Attachment I
JCS Templates

Iowa Department of Human Services

CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES

Name of Child	Birthdate

INDEPENDENT TEAM ASSESSMENT

Yes No (Please check one choice for each item.)

❑ ❑ 1. Available community resources for ambulatory care do not meet the treatment needs of this child.

❑ ❑ 2. Proper treatment of this child's psychiatric condition requires service on an inpatient basis, under the direction of a physician.

❑ ❑ 3. These services can reasonably be expected to improve this child's condition or prevent regression so that the services will no longer be needed.

Physician Name	Date
Name and Profession	Date
Name and Profession	Date
Name and Profession	Date
Name and Profession	Date

IOWA DEPARTMENT OF HUMAN SERVICES

FOSTER GROUP CARE REFERRAL

Referral Information

Date:	FGCS Contractor:	DHS Service Area:

Referring Worker

Name:	Email:	Phone:
City:	County:	Cell Phone:

Referring worker Supervisor Information

Supervisor Name:	
Email:	Cell Phone:

FSRP Care Coordinator Information

Name:	Email:	Cell Phone:
FSRP Supervisor:	Email:	Cell Phone:

Child Demographics

Name:		
Date of birth:	State ID:	Language:
Male Female	Does Child Identify as LGBTQ ? Yes No	Race:
Current Care Setting:		
City:	State:	Phone Number:

Education

School District:	Current School:	Grade:
IEP? Yes No	Behavioral Educational	Special Education : Yes No

Mental and Physical Health

Date of last Physical Exam:	Date of last Dental Exam:	Date of last Vision Exam:

IOWA DEPARTMENT OF HUMAN SERVICES

FOSTER GROUP CARE REFERRAL

Medical or Physical Needs Known:

Mental Health Diagnosis (include known alcohol/drug abuse):

Current Medications:

Known Allergies:

Insurance

MCO:	TXIX Number:	Private Insurance:	Indian Child Welfare Act (Y/N):

Court and FTDM/YTDM Meetings

Next Court Date:	No Contact Order: Yes No With Whom:
Next FTDM Meeting Date:	Next YTDM Meeting Date:

Responsible Parties

Parent Name: Phone: Address: Email:	Parent Name: Phone: Address: Email:
Who Has Custody:	

Child's Supports

Relative's Name: Phone: Address: Email:	Relative's Name: Phone: Address: Email:
Others who are a support: Name: Phone: Address: Email:	Others who are a support: Name: Phone: Address: Email:
Guardian ad litem: Phone Number: Email:	Attorney: Phone Number: Email:

Child's Needs & Expected Outcomes

Reason for referral:

Specific treatment needs to be addressed:

Plan for family involvement, contacts and frequency:

If not included in the above narrative, identify any risks the child would present to self or others:

Current permanency plan after completion of group care stay:

The information/documents below are to be included with all FGCS referrals. In the "Included" box, place an "X" if the item is attached or an "N/A" if the item is not available or not applicable.

Included	Referral Items
	Placement Agreement 470-0719
	3055
	DHS Case plan (part A, B, C)
	Social History
	Criminal/Delinquency History
	Treatment History, including indication of previously successful modalities Current Services – if not part of DHS Case Plan Court Report (most recent) FSRP Service Plan/Case Progress Report (most recent) Transition Plan (If child is over 14yo) IEP/School Behavior Plan
	Any pertinent evaluations or screening tools (substance abuse, mental health, domestic violence, risk, level of care)
	Most recent psychological report Most recent psychiatric report
	Court Order No Contact order
	Explanation for items Not Included:

GROUP CARE WAITING LIST REQUEST

(Do NOT include PMIC Placements!)

Child's Name: _____ DOB: _____

FACS ID: _____ County #: _____ Date Court Order Filed: _____

* * * A copy of the court order ***must*** be attached * * *

Where is child currently residing: _____

Proposed facility: _____

Projected length of stay: _____ months

Worker name: _____ Ph#: _____ Co#: _____ FAX#:_____

Supervisor name: _____

Worker notification:

Above named child has been approved for a group care slot. Effective date: _____

Notification provided to _____ (wkr name) on _____ (date)

Signature: _____ (Melissa Nation, Community Liaison)

Notification of placement for DHS CW budgeting:

Above named child entered _____ on _____

He/she is projected for discharge from group care on _____

Worker: _____

Mail, fax or email court order and request form to: Melissa Nation mnation@dhs.state.ia.us, Tom Bouska tbouska@dhs.state.ia.us and Linda Tapke ltapke@dhs.state.ia.us

DHS, 417 E. Kanesville Blvd., Council Bluffs, IA 51503.

FAX #: 712/328-4850 (Phone: 712-328-5640)

Cc: Provider (provide at time of placement / Worker's supervisor

Updated 5/27/15

Iowa Department of Human Services

IV-E Changes

SECTION 1: SWCM or IV-E Worker

SWCM name / County #:	IV-E worker:	☐ Change ☐ IV-E Worker Review MM/YY:	Today's date:
Child's name:		FACS ID:	SID:

Child's current case permanency goal:
If attaching a court order, what was the case permanency goal in effect at the time of the hearing?

SECTION 2: SWCM – Place an 'x' in the box by the applicable changes and complete the information for those changes only.

