SACRAMENTO COUNTY

Screening Tool for Therapeutic Foster Care (TFC)

Screening/CFT Date: _____

Avatar # (if known): _____ Client Name: _____ DOB: _____

CLIENT INFORMATION	
1. Does the child/youth have an open case with: ☐ Child Welfare ☐ Probation ☐ N/A	
2. Was a CPS Mental Health Screening Tool or CANS completed? IF YES – Date CPS MH Screening Tool or CANS was completed: _____ Date Access Referral was submitted: _____ IF NO – Please complete CPS MH Screening Tool or CANS.	☐ Yes ☐ No
3. Is the child/youth transitioning from any of the following facilities? ☐ STRTP/Group Home ☐ Inpatient Psychiatric Hospital ☐ Juvenile Hall/Jail	
4. Is the child/youth immediately at risk of losing placement or in need of placement stability?	☐ Yes ☐ No
5. Is the child/youth immediately at risk of the following: ☐ Locked Treatment Facility ☐ Inpatient Care ☐ Residential Care	

STEP 1 – DETERMINE IF CHILD/YOUTH MEETS ELIGIBILITY CRITERIA:	
a. Is the child/youth under the age of 21?	☐ Yes ☐ No
b. Is the child/youth eligible for Full-Scope (EPSDT) Medi-Cal?	☐ Yes ☐ No
c. Is the child/youth currently receiving specialty mental health services (SMHS)?	☐ Yes ☐ No
STOP **IF ANSWER IS "NO" FOR EITHER A, B, AND/OR C, THE CHILD/YOUTH MAY NOT BE APPROPRIATE FOR TFC SERVICES.** Consult with CFT regarding next steps and determine appropriate services.	

STEP 2 – DETERMINE IF TFC SERVICES ARE APPROPRIATE:	
a. Has the child/youth received Intensive Care Coordination (ICC) within the past year?	☐ Yes ☐ No
b. Has the child/youth received Intensive Home Based Services (IHBS) within the past year?	☐ Yes ☐ No
c. If "Yes" to 2a and 2b, were ICC or IHBS insufficient to meet the child/youth's mental health needs?	☐ Yes ☐ No
STOP **IF ANSWER IS "NO" FOR EITHER A, B, AND/OR C, THE CHILD/YOUTH MAY NOT BE APPROPRIATE FOR TFC SERVICES.** Consult with CFT regarding next steps and determine appropriate services.	