SAN BERNARDINO COUNTY

SCREENING TOOL FOR THERAPEUTIC FOSTER CARE (TFC) SERVICES
Must be completed during a Child and Family Team Meeting (CFTM)

Check Box – TFC Eligibility—must answer "yes" to criteria 1, 2, 3, and 4.

☐ **1.** Child/youth is a full-scope Medi-Cal beneficiary.
☐ **2.** Child/youth is under the age of 21 years old.
☐ **3.** Child/youth is currently receiving specialty mental health services.

- Primary Agency Providing Services: _____
  - *Agency must be a provider within the San Bernardino County Mental Health Plan*
- Check all services provided in the past 90 days even if provided by other agencies:

☐ Targeted Case Management ICC	☐ Group Psychotherapy	☐ Medication Support Services
☐ Individual Psychotherapy	☐ Psychosocial Rehabilitation	☐ TBS
☐ Family Psychotherapy	☐ Psychosocial Rehab/IHBS	☐ Other: _____

- Check all services not being provided, but were considered as options to address concerns and the Child and Family Team (CFT) concludes such additional services would not be as effective as TFC:

☐ Individual Psychotherapy	☐ Psychosocial Rehabilitation	☐ Medication Support Services
☐ Family Psychotherapy	☐ Psychosocial Rehab/IHBS	☐ Other: _____
☐ Group Psychotherapy	☐ TBS	

☐ **4.** The CFT has determined that TFC will best address current high-risk behaviors and areas of dysfunction.

Check Box - Child/Youth meets TFC Eligibility due to at least one of the following:

Please select the areas of dysfunction that apply to the Child/youth:

☐ **5.** Is at risk of psychiatric hospitalization due to the presenting concern.
☐ **6.** Is at risk of placement in a group home or STRTP.
☐ **7.** Has transitioned from a group home, STRTP, or psychiatric hospital within the last 6 months.
☐ **8.** Is at risk of losing current placement.
☐ **9.** Is at risk for losing current school enrollment/placement.
☐ **10.** Is stepping down from a residential care facility.
☐ **11.** Is experiencing behaviors that if left untreated will lead to further deterioration in functioning.

12. Please select **all** the High-Risk Behaviors that apply:

☐ Violent Offenses	☐ Eating Disorder	☐ Suicidal / Homicidal Ideation
☐ Significant Property Damage	☐ Fire Setting	☐ Self-Harm Behavior
☐ Sexual Aggression	☐ Gang Activity	☐ Substance Use/Abuse
☐ Aggressive and Assaultive	☐ Habitual Truancy	☐ Exploitation
☐ Animal Cruelty	☐ Runaway	☐ Other: _____
☐ CSEC	☐ Psychiatric Hospitalizations	

13. Please select **any** recent major life stressor that, if unaddressed, would create a risk for the above concerns:

☐ Loss	☐ Change of Schools	☐ Other: _____
☐ Change of Placement	☐ Traumatic Event	

Child/Youth meets TFC Eligibility if at least one of the following is highly likely to occur if TFC services are not provided.

Must check at least one:

a. ☐ Child/youth may need higher level of residential care or acute care.
b. ☐ Child/youth may not successfully transition to a lower level of care.

Staff Signature/Title_____ Date: _____

Printed Name/Title _____

AGENCY:
Confidential Patient Information
See W&I Code 5328
TFC Screening Tool Rev. 2-3-2025

NAME:
MEDICAL RECORD #:
DOB:
PROGRAM: