

Intensive Placement Stabilization (IPS) Referral Form

Directions: This form must be completed by the child's caseworker to begin the IPS referral process.

Date of Referral: _____ **LAN of Placement:** _____

Child Information

Name: _____ **Child ID:** _____ **DOB:** _____ **Gender:** _____

Child Primary Language: _____ **Date of DCFS Case Opening:** _____

Foster Parent(s) Name(s): _____

Foster Parent Address: _____ **Zip Code:** _____

Foster Parent Phone: _____ **Foster Parent Primary Language:** _____

Caseworker Agency: _____ **Caseworker Name:** _____

Caseworker Agency Address: _____

Caseworker Phone: _____ **Caseworker Fax:** _____

Supervisor Name: _____ **Supervisor Phone:** _____

Current Setting:

- POS Traditional/HMR Foster Home
- POS Specialized Foster Home
- DCFS Foster Home
- Home of Parent
- Emergency Shelter
- Institution/Group Home
- Hospitalization due to medical condition
- Psychiatric Hospitalization
- Other, Specify Setting: _____

Prior Services (last year):

- Counseling/Therapy
- Psychological Assessment
- Substance Abuse Treatment
- Speech/Occupational/Physical Therapy
- Recreational (i.e., memberships)
- Medical Assessment/Treatment (beyond routine care)
- Special Educational Services
- SASS
- Tutoring
- Respite
- Mentoring

If requesting IPS services because the child is stepping-down, please indicate the following:

Future setting: _____ *Expected Step-Down Date:* _____

14 Day Notice of Placement Change has been Issued: Yes No

Briefly describe the presenting issues that have caused you to seek assistance from IPS, and state specifically what you are seeking from IPS (pertinent documentation may also be attached). Include why the referral is being made now:

Caseworker Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

IPS Provider: _____ **Child Name:** _____ **Child ID:** _____

FP Phone Number(s)

Best Time to Call

Check Available Days

FP Work: Beginning: am/pm End: am/pm S M T W T F S

FP Home: Beginning: am/pm End: am/pm S M T W T F S

FP Other: Beginning: am/pm End: am/pm S M T W T F S

Additional Information Requested

- DCFS Client Service Plan**
- Psychological Assessments -- Type:** _____
- Additional Collateral Information -- Type:** _____
- Counseling Reports—Type:** _____
- Initial Social History/Comprehensive Assessment/Addendums**
- Release(s) of Information (needed for release of confidential information)**
- Other -- Type:** _____

