



AIFACS

American Indian Family and Children's Services

Placement Referral Form

Date:	
Placement Type:	<input type="checkbox"/> Short-Term <input type="checkbox"/> Long-Term <input type="checkbox"/> Permanency <input type="checkbox"/> Relative/Kinship <input type="checkbox"/> Respite <input type="checkbox"/> Other
Child's Current Location:	

County	County Worker	Phone Number
Tribe	Tribal Worker	Phone Number

Child's Information		
Name:	DOB:	Gender:
Race:	Tribe:	Tribe status: <input type="checkbox"/> enrolled <input type="checkbox"/> eligible <input type="checkbox"/> NA/UKN
Parent's Information		
Mother's name:	Address:	Phone number:
Father's name:	Address:	Phone number:
Siblings/Locations:		
Visitations/How/Where/Who:		

Placement Needs			
Placement goal:	Est. length of placement:	Siblings placed together:	# of siblings:
Sibling placement comments:			
Transportation comments:			
Do you have a preferred home:		Name of preferred home:	
Is location important:	Wanted location:	Unwanted locations:	
Location comments:			
Attends school:	Prefer to attend same school:	School location:	
School name:		IEP:	Grade:

Reasons for Placement
Reasons for placement:

Current placement's comments:
Abuse/Neglect comments:

Emotional Abuse/Neglect: Physical Abuse: Sexual Abuse: Physical Neglect:

Child's Needs
Child's attitude towards and preference for placement:
Parent's attitude towards and preference for placement:
Foster family structure comments:

- | | |
|---|--|
| <input type="checkbox"/> ICWA Eligible | <input type="checkbox"/> Adolescent Parent |
| <input type="checkbox"/> Juvenile Probation | <input type="checkbox"/> Mother/Child Placement |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Receiving DD Case Management Services |
| <input type="checkbox"/> Home w/Special DD Skills | <input type="checkbox"/> Non-Smoking Home |
| <input type="checkbox"/> Stay at Home Parent | <input type="checkbox"/> American Sign Language Home |
| <input type="checkbox"/> Pet Restrictions | <input type="checkbox"/> Religion/Language a Placement Factor |
| | Language of Child: |
| | Religion of Child : |

Medical/Psychological Needs
List and describe any medical equipment required:
Medical and/or Mental Health Diagnosis:
List all medications:

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nebulizer Required |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Drug/Alcohol Exposed or Affected |
| <input type="checkbox"/> Exposed to Domestic Violence | <input type="checkbox"/> Physically Handicapped or Disabled |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Non-Ambulatory |