☐ **No change/court order attached** ☐ Entered on FCTL

☐ **Change in placement (includes return home)** Effective date of change:
New placement name (including cottage): Relationship:
Address:
Prior placement name: Relationship:
Address:

☐ **Relative placement license approved** Effective date of license:

☐ **Guardianship transferred for permanent placement** Date guardianship transferred:

☐ **Subsidized guardianship placement** Effective date of subsidized guardianship:

☐ **Child in adoption presubsidy placement** Effective date:

☐ **Court-ordered supervision has ended** Date:

☐ **Parental rights have been terminated** Date:

☐ **Change in child's circumstances** Date of change:
☐ School aged child is no longer attending school full time/obtaining GED or other training
☐ Child's income or resources have changed

☐ **Change in *initial* removal household** Date of change:
☐ Someone moved into the home. Complete the information listed below.

Name	DOB	SSN	Relationship to Child	Income	Source Where employed or type of income	Gross Amount Hours/week and rate or monthly amount
				☐ Y ☐ N		
				☐ Y ☐ N		

If both parents are in the home, is either parent unable to work? ☐ Yes ☐ No Name:
☐ Parent recovered from incapacity Name:
☐ Someone moved out of the home Name: Relationship to child:
☐ Income started or changed Name: Source:
Amount (hrs/week or monthly amount):
☐ Income stopped Name: Source:

Comments:

SECTION 3: SW4

☐ **RE2** Date due:
☐ Yes Date obtained: Date FCTL / database entered:
☐ No If not obtained by due date, stop claiming for the month following the due date until RE2 obtained.

Comments:

SW4 signature:	**Date:**

SECTION 4: IV-E Worker – Place an 'x' by the applicable changes and complete the information for those changes only.

☐ **RE1 (initial eligibility criteria)**
- ☐ Yes – Date obtained:
- ☐ No

IVED entered?
- ☐ Yes – Date entered:
- ☐ No

☐ **Reasonable efforts waived due to aggravated circumstances (initial eligibility criteria)**
Date: Date of permanency hearing:

☐ **VPA – child left care from VPA placement with no RP&C** Date: ☐ Ended episode on IVED

☐ **VPA – court order giving DHS/JCS RP&C received prior to expiration of VPA (90 days)**
- ☐ Yes
- ☐ No – IV-E eligibility ends until such order is received

☐ **VPA – best interest finding within 180 days**
- ☐ Yes – Date obtained: Date FCTL entered:
- ☐ No – IV-E eligibility ends for remainder of episode

☐ **Court-ordered supervision ended** Date: ☐ Ended episode on IVED

☐ **Child no longer meets age/school attendance requirements**
Comments:

☐ **Change in deprivation**
- ☐ Deprivation no longer exists in the removal household
- ☐ Deprivation met initially and now exists again in the removal household
- ☐ Parental rights have been terminated so deprivation will continue to exist on an ongoing basis

Comments:

☐ **Change in child's income**
Child's countable income: vs. (maintenance payment x 1.85)
Child's income meets IV-E criteria: ☐ Yes ☐ No

☐ **Change in child's resources**
Child's countable resources: vs. limit
Child's resources meet IV-E criteria: ☐ Yes ☐ No

☐ **Change in placement**
IV-E claimable placement: ☐ Yes ☐ No **Reminder!** If a THV, review order for ongoing RP&C.

☐ **Annual review**
- ☐ Yes ☐ No Child meets age/school attendance requirements
- ☐ Yes ☐ No Child continues to be deprived Reason:
- ☐ Yes ☐ No Child's income within limits vs. (maintenance payment x 1.85)
- ☐ Yes ☐ No Child's resources within limits vs. limit

SECTION 5: IV-E Worker

IV-E funding **can** be claimed: ☐ SSI child (administrative and training funding only)
- ☐ Yes
- ☐ No – reason:

If IV-E claiming status changed, effective date:

ABC entries
- ☐ Child eligible under a different coverage group Aid type: Effective date of change:
- ☐ Opened ABC case Aid type: Effective date:
- ☐ Closed ABC case Reason: Effective date:

Cancellation/redetermination forms sent: ☐ Yes ☐ No If no, reason:

Comments (include months of retroactive claiming, claiming in error, end of episode, etc.):

IV-E Worker signature:	**Date completed:**

Iowa Department of Human Services

IV-E Initial Placement Information

SWCM name:		SWCM county #:	Today's date:
Child's name:	DOB:	FACS ID:	SID:

SECTION 1: Information Needed About the Removal (SWCM complete questions 1 – 10)

1. Removal order/VPA date:	2. Placement date:	3. Placed with relatives or suitable person? ☐ Yes ☐ No	4. Placement name and address:

5. Who did the court find responsible for the events leading to the child's removal or who signed the VPA? Relationship:

6. Did the child live with the person listed in #5 above in the month of removal? ☐ Yes ☐ No If no, when did the child last live with this person? Dates:

7. Is the child in a licensed foster care placement? ☐ Yes ☐ No If yes, attach completed Medicaid application.

8. Removal household information (this is the home of the person identified in #5 above)

Name (list everyone in home)	**DOB**	**SSN**	**Relationship to Child**	**Income**	**Source** Where employed or type of income	**Gross Amount** Hours/week and rate or monthly amount
				☐ Y ☐ N		
				☐ Y ☐ N		
				☐ Y ☐ N		
				☐ Y ☐ N		
				☐ Y ☐ N		
				☐ Y ☐ N		

Resources: List any resources owned by any member of the household (e.g., vehicles, bank accounts, etc.)

