



Dear Referring Agency, Caseworker, Parent, or Guardian,

Thank you for thinking of The Partnership for Children in your efforts to place this child in Therapeutic Foster Care or Family Support Services. In order to make an official referral to our program, we require that you have the authority to place the child in our care, the ability to pay or arrange payment for the child's care, the ability to provide health insurance coverage for the child, and provide a complete written application.

To apply for services we require the following documentation:

- A completed Partnership for Children application
- An up-to-date and comprehensive psychosocial history written within the last year.
- A copy of all valid psychological/psychiatric evaluations and reports completed within the last five years.
- Legal documentation of child's current custody status
- A completed Certificate of Need
- Written report(s) from the child's most recent placements detailing treatment, progress, behavior, and current needs
- Signed releases allowing us to consult with current and former treatment providers and permission to visit and interview the child and family

Once our office receives the above, completed information, we will review the case, interview the child and/or family, and present the case to the Partnership for Children's Admissions Committee where the case will be reviewed for appropriateness of our treatment.

If the child is accepted by the Admissions Committee, we will require further information before services begin. At that time we will request and require the following information from you:

- Complete and comprehensive medical, educational, and legal histories
- Authorization to place the child in our program
- Copies of the child's Birth Certificate and Social Security Card
- Signed payment and discharge agreements
- Other information deemed necessary by PFC

We look forward to working with you in providing comprehensive and the best possible services for this child or family. If you have any questions about our programs or the application process, please call Meaghan Lee, Program Director of Foster Care at 531-0671, or Loree West, the Program Director of the Partnership for Children at 370-6651.

Loree West
Director of Partnership for Children

Meaghan Lee, MSW
Program Director of Foster Care

Montana Medicaid and Mental Health Services Plan
Therapeutic Living Services
For Individuals under 21
CERTIFICATE OF NEED

Check One: **Therapeutic Youth Group Home** **Therapeutic Family Care:**

Recipient Name: _____ Date of Birth: _____

Address: _____

SSN: _____ Medicaid/MHSP ID Number: _____

Admitting Facility: _____ Provider Number: _____

Proposed Admission Date: _____ Expected Discharge Date: _____

A child or adolescent must meet at least 4 of the following criteria for moderate or campus-based therapeutic group home services and 5 of the following criteria for intensive therapeutic group home services; or A child or adolescent must meet at least 4 of the following criteria for moderate therapeutic family care treatment services and 5 of the following criteria for intensive therapeutic family care treatment services:

1. The recipient is experiencing psychiatric symptoms of a severe or persistent nature that require more intensive treatment and clinical supervision that can be provided by outpatient mental health services

2. The beneficiary exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if therapeutic living care is not provided or the person is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting.

3. The prognosis for treatment of the individual's mental illness or emotional disturbance at a less restrictive level of care is very poor because the individual demonstrates 3 or more of the following due to the emotional disturbance or mental illness:

- (i) Significantly impaired interpersonal and/or social functioning;
- (ii) Significantly impaired education and or occupational functioning;
- (iii) Impairment of judgment; or
- (iv) Poor impulse control.

4. As a result of the emotional disturbance or mental illness, or eating disorder the individual exhibits an inability to perform daily living activities in a developmentally appropriate manner.

5. As a result of the emotional disturbance or mental illness, the beneficiary exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

Print/Type Name of Physician Team Member

Title

Signature of Physician Team Member

Date

Print/Type Name of Mental Health Professional

Title

Signature of Mental Health Professional

Date

Print/Type Name of Case Manager

Mental Health Center

Signature of Case Manager

Date

Telephone Number

Document (original or copies)	Attached	Forthcoming	Not Available	Does not apply
IMMUNIZATION				
ATTENDANCE				
SPECIAL EDUCATION				
ED DIAGNOSIS				
PSYCHOLOGICAL EVALUATIONS				
Physical Health/Disabilities				
PHYSICAL EXAMINATION/EPST/WELL CHILD PHYSICAL				
IMMUNIZATION RECORD				
VISION RECORDS				
DENTAL RECORDS				
NUTRITION INFORMATION				
Mental Health				
TREATMENT HISTORY				
PSYCHOLOGICAL REPORTS				
PSYCHIATRIC REPORTS				
CERTIFICATE OF NEED				
UR CERTIFICATION				
PSYCHO-SEXUAL EVALUATION				
Other				
IV-E ELIGIBILITY				
PSYCHO/SOCIAL HISTORY				
REPORTS TO THE COURT				
DISCHARGE SUMMARIES FROM PREVIOUS TREATMENT				
SNAP PLAN				
MEDICAID CARD				
PRIVATE INSURANCE INFORMATION				
RELEASE OF INFORMATION				

Additional Information

PART B

Intake Information

Identifying Information:

Height	Weight	Religious Preference
Eye Color	Hair Color	Identify Characteristics/Scars

Child's Current Location or Placement: _____

Agency and County of Financial Responsibility: _____

I. Case Plan

1. Briefly describe your impressions of this child including current needs:

2. Briefly describe the child's strengths:

3. What length of time do you anticipate this child will be receiving services at this level of care?

4. Please document which social services were provided to preserve and strengthen the family unit.

5. What alternatives to out-of-home placement were explored with the child's family?

6. What are the reasons for the selection of family care (foster care or adoption) and how does it meet the child's and family's needs?

