** | | | | | |
| **Previous Placements:** | | | | | |
| **History of previous hospitalizations?** | | | | | |
| **What search efforts have been made today? (*Attach documentation of placement search efforts*)** | | | | | |
| **Mother’s Name:** | | **Father’s Name:** | | | **Other Family Contact:** |
| **Mother’s Zip:** | | **Father’s Zip:** | | | **Other Family Contact Zip:** |
| **Phone:** | | **Phone:** | | | **Phone:** |
| **List the placement resources explored including relatives and Non-Relative Extended Family Members (NREFM). Please specify which relative(s) and/or NREFMs were explored, the date of the latest attempt, and the outcome:** | | | | | |
| **CSW Signature:**       **Date:**  **SCSW Signature:**       **Date:**  ***ARA & RA Signatures must be obtained prior to transporting youth to a Transitional Shelter Care (TSC) Facility:***  **ARA Signature:**       **Date:**        **RA Signature:**       **Date:** | | | | | |
| **Note: For approval to transport a child/youth to a TSC Facility, contact the Placement Support Division (PSD) TSCF Intake SCSW at (323) 409-4401 or (424) 758-9014. Email completed forms to:** [**EXD-DCFS\_APT@dcfs.lacounty.gov**](mailto:EXD-DCFS_APT@dcfs.lacounty.gov)**:**   * **DCFS 280** * **The most recent PMA on file for each child/youth (if applicable)** | | | | | |
| **Confidential Information:** *All information contained in this document and any information exchanged during the client’s placement, is strictly confidential. This information is protected by federal and state laws governing mental and medical health records and privacy, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and Welf. & Inst. Code 827. It is intended solely for the purpose of service planning and addressing the client’s needs. Its purpose is to guide treatment decisions, interventions, and support strategies aimed at meeting the client’s specific needs and promoting their wellbeing. It is not intended for any other use or disclosure. Unauthorized disclosure or use of this information is strictly prohibited. Please be aware that mental health diagnosis are not static and may change over time. The information presented in this document reflects the current understanding of the client’s mental health condition based on available assessments and clinical observations at the time this document was signed. Mental health diagnoses are subject to reevaluation by a qualified professional and may evolve as the client’s circumstances and symptoms change. By accessing or using this information, you acknowledge and agree to adhere to the principles of confidentiality, limited use, and an understanding of the fluid nature of mental health diagnoses as outlined in this disclaimer.*     **Caregiver reviewed, understands and agrees to support the child’s case plan as described above. Caregiver has determined the child is compatible with others in the home. Caregiver agrees to keep all of the child’s case information confidential. Caregiver acknowledges receipt of the Health and Education Passport with the above information included or an explanation of why the information is not included.**  **Caregiver Signature:**       **Date:** | | | | | |