COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Therapeutic Foster Care (TFC) Service Referral Form

BENEFICIARY INFORMATION			
Last Name:		First Name:	
Date of Birth:	Age:	Ethnicity:	Language:
Gender:	Current BH Service Provider/Program		
Current Caregiver:		Placement Type:	
Address:			Phone:
School Name:	District:	Grade:	
Social Worker or Probation Officer Name:			Phone:

TFC REFERRAL (TO BE COMPLETED IF BENEFICIARY MEETS CRITERIA AND ACCEPTS SERVICE)	
Referral Date:	Requesting Agency:
Requested Service Period: (UP TO 12 MONTHS)	Requested Service Agency:
Date of TFC Need Identified By CFT:	Date of Most Recent CFT Meeting:
Was TFC agreed upon by the CFT?	☐ Yes ☐ No (NOT ELIGIBLE FOR TFC)

Current and Past Behavioral Health or Support Services
List Behavioral Health or Support Services that are in place now, including past services.

Reason for TFC Referral
1. Youth and family strengths:
2. Presenting needs, including the severity, duration, and frequency:

3. Psychiatric hospitalization history/current medication:
4. Diagnosis, if available, including name of assessor, title, and date of diagnosis:
5. Summary of placement history:

Transition or Permanency Plan
Provide details about the transition or permanency plan for the beneficiary.

ICC Coordinator		
☐ I attest that TFC is a medically necessary service for this beneficiary.		
NAME OF LPHA (CREDENTIALS & LICENSE NUMBER)	SIGNATURE	DATE

Submit completed form to ICP MHP Representative.

TO BE COMPLETED BY INTERAGENCY PLACEMENT COMMITTEE (IPC)

Service Referral Determination	
TFC Referral: ☐ Approved ☐ Denied	Approved Service Agency:
Approved Service Period:	Approved Start Date:
Notes:	

IPC Signatures			
Mental Health Representative	NAME	SIGNATURE	DATE
Child Welfare Representative	NAME	SIGNATURE	DATE
Juvenile Probation Representative	NAME	SIGNATURE	DATE