7. Please describe any visitation plans between the child, parents, and/or siblings.

8. Who should be considered a part of the child's Treatment Team?

9. Please provide specific case goals for the child and family.

Goal 1: _____

Goal 2: _____

Goal 3: _____

Goal 4: _____

II. Discharge Plan

What would be necessary for this child to be discharged to a lower level of care?

1. Discharge Plan

III. Custody Status

Who has custody of this child?:

Mother	_____ Yes	_____ No			
Father	_____ Yes	_____ No			
Guardian	_____ Yes	_____ No			
DPHHS	_____ Yes	_____ No	If yes, is it	Permanent	___ Yes ___ No
				Temporary	___ Yes ___ No

Have parental rights been terminated?

Mother	_____ Yes	_____ No	_____ Unknown	_____ Date
Father	_____ Yes	_____ No	_____ Unknown	_____ Date

Can this child return home?

Permanently	_____ Yes	_____ No
For Visits Only	_____ Yes	_____ No
Not At All	_____ Yes	_____ No
Unknown	_____ Yes	_____ No

Parent(s) Mother: _____ Phone# _____

Address: _____

Father: _____ Phone# _____

Address: _____

Step-Parent(s) _____
Name _____ Phone# _____
Address: _____

Step-Parent(s) _____
Name _____ Phone# _____
Address: _____

Guardian: _____
Name _____ Phone# _____
Address: _____

Siblings: Name(s) D.O.B Residence

Other individuals significant to this child:
Name Relationship Address Phone

IV. Abuse History

Does child have a history with DPPHS? _____ If yes, How long? _____
Does this child have a history of abuse? ____ Yes* ____ No ____ Unknown
*If yes: ____ Physical ____ Sexual ____ Emotional
Does this child have a history of neglect? ____ Yes* ____ No ____ Unknown
*If yes to either or both questions, briefly explain: _____

V. Placement History

Has this child been placed away from home before? ____ Yes ____ No
If yes: How many times? _____
How many in Foster Care? _____
How many in Group Care? _____
How many in Residential Care? _____
How many in Hospitalization? _____
What has been the most restrictive placement? _____

Placements – End with most current:

This section is designed to reflect disruptions or changes in the child’s living situation. Include all agency out of home placements, independent placements, adoptive placements, and breakdowns. If the information is available in the social history, make that notation. You do not have to complete this section if the information is available on another document. Make the notation that the document is attached.

Name of Provider/Relative/Other	From – To	Reason for Termination

VI. Placement Recommendations

Section A: If this is a birth family or the foster family is not or will not be licensed with the Partnership for Children, please complete section A.

1. Please describe the strengths of the birth family.

2. Please detail the current involvement of the child’s parent(s) and significant others in his/her care.

3. What are the resources available to this family?

B. Section B: If the child is being referred to foster care without a placement family, please complete section B.

4. Describe the ideal number, age range, and sex of the parents in a possible placement family. Please give a brief explanation of the reasons for your answer.

5. Describe the ideal number, age range, and sex of siblings in a possible placement family. Give a brief explanation of the reasons for your answer.

6. What is the ideal geographic location for this child and why?

7. Which services should this child continue to receive? Would you like to see new services put in place? Please list.

8. Could the child and family switch family therapists if necessary?

9. Could the child relocate to a new school?

10. What type of family situation would be inappropriate for this child and why?

11. Do you know of a family that would meet this child's placement needs? List names and relationship to the child.

12. What length of time will be needed for this child to have a transition from their current placement to their foster family? Explain.

VII. Education

Highest Grade Completed: _____ Currently Enrolled: _____

District of Residency: _____

District of Current Enrollment: _____

Educational Needs:

Regular Classroom: _____

Full Special Education: _____

Part-Time Special Education: _____

Day Treatment: _____

Other: _____

Does child have a Guardian ad Litem? _____ Yes _____ No

Does child have A Surrogate? _____ Yes _____ No

If yes, provide name, address, and phone numbers:

VIII. Juvenile Justice History

Does this child have a history of involvement with the juvenile justice system?

