Referral for QRTP Assessment For Child in DCF Custody

SECTION I: Identifying Information

Child's Name: _____ **Child's DOB** _____ ☐ **Male** ☐ **Female**

Client ID: _____ Date Referred: _____ Time Referred: _____ ☐ AM ☐ PM

FACTS Case Number: Permanency Goal:

CINC Court Case Number: Judicial District:

Parent/Caregiver Name: _____	Parent/Caregiver Name: _____
Address: _____	Address: _____
Phone:	Phone:

SECTION II: Agency Contact Information

Referring CWCMP Case manager: _____ Phone: _____

Address: _____ Email: _____

DCF Foster Care Liaison: _____ Phone: _____

Address: _____ Email: _____

SECTION III: Child's Placement Information

Date of QRTP Placement:

Name of Child's Current Placement: _____ Email Address:

Address: Phone Number:

SECTION IV: Other Individuals able to provide information on child's functioning (IE: Foster Parents, School Personnel, Therapists, etc.)

Name	Relationship to Child	Contact Information

SECTION V: Rationale for requesting an assessment for QRTP placement (Presenting problem and/or description of child's behaviors)

Attach all completed assessments to assist with the functional assessment of the child. These assessments may include, but are not limited, to the following:	
☐ Structured Decision Making (SDM) ☐ Child Stress Disorder checklist-KS (CSDC-KS) ☐ Child Report of Post-Traumatic Symptoms (CROPS) ☐ Parenting Stress Index – Short Form (PSI-SF) ☐ Individual Education Plan (IEP)	☐ Child and Adolescent Functional Assessment Scale (CAFAS) ☐ North Carolina Family Assessment Scale (NCFAS)

Once this form is complete please email to: QRTP@healthsrc.org

Call HealthSource Integrated Solutions Program administration support to discuss referral: 1-800-466-2222

Kansas
Department for Children and Families
Prevention and Protection Services