Who owns it?	Type of Resource	What is it worth?	Who owns it?	Type of Resource	What is it worth?

9. Absent parent information (name/child):

10. Is the child a full time student, obtaining a GED or other training? ☐ Yes ☐ No

Comments:

SWCM signature:	**Date completed:**	**Date sent to IV-E Worker:**

SECTION 2 (IV-E Worker)

1. Child enters care via:

Removal Type	**Removal Month**	**CTW / BI Finding**	**RE1 Finding**
☐ **Emergency Removal/ Court Order** Court order date:		In removal order? ☐ Yes – date: ☐ No – child not IV-E eligible	Within 60 days of removal? ☐ Yes – date: ☐ No ☐ Not due – due date:
☐ **Voluntary Placement Agreement** ▪ VPA effective date: ▪ Date signed by parent/ guardian and DHS:		Within 180 days of placement? ☐ Yes – date: ☐ No ☐ Not due – due date:	Not applicable
☐ **No court order or VPA for removal**			

SECTION 2, continued

2. Age/School Attendance – child is under 18 or is 18 and expected to graduate before age 19. ☐ Yes ☐ No

3. Citizen/Alien Status – child is a U.S. citizen or qualified alien. ☐ Yes ☐ No

4. Specified Relative

a. Subject of CTW / BI finding or person who signed the VPA is a specified relative to the child. ☐ Yes ☐ No
Name: Relationship:

b. Child lived with this person in the removal month or within the six months before the removal month. ☐ Yes ☐ No

5. Deprivation – exists in removal household in month of removal. If yes, indicate reason: ☐ Yes ☐ No

☐ Death – deceased parent(s):
☐ Absence – absent parent(s):
☐ Incapacity – incapacitated parent(s):
☐ Unemployment or under employment (complete *IV-E Financial Worksheet* to document UP determination)
Mother's name: Father's name:

Complete *IV-E Financial Worksheet* ONLY if 1-5 are answered yes.

6. Removal Household Income is under the Standard of Need in the removal month. ☐ Yes ☐ No

7. Removal Household Resources are under $10,000. ☐ Yes ☐ No

INITIAL IV-E ELIGIBILITY

☐ Yes ☐ No All initial/one time (1-7) IV-E eligibility criteria met.
If no, reason:
Important! If no, child will never be IV-E eligible or claimable for this episode. Go to IV-E Claiming.

SECTION 3: IV-E Claiming (IV-E Worker complete 1-4 only if IV-E eligible, otherwise indicate claiming)

1. Child's Income is less than 185% of the child's maintenance payment. ☐ Yes ☐ No

2. Child's Resources are less than $10,000. ☐ Yes ☐ No

3. Responsibility for Placement and Care (RP&C) given to DHS/JCS. ☐ Yes ☐ No
If yes, indicate date obtained:

4. Claimable Placement – child is in a IV-E claimable placement. ☐ Yes ☐ No

IV-E CLAIMING

☐ Yes ☐ No IV-E funding can be claimed for this child.
If no, reason:

☐ Yes ☐ No SSI child (Administrative/training funding only)

Comments (include months of retro claiming…):

SECTION 4: System Entries (IV-E Worker)

1. FACS IVED screen completed. ☐ Yes ☐ No
Date:

2. Tracking Database entries completed. ☐ Yes ☐ No
Date:

3. ABC entries completed. ☐ Yes ☐ No

☐ Medicaid approved – aid type: Date:
☐ Relative/suitable person case established – aid type:

SECTION 5: Signature (IV-E Worker)

IV-E Worker signature:	**Date:**

Iowa Department of Human Services

JCS REFERRAL FOR PAYMENT

New cases: Complete all sections on the same day as the IFMC referral. Send to the DHS service unit. When applicable, send to Benefit Team Services, 4949 Westown Parkway, Suite 165-200, West Des Moines, IA 50266. Phone: 515-327-1200 or 1-800-707-9705 Fax: 515-327-0566

Reviews and changes: Fill in the JCO INFORMATION section, then only the parts that change. Check the box in the left margin of the sections with changes.

❑	**JCO INFORMATION**
	Child's full name
	JCO name / County
	Mailing address
	Phone number / Today's date
	CHILD'S DEMOGRAPHIC INFORMATION
❑	Child's date of birth / Social security number
	Sex: ❑ Male ❑ Female / Pregnant: ❑ Yes ❑ No
	Race/ethnicity / County of residence
❑	Disability: ❑ Mental retardation ❑ Blind/visually impaired ❑ Deaf/hard hearing ❑ Emotionally disturbed ❑ Learning disability ❑ Medical condition ❑ Physically disabled ❑ Conduct disorder ❑ AIDS (obtain release)
	Document disability. Make referral to BTS for determination of SSI eligibility if any box is checked.
❑	**Mother's** name & address
	Social security number / Deceased: ❑ Yes ❑ No
	Date of birth / Race/Ethnicity
	Marital status at time of birth (or adoption) of the child _____.
	Employment information (Including: Place of employment, hours worked per week and rate of pay)
❑	**Father's** name & address
	Social security number / Paternity established: ❑ Yes ❑ No
	Date of birth / Deceased: ❑ Yes ❑ No
	Race/Ethnicity / Marital status
	Employment information (Including: Place of employment, hours worked per week and rate of pay)
❑	**SCHOOL STATUS**
	In school: ❑ Full time ❑ Part time ❑ Not in school ❑ Last grade completed:
	Current school / Last school
❑	**REMOVAL/JUDICIAL FINDINGS** (Answer for this "episode" of care)
	County of current court order / County of financial responsibility
	Date of adjudication order / Date of dispositional order
	Date child was removed from home (most recent removal)
	Custody placed with: ❑ JCS ❑ DHS ❑ Other:

Removal order contains language that the removal was in the best interest of the child or that remaining in the home was contrary to the welfare of the child. ❑ Yes ❑ No. Date of current initial removal order _____.

