REFERRAL INFORMATION

Referral Date _____ Placement Date _____

Placement Legal Status ☐ Voluntary ☐ Court Ordered

Placement Type ☐ Treatment ☐ Standard ☐ Respite Anticipated Length _____

MAPCY Level _____ Reimbursement Rate _____

Referring County _____ Billable County _____

Referring County Worker _____ Phone _____

County Emergency Contact _____ Phone _____

Foster Parent(s) Name(s) _____

Address _____ City, St. Zip _____

Phone Number _____ Alternative _____

IDENTIFYING CHILD INFORMATION

First Name _____ Middle _____ Last _____

Date of Birth _____ Birthplace _____ Age _____

Gender: ☐ Male ☐ Female ☐ Agender/Gender-Neutral ☐ Binary/Bigender
☐ Transgender Male ☐ Transgender Female

Race _____ Tribe _____ SSN _____

MA# _____ Diagnosis _____

ADOPTIVE / BIRTH FAMILY INFORMATION

PARENT

First Name _____ Last Name _____ Date of Birth _____

Address _____ City, St. Zip _____

Phone Number _____ Alternative _____

Marital Status ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

PARENT

First Name _____ Last Name _____ Date of Birth _____

Address _____ City, St. Zip _____

Phone Number _____ Alternative _____

Marital Status ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

SIBLINGS			
Name(s)			
Address			
Age			
Living with other sibling(s)	☐ No ☐ Yes — *If yes, specify siblings:* _____	☐ No ☐ Yes — *If yes, specify siblings:* _____	☐ No ☐ Yes — *If yes, specify siblings:* _____
Living arrangements	☐ Birth Parent ☐ Relatives ☐ Relative foster care ☐ Non-relative foster care ☐ Adoptive home ☐ Other — specify: _____	☐ Birth Parent ☐ Relatives ☐ Relative foster care ☐ Non-relative foster care ☐ Adoptive home ☐ Other — specify: _____	☐ Birth Parent ☐ Relatives ☐ Relative foster care ☐ Non-relative foster care ☐ Adoptive home ☐ Other — specify: _____

TREATMENT TEAM MEMBERS

Parent(s) _____ Phone _____
County Social Worker _____ Phone _____
Guardian ad Litem _____ Phone _____
Probation Officer _____ Phone _____
Other _____ Phone _____
Other _____ Phone _____

MEDICAL PROVIDERS

Doctor _____ Phone _____
Dentist _____ Phone _____
Therapist _____ Phone _____
Psychiatrist _____ Phone _____
Other _____ Phone _____
Other _____ Phone _____

INSURANCE INFORMATION - OTHER HEALTH COVERAGE

Name of Insurance Company _____

Name of Policy Holder _____

Policy Group # _____

Policy Group # _____

DOB of Policy Holder _____

Telephone number on back of insurance card for claims _____

Have previous placement/counseling services been received this year? ☐ Yes ☐ No

If yes, where? _____

Dates of previous services _____

Assignment of Insurance Benefits

I (we) certify that the financial and insurance information I (we) have provided is true and accurate to the best of my knowledge. I (we) authorize Lutheran Social Service to verify insurance information from my clinical records to my insurance company, Medical Assistance, MN Care, or other third party sources for payment of services for my minor child(ren). I (we) authorize payments directly to Lutheran Social Service. I (we) agree that this authorization shall be valid for the entire length of placement in the Treatment Foster Care program, unless I (we) revoke this consent in writing, prior to that date.

_____ _____

Parent/Guardian Date

_____ _____

Parent/Guardian Date

FAMILY INVOLVEMENT & PERMANENCY

☐ Reunification ☐ Adoption/TPR ☐ Relative Placement

Permanency plan (if family reunification is not the goal, explain why)

How will the parent(s) sibling(s) and/or extended family be involved in the placement? Include visitation agreements)

30 DAY PRELIMINARY PLAN

Child's strengths, weaknesses, skills and interests:

Strategies to ease the child's adjustment to the foster home:

Short term 30 day goals:

Potential problems during the first 30 days of placement:

Name of child (please print)

Parent(s)/Guardian (please print)

Name of foster parent(s) (please print)

CONSENTS REQUIRED FOR PLACEMENT

_____ **Emergency Medical & Dental Treatment**
Initials

I (we) the undersigned, _____ and, _____ parent(s) of _____ hereby consent to and authorize the administration and performance of all treatments, operations, and anesthetics, as may be considered medically advisable or necessary, in the judgment of attending physician(s) for our child, in our absence.

_____ **Authorization for Pictures**
Initials

I (we) give permission for the LSS Treatment Foster Care family to take pictures/videotapes of my son/daughter in his/her day to day activities while in LSS Treatment Foster Care. I (we) also give permission to have pictures taken at school, or in other settings as appropriate. I (we) also give permission for a picture of my son/daughter to be kept in the foster family file in case my child must be located in an emergency situation.

_____ **Authorization to Acknowledge Presence**
Initials

I (we) authorize LSS Treatment Foster Care staff and foster parents to acknowledge the presence of my son/daughter at this treatment foster home to his/her family, attorney, school friends, possible respite homes or other people who may inquire about my son/daughter's whereabouts while he/she is here.

_____ **Authorization for Religious Preference**
Initials

I (we) grant consent for my child to attend any or all of the following (please specify):

- ☐ To attend any church service of his/her choice.
- ☐ To attend only services of the _____ denomination.
- ☐ Church youth group meetings for any denomination.
- ☐ Church youth group meetings for only the _____ denomination.

CONSENTS REQUIRED FOR PLACEMENT CONTINUED

_____ **Authorization for Out-of-State Travel**
Initials

I (we) give permission for my (our) son/daughter to travel out-of-state with the above named foster family while in their care as a part of the LSS Treatment Foster Care Program.

_____ **Permission to Transport**
Initials

I (we) give permission for my (our) child, to be transported by Lutheran Social Service of Minnesota staff to activities pertaining to services provided for my child. As parent(s) or legal guardian of the child receiving services I (we) hereby release, waive, discharge Lutheran Social Service and their agents, employees or other representatives, from all responsibility and damages regarding injury or harm to my child.

In the event of an accident and/or injury and the parent(s) or guardian is (are) not available to give notice, I (we) authorize Lutheran Social Service staff to take my child to a licensed medical facility (emergency room, medical clinic, hospital) for treatment.

_____ **Authorization for Special Activities**
Initials

I (we) give permission for my (our) son/daughter to participate in the following special activities (not included in the general activity consent) while in the LSS Treatment Foster Care program. Examples of special activities include: Snowmobiling, water skiing, attending camps, etc.

Please specify the activity and the dates it will occur:

_____
_____
_____

By signing, I (we), approve of the above conditions. This release is valid for the duration of services provided.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

EMERGENCY CONTACT NUMBERS	
Name	**Phone Number**

This list would normally include parent(s), law enforcement, referral sources, etc.

EMERGENCY CONTACT NUMBERS

The following information must be obtained and mailed to LSS prior to placement date:

- ☐ Diagnostic assessments
- ☐ Social histories
- ☐ Out of Home Placement Plan
- ☐ All signed consent forms
- ☐ 30 Day Preliminary Treatment Plan
- ☐ MAPCY Assessment Schedule

The following information must be obtained and mailed to LSS prior to the 30 day staffing:

- ☐ Medical Records
- ☐ Record of immunizations
- ☐ Psychological/psychiatric evaluations
- ☐ Releases of information