_____ Yes _____ No _____ Unknown

If yes: Number of referrals to Juvenile Probation: _____

Number and types of adjudications: _____

Offenses: _____

Present Status: _____

IX. Special Needs or Behaviors

Is child danger to self? _____ Yes _____ No _____ Unknown

Has child had: a. Suicidal Gesture _____ Yes _____ No _____ Unknown

b. Suicidal Attempts _____ Yes _____ No _____ Unknown

Suicide Risk Assessment: _____ High _____ Moderate _____ Low

Other: Explain: _____

Is child a danger to others? _____ Yes _____ No _____ Unknown

If yes, explain _____

Number of runaways From home: _____ From placements: _____

History of fire setting _____ Yes _____ No _____ Unknown

History of cruelty to animals _____ Yes _____ No _____ Unknown

History of explosive behaviors _____ Yes _____ No _____ Unknown

Is this child a sex offender? Yes No
If yes, what is the risk to re-offend? High Moderate Low
Explain Sexual Offense History _____

X. Mental and Physical Health/Disability

Does this child have a diagnosed or suspected health condition or disability?
 Yes No Unknown

Describe the condition/disability and treatment required, if any: _____

Does the disability fit the definition of Developmental Disabilities as defined by MCA?
 Yes No Unknown N/A

Is child currently receiving D.D. Services? Yes No
If yes, describe the service and provide the name and address of the provider: _____

Does the child receive any medications for this condition/disability?
 Yes No Unknown

If yes, specify drug, dosage, and length of time on this medication: _____

Name, address, and phone number of prescribing physician: _____

Does child/youth receive SSI? Yes No
If yes, amount: _____ Payee: _____
Name/Address

Does the child require physical therapy for this disability/condition?
 Yes No Unknown

If yes, specify type, frequency, and providers name and address: _____

Specify any additional information, which is pertinent to the mental and physical health/disability of this child:

XI. Mental Health/Disabilities

Does this child have mental health needs, which require treatment?
 Yes No Unknown

If yes, date of most recent psychological/psychiatric evaluation and name of the person completing the evaluation:

DMS IV Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Have medications been prescribed? _____ Yes _____ No _____ Unknown

If yes, specify drug, dosage, and length of time on these medications:

Name of prescribing physicians(s) and phone numbers: _____

XII. Other:

Please provide any additional information you feel is pertinent:

Signature of agency representative completing form

Date



RELEASE FOR ROUTINE MEDICAL CARE & EMERGENCY MEDICAL CARE

I, _____, parent/legal guardian for
_____, a youth in care with the Partnership for Children Therapeutic
Foster Care, do hereby give my permission to Partnership for Children and its agents, to authorize all necessary and
routine medical care, routine tests, immunization and emergency medical or surgical treatment.

This release is in force as of the date of this signing.

Signature: _____ Date _____ - _____ - _____

Witness: _____ Date _____ - _____ - _____



RELEASE OF AND REQUEST FOR INFORMATION

Youth's Name: _____

I give my permission to Partnership for Children to RELEASE information to the following persons and/or agencies: _____

I give my permission to Partnership for Children to OBTAIN information from the following persons and/or agencies: _____

The information to be RELEASED and/or OBTAINED may include: _____

I voluntarily allow the above named persons and/or agencies to disclose information to facilitate my appropriate involvement Partnership for Children. No threat or other coercive measures have induced me to sign this document. I understand that this information will not be forwarded to anyone other than those participating in my involvement in this program without my written permission.

Parent/Guardian Signature _____
Date

Partnership for Children Representative _____
Date

This release is valid until: _____



Media Release of Information

I, _____, parent/legal guardian of

_____, a youth referred to the Partnership for Children, do hereby give my permission to Partnership for Children and its agents to use information and photographs of this child for the purposes of publicity and public information, including the news media. I understand that no personal information will be released that allows any direct connection to my child's picture, name, or identity. This release is in force as of the date of the signing.

Signature

Date

Witness

Date

The parties agree that current custody of the child or youth is with: ___ the parent ___ Youth Court ___ DPHHS ___
DOC ___ Other, describe: _____

Signatures:

Date:

PFC Staff Representative

____-____-____

Placing Worker

____-____-____

Parent/Guardian

____-____-____

Other Party

____-____-____



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 03/01/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, answering machine messages, postcards, or letters) at any telephone numbers you have provided our office.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you \$0.10 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: You are entitled to receive this Notice in written form.

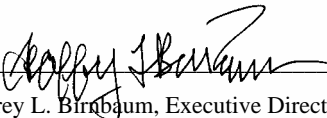
QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____


Geoffrey L. Birnbaum, Executive Director

PO Box 8134

Missoula, MT 59807-8134

Telephone (406) 721-2704 Fax (406) 721-0034