Court has made a finding indicating reasonable efforts were made to prevent removal within 60 days of the date the child was removed from the home? ❑ Yes ❑ No ❑ N/A. Date of order _____.

Court has made a finding indicating reasonable efforts were made to achieve permanency within 12 months of the date the child was removed from the home? ❑ Yes ❑ No ❑ N/A . Date of most recent order with this finding _____.

❑ **CIRCUMSTANCES OF REMOVAL** ("P" for primary, "X" all others)

_____ Physical abuse	_____ Child behavior problem	_____ Caretaker illness/incapacity
_____ Sexual abuse	_____ Delinquent act	_____ Caretaker inability to cope
_____ Child disability	_____ Substance abuse (parent)	_____ Parental abandonment
_____ Death of parent	_____ Substance abuse (child)	_____ Incarceration of parent
_____ Other:		

❑ **CURRENT LIVING ARRANGEMENT** Effective Date_____

Provider name and address	Distance from home	Phone ( )

Level of care: ❑ Family foster care ❑ Treatment family foster care ❑ Shelter care ❑ Group care ❑ PMIC

Type of care: ❑ Comprehensive ❑ Community ❑ Enhanced

Status of care: ❑ Locked ❑ Unlocked

❑ **CURRENT PERMANENT PLACEMENT PLAN**

Select one: ❑ Reunify with parents/relative ❑ Guardianship to relative/suitable person ❑ Adoption ❑ Another planned permanent living arrangement

❑ **FOSTER CARE ADMINISTRATIVE REVIEWS** (every 6 months)

Date of last review _____. Type: ❑ Court ❑ FCRB ❑ DHS administrative review

Has there been a court determination that reasonable efforts have been made to achieve the permanency goal?
❑ Yes ❑ No. Date of most recent court order _____.

❑ **CHILD'S FINANCIAL INFORMATION**

Does child receive any income? If yes, source:
❑ Yes ❑ No

If child receives Social Security, under whose name and number:

Does child own any resources? If yes, describe and indicate value:
❑ Yes ❑ No

Does child own a checking or savings account?	Does child have cash in excess of $100?
❑ Yes ❑ No. If yes, indicated amount _____.	❑ Yes ❑ No. If yes, indicated amount _____.

❑ **FIP, SSI, AND PARENTAL SUPPORT INFORMATION (**Check all that apply.)

❑ Child received FIP in or for month in which court action leading to removal was initiated.
❑ Child does not receive SSI currently.
❑ Child is an unaccompanied refugee minor.
❑ One or both parents are absent from the home from which the child was removed.
❑ One or both parents are deceased.
❑ Parental rights are terminated.
❑ A parent is unable to work due to documented physical or mental reasons.

❑ **REMOVAL HOUSEHOLD** (Complete this section if child was not living with parent at time of removal.)

Name and address of caretaker(s):

Relation to child	If the removal household was not a relative, was the child living in the home of a parent or relative in the last 6 months. ❑ Yes ❑ No

❑ **EXPLANATIONS OR ADDITIONAL INFORMATION**

(Examples are change in child's income or resources, runaway, return home, sibling information, change of placement, etc.)

Juvenile Court Services - Transition Plan from Out of Home Placement to Adulthood

[Required for all youth age sixteen and older, must be reviewed & approved by Transition Committee by age 17 1/2]

Youth's Name:	DOB:
Type of Placement:	Anticipated Date of Exit from Foster Care:
Date of Transition Plan:	Anticipated High School Graduation Date:
Date of Adjudication:	Level of Offense:

List the members of the youth's Transition Team:

List dates that the team met to develop/update the Transition Plan:

Youth Rights Document: A list of rights with respect to education, health, visitation, and court participation has been discussed with the youth. Also addressed was the right to stay safe and avoid exploitation. The Rights document was provided to and signed by the youth, most recently on (date). The Rights document was provided to all legal parties of the case and was made part of the case plan. The document is stored in the case file.

STRENGTHS & CONCERNS

Check the level of competency for each area below, addressing how each need will be met in the action steps:

Documented Strengths & Needs

	Need	Making Progress	Satisfactory
Daily living skills: laundry, cleaning, shopping, cooking	☐	☐	☐
Self care: hygiene, access to physical/mental health care	☐	☐	☐
Housing: awareness of future options and how to obtain	☐	☐	☐
Money Management	☐	☐	☐
Social skills development	☐	☐	☐
Emergency/safety skills	☐	☐	☐
Community resources: knowing what is available and how to access	☐	☐	☐
Positive support system	☐	☐	☐
Employment skills	☐	☐	☐
Education plan	☐	☐	☐
Transportation	☐	☐	☐
Parenting skills (*if the youth is pregnant or parenting*)	☐	☐	☐
Other _____	☐	☐	☐

Photo ID: ☐ Has ☐ Needs **Driver's permit/license**: ☐ Has ☐ Needs ☐ Doesn't want

Youth with Mental Health and/or Physical Health Needs: –

Check here if Not Applicable and proceed to the next section ☐

Date of the youth's most recent medical/psychiatric/psychological evaluation:

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____ Full Scale IQ: _____

Current medications: _____

Will this youth reasonably need adult disability services upon reaching adulthood? ☐ Yes ☐ No ☐ Unsure
Was the transition plan developed with representation from the adult disability system (i.e. Integrated Health Home or adult case management)? ☐ Yes ☐ No

Does the youth receive Social Security on a parent's death or disability? ☐ Yes ☐ No
If yes, has the youth been determined to be disabled? ☐ Yes ☐ No ☐ Pending

Has Supplemental Security Income (SSI) been applied for (i.e. referral to PCG)? ☐ Yes ☐ No
If yes, was the youth found eligible? ☐ Yes ☐ No ☐ Pending
Does the youth have an IEP? ☐ Yes ☐ No
Is Department of Vocational Rehabilitation Services (IVRS) currently involved? ☐ Yes ☐ No

Review of progress:
Describe efforts and progress on coordinating with the adult disability service system.

Youth's Plan for Adulthood:
Describe the youth's plan after out-of-home placement ends in each of the 5 Fostering Connections areas and any progress toward the plan:

Housing Plan:

Education Plan:

Employment Plan:

Medical Needs:

Relationships/Supports:

Referrals:
Check referrals that **will** be made to assist the youth in the above plan (add specifics in Action Steps below):

☐ Integrated Health Home (IHH)
☐ Reproductive Health services and education
☐ Housing Assistance
☐ Iowa College Student Aid Commission (ICSAC) program of assistance in applying for financial aid for higher education
☐ Job Corps
☐ Mental health provider
☐ Vocational Rehabilitation Services
☐ Legal Guardian after age 18
☐ Protective Payee after age 18
☐ Public Assistance (Food Assistance, FIP, Medicaid)
☐ Substance abuse treatment
☐ Workforce Investment Act (WIA)
☐ Other:

Discharge Preparation:

Youth will have high school diploma/HSED at age 18. ☐ Yes ☐ No
If no, does youth plan to remain in care (over age 18) in order to complete high school? ☐ Yes ☐ No

The youth has been informed that the following supports may be available for youth leaving care at 18 or after:
☐ Education & Training Voucher (ETV)
☐ Title XIX – EMIYA coverage group
☐ Iowa Aftercare Services Network/Preparation for Adult Living (PAL)

As required by State and Federal law, youth has been given:
☐ A certified birth certificate ☐ A Social Security card
Comments:

Action Steps:

What steps need to happen that will assist the youth in meeting needs identified above and to facilitate a successful transition to adulthood?

What are we going to do?	Who's going to do it?	By When?

This information must be reviewed with the youth, and updated with each case review. It must also be reviewed and updated in the 90 day period before a youth reaches age 18, and for youth who remain voluntarily beyond 18, in the 90 day period before the anticipated discharge date.

Date this plan was approved by the Transition Committee:

Department of HUMAN SERVICES

Placement Agreement: Child-Placing Provider

Child's Name	Birthdate
Date of Placement	State ID

The parties to this agreement are _____ and the Iowa Department of Human Services. We, _____, for and in consideration of the Iowa Department of Human Services placing _____ in our care and paying therefore, do hereby agree to the following:

A. The Provider agrees that:

1. As a licensed child-placing provider, the provider assumes responsibility for the care and treatment of this child in accordance with the service plan developed jointly by the agency and the Department.
2. The Provider shall make periodic written reports covering the care and progress of the child every three months to the Department.
3. The Provider shall report promptly any illness of the child and will cooperate with the Department's plans for medical care through the use of Medicaid.
4. The Provider shall give a minimum of ten days written notice, except in an emergency, before requesting the removal of this child from care.
5. The Provider shall provide clothing and personal allowance to the child which will be included in computing their unit cost.

B. The Department agrees that:

1. The Department shall provide payment for services and maintenance as agreed upon in the contract between the Department and the Provider.
2. The Department shall be actively involved in carrying out the responsibilities of the service plan.

C. Special provisions:

Iowa Department of Human Services

Signature of Worker	
Approved by: Name	
Title	Date

Provider

By	
Title	Date
Address	

Iowa Department of Human Services

Placement Agreement and Service Authorization for Supervised Apartment Living (SAL)

Placement Agreement

Contractor Name		Child's Name	
Address Line		Date of Birth	
City	Zip Code	State ID	FACS ID

The parties to this agreement are and the Iowa Department of Human Services (Department). We, , for and in consideration of the Department placing in our care and paying therefore, do hereby agree to the following:

A. The Contractor agrees that:

1. As a licensed child placing agency, the contractor assumes responsibility for the care and treatment of this child in accordance with the service plan developed in consultation with the child, the child's family (unless a reason for noninvolvement is documented in the case record) and referral worker and shall be signed by all involved.
2. The contractor shall make periodic written reports to the Department covering the care and progress of the child according to contract-defined time frames or otherwise defined by rule.
3. The contractor shall immediately notify the child's parents or guardian and referral worker of any serious illness or incident involving serious bodily injury and will cooperate with the Department's plans for medical care through the use of Medicaid.
4. The contractor shall give a minimum of ten days written notices, except in an emergency, before requesting the removal of this child from care.

B. The Department agrees that:

1. The Department shall provide a monthly stipend payment to the child (or their payee).
2. The Department shall provide payment for services authorized below.
3. The Department shall be actively involved in the provision of the child's service plan.

☐ New ☐ Reauthorization ☐ Termination

Service Authorization

Service Code	Effective Date	End Date

Service Code	Effective Date	End Date

Special Provisions

Iowa Department of Human Services		Contractor
Signature of Worker		Signature
Approved by:		Title
Title	Date	Date

Iowa Department of Human Services

Referral and Authorization for Child Welfare Services

Contractor Name		
Address Line 1		
Address Line 2		
City	State	Zip Code

☐ New ☐ Reauthorization ☐ Termination

DHS Referring Worker		Phone	
Address			
City		State	Zip Code

Billing Child's Name		State ID	
Date of Birth	County of Financial Responsibility	Case ID	FACS ID

Service Code	Authorization Date	Effective Date	Final Eligibility Date

You are authorized to provide the services listed above for the duration listed. This notice supersedes any prior authorization of these same services as of the EFFECTIVE date indicated.

DHS Case Manager Signature	Date

Supervisor Signature	Date

Iowa Department of Human Services

Request for Approval of Supervised Apartment Living Foster Care Placement

Child's Name	Date of Birth	County	Date

The child must meet the following criteria for approval of supervised apartment living foster care:

- ☐ Child is at least 16½ years old for cluster site placement.
- ☐ Child is at least 17 years old and determined eligible for scattered site placement. (Explained on preplacement screening form.)
- ☐ Child needs foster care placement and services according to Employees' Manual 17-E.
- ☐ *Pre-Placement Screening for Supervised Apartment Living Foster Care*, form 470-4063, is attached.
- ☐ Child will have an approved living arrangement that meets required standards.

If under age 18 (check one):

- ☐ Attending high school leading to a high school diploma, or
- ☐ Attending a high school equivalency program leading to a high school equivalency diploma, or
- ☐ Attending post-secondary education on a full-time basis, or
- ☐ Attending post-secondary education on a part-time basis and working part-time or participating in a work training program leading to employment, or
- ☐ If no longer attending school, employed an average of 80 hours per month or participating in a work training program leading to employment.

If age 18 or over (check one):

- ☐ Attending high school leading to a high school diploma, or
- ☐ Attending a high school equivalency program leading to a high school equivalency diploma.
- ☐ Request waiver of requirement for continuous placement in order for child to return to foster care to complete high school or obtain a high school equivalency diploma.

An initial allowance in the amount of _____ *(maximum $630)* is requested to assist the child in paying for deposits, furnishings, and other start-up costs.

Worker	Date	Supervisor	Date

Approval for Supervised Apartment Living Foster Care Placement

The request for a supervised apartment living foster care placement is: ☐ Approved ☐ Denied

Continuous placement requirement waiver is: ☐ Approved ☐ Denied

The request for an initial allowance is approved in the amount of: _____

Service Area Manager or Designee	Date

If the child is under age 18, obtain juvenile court order for supervised apartment living placement after receiving SAM approval.

REQUEST TO RECOMMEND COMMITMENT
TO THE STATE TRAINING SCHOOL

TO:

JCO: Date:

☐ I am requesting approval to recommend that the Juvenile named below be committed to the State Training School at Eldora.

☐ I am requesting approval to recommend that the Juvenile named below be placed at the State Training School at Eldora for the purpose of a 30 day evaluation.

Name of Juvenile:

DOB: Date of Hearing:

County of Committing Court:

Place a checkmark beside the following criteria which apply. All of the criteria under Section A or three of the four criteria under Section B must apply before approval to recommend commitment will be granted.

A. ☐ Juvenile is 12 years of age or older and
☐ Commitment is in the best interest of the child or necessary for the protection of the public
☐ The delinquency adjudication was based on a forcible felony, or a felony violation of Section 124.401 or Chapter 707.

OR ANY THREE OF THE FOLLOWING CONDITIONS EXIST:

B. ☐ Juvenile is 15 years of age or older and placement is in the best interest of the child or necessary for the protection of the public.
☐ The delinquent act was against a person and would be classified as an aggravated misdemeanor or felony.
☐ There is a prior delinquency adjudication.
☐ There has been prior placement in a treatment facility outside of the child's home or in a supervised community treatment program established pursuant to Section 232.191, subsection 4.

_____ Date: _____
Signature of Supervisor

This request is APPROVED: ☐ DENIED: ☐

_____ Date: _____
Chief Juvenile Court Officer

Revised 2/17

PREPLACEMENT SCREENING FOR SUPERVISED APARTMENT LIVING FOSTER CARE

Date:

Client Name	Date of Birth	FACS ID	County

Current Living Arrangement	Legal Status: ☐ CINA ☐ Delinquent ☐ Voluntary
Date Life Skill Assessment was completed: *(Attach a copy of the results to this assessment.)*	

School and Work History

☒ **Currently enrolled in school or GED**

Grade	School	IEP? ☐ Yes ☐ No

☐ Performing at appropriate level in school
☐ Mild to moderate problems at school including underachievement or discipline problems
☐ Serious school difficulties including suspensions, frequent truancy, significant discipline problems or failing

☐ **Not currently enrolled in school**

Last School Attended	Last Grade Completed

☐ **Currently employed**

☐ Full-time
☐ Part-time

☐ **Not currently employed**

Date Last Worked

☐ Has held a job for at least six months with few to no problems
☐ Has held a job for at least one month or has mild attendance or disciplinary problems
☐ Serious difficulties finding or maintaining employment
☐ No work history
☐ No opportunity to work

Medical or Mental Health Issues (Including Pregnancy)

Diagnosis:

Medications:	Is the youth able to manage own medication? ☐ Yes ☐ No ☐ N/A

Substance Abuse

- ☐ No notable substance use difficulties currently or in recovery for at least one year
- ☐ Mild to moderate substance use problems that occasionally present problems of living or in recovery for less than one year
- ☐ Moderate to serious substance abuse problem that requires treatment and exacerbates current problems and conditions

Describe current substance abuse treatment:

Parenting

Does the youth have any children?

- ☐ Yes. If yes, how many?
- ☐ No

Does the youth have custody of the children?

- ☐ Yes
- ☐ No

Does the youth's child have any health concerns or special needs?

- ☐ Yes. If yes, please describe:
- ☐ No

Cooperation/Compliance at Current Placement

- ☐ Generally compliant and cooperative
- ☐ Occasionally noncompliant to some rules or adult instructions
- ☐ Frequently noncompliant to rules and adult instructions

History of Delinquency

- ☐ Yes. If yes, describe:
- ☐ No

Date and degree of most recent charge:

Currently on probation?

- ☐ Yes. If yes, describe youth's compliance with terms of probation:
- ☐ No

History of Violence Toward Self, Others, or Property

- ☐ Yes. If yes, describe:
- ☐ No

Current (within past three months) violent/aggressive behavior:

- ☐ Yes. If yes, describe:
- ☐ No

List names of team members consulted in making the recommendations for SAL placement:

Other comments:

List the plan of services and resources available to address the identified needs of the youth in SAL placement (i.e., positive connections, economic, community programs):

Number of hours of supervision that will be authorized:

Overall assessment of suitability for Supervised Apartment Living Foster Care:

- ☐ Appropriate for SAL-scattered site
- ☐ Appropriate for SAL-cluster site
- ☐ Not appropriate for SAL

What is the plan if SAL placement is not approved or if SAL services are terminated:

Case Manager/JCO	Date

State Training School Placement Worksheet

Student's Name:
Date of Birth:
SSN:
Proposed Placement Date:

Committing Judge:
County Attorney:
Student's Attorney:
Juvenile Court Officer:

Risk Level: Select
List 3 High Risk Areas:
1.
2.
3.
Other notes:

Date of Assessment:

Medical Billing for Court Evaluations Only:

Please attach a copy of the card, if possible.

Title XIX #: **OR** Health Insurance Name/Policy #:

History of Adjudications:

DATE	DOCKET #	ADJUDICATED CHARGE	CODE #

Criteria for STS placement (delinquency only) – check all that apply (must be three of four):

☐ Child is at least 15 years of age
☐ Child has committed a crime against a person that is an Aggravated Misdemeanor or Felony
☐ Child has previously been found to have committed a delinquent act
☐ Child has previously been placed in a treatment facility outside the child's home as a result of a delinquency act (day treatment/intense community supervision counts)

OR

Child is at least 12 years of age, and has been found to have committed:
☐ a Forcible Felony ☐ a Felony violation of Code of Iowa Section 124.401

Desired Services:

☐ Substance Abuse Evaluation
☐ Substance Abuse Treatment
☐ Mental Health and/or Medication Management
☐ Sex Offender Treatment
Registry Required? ☐ Yes ☐ Deferred ☐ Exempt

Intake Checklist:

☐ Completed Placement Worksheet (this form)
☐ Committing Court Order
☐ Most recent Pre-Dispositional Report
☐ Psychiatric / Psychological Information
☐ Discharge reports from previous placements

Referral form: Universal Referral, ICIS Word Template

Referred To: Click or tap here to enter text.

Professional Contacts

JCO: _____
Last *First* *Work Phone #*

Other Agencies: *Click here to enter text.* _____
Last *First* *Cell Phone #*

Juvenile Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Gender: _____ DOB: _____

Race: _____ SSN: Click here to enter text.

Custodian: Click here to enter text. Guardian: Click here to enter text.
Agency, state, or county *Name and relationship*

Current Placement: Click here to enter text.

Family Information

Mother: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____

Father _____ Cell Phone: _____
Home Phone:
Family Information _____ Work Phone: _____

Step-Mother: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____

Step-Father: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____

Siblings: _____

Insurance

Title XIX: / Medicaid ☐

Insurance Information: ☐ Click here to enter text.

(Please attach a copy of current insurance cards/documents)

Medical Data

Use of Illegal Drugs: Yes ☐ No ☐ Click here to enter text. (*Drug Name*) Click here to enter text. (*Frequency*) Click here to enter a date. (*Last Usage Date*)

Misuse of Prescription Drugs: Yes ☐ No ☐ Click here to enter text. (*Drug Name*) Click here to enter text. (*Frequency*) Click here to enter a date. (*Last Usage Date*)

Use of Alcohol: Yes ☐ No ☐ Click here to enter text. (*Frequency*) Click here to enter a date. (*Last Usage Date*)

Current Medications: _____

Past Medications: _____

Psychiatric Diagnosis: _____

Medical Needs: Click here to enter text.

Delinquency Risk Level and Risk Factors

Risk Level: Choose an item. Date: Click or tap to enter a date.

Criminogenic Risk Factors: Click here to enter text.

☐ *Refer to attached risk reduction case plan*

Complaint/Allegations History

Click or tap here to enter text.

Placement and Services History

Service & Placement			
Service/Placement Name	Beg Date	End Date	Exit Reason

Evaluations Click here to enter text.
(Please attach evaluations)

School

School: _____ Grade Level:
(Please attach school transcript)

IEP:

Notes: Click or tap here to enter text.

Case Description and Request for Services

Description of Case: Click here to enter text.

Service Request: Click here to enter text.

Other: Click here to enter text.
List safety concerns, victim issues, restitution, etc.

Attachments: Click here to enter text.

Iowa Department of Human Services

Voluntary Foster Care Placement Agreement

This is a mutual agreement for temporary foster care placement for .

The Iowa Department of Human Services (hereafter known as DHS) and (hereafter known as client) are parties to this agreement.

BOTH PARTIES AGREE TO THE FOLLOWING:

1. DHS has authority to select the foster care placement, and has responsibility for care and supervision. Except in emergency situations, no change in placement will be made without prior notice to the client.

2. The client will provide a physical examination for the child before placement, except that in an emergency placement the examination will be provided within 72 hours after placement.

3. Parties will participate in developing a mutually agreed-upon case permanency plan before placement and every six months thereafter. Parties will comply with provisions of the case permanency plan and will maintain regular contact as specified in the case permanency plan. The client will notify the social worker or supervisor of any changes in family composition, phone number, address, employment, or income. DHS will inform the client of any changes in case worker or in the child's circumstances and progress. Failure to comply with the conditions of the case permanency plan could lead to juvenile court action. Be advised that any removal through juvenile court may lead to termination of parental rights.

4. The client will continue to take an active role in decision-making. Should an emergency arise where immediate medical attention is needed and the client is unable to authorize such attention, DHS has permission to call a physician and to consent to emergency medical and surgical care.

5. The client understands that the child's parents and the child are primarily and legally responsible for the costs of this out-of-home placement from the first day of this placement and that DHS has the duty under Iowa Code 234.39 to determine the amount of parental liability using the Iowa Uniform Child Support Guidelines. The client agrees to provide DHS with financial and health insurance information as necessary to determine the parents' liability for the cost of the placement. DHS will inform the client of the amount of parental liability. DHS will exchange information with other governmental agencies to verify the child's and the parents' social security numbers, income, and resources.

6. The client agrees to assign the child's unearned income. The client understands that the placement of this child in foster care creates an automatic assignment of court-ordered child support and medical support rights to the Department. This assignment is in addition to the parental liability assessment discussed in item 5. This assignment includes interest in support payments which come due for the child during the placement, regardless of whether the payment is paid before, during or after the placement period.

7. This mutual agreement is effective .

8. This agreement can be terminated by either party upon ten days' written notice. DHS may terminate the agreement if the client fails to follow its terms. The client may terminate the agreement for any reason. This agreement will be terminated if the client or child moves outside the state of Iowa.

9. For children under age 18, no voluntary placement agreement can be continued beyond 90 days. DHS payment for the placement will end unless continued foster care placement is court-ordered.

10. A voluntary placement agreement for a child age 18 or older will end six months from the effective date above. DHS payment will end unless a new agreement is negotiated. The agreement will also terminate, upon 10 days' written notice, if the child fails to attend an approved school in courses leading to a high school diploma (or its equivalent) or special education classes.

SPECIAL REQUIREMENTS FOR VOLUNTARY FOSTER CARE PLACEMENTS OF INDIAN CHILDREN

Is the child entering voluntary foster care an Indian child (meaning "a child under 18 years of age that a recognized Indian tribe has identified as a child of the tribal community"). ☐ Yes ☐ No If yes, follow the special procedures described below.

1. The voluntary release of custody shall not be valid until the Indian child is at least 10 days old.

2. The voluntary placement agreement must be executed in writing and recorded before a judge of a court of competent jurisdiction.

3. The placement agreement must be accompanied by the judge's certification that the terms and conditions of the placement agreement were fully explained in detail and were fully understood by the Indian child's parent or Indian custodian and that the parent or Indian custodian fully understood the explanation in English or that it was interpreted into a language that the parent or Indian custodian understood.

If the parent states that the child is identified by a recognized Indian tribe as a member of their community, or the Department worker knows based on other information that the child is an Indian child, the Department worker should contact a judge as soon as possible, based on local court protocols, and arrange to have this agreement recorded before and certified by a judge. This judge's certification should be attached to this voluntary placement agreement. A sample judge's certification form is available from FOSU or CFS.

Signatures designate that the agreement has been reached.

Parent or Guardian	Date	Worker	Date
Parent or Guardian	Date	Supervisor	Date
Child Age 18 or Older	Date	Service Area Manager	Date