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Intensive Treatment in Foster Care (ITFC) Referral Form

Intensive treatment in foster care (ITFC) is a bundled service for children who are in a family foster care setting with a mental illness diagnosis and require intensive intervention without 24-hour medical monitoring. The bundled service includes psychotherapy, psycho-education, clinical consultation and crisis assistance.

Please fill in as much information that you have available. Please do not hesitate to make a referral because you do not know all of this information as we will work on our end to gather missing information.

Please provide some narrative as to what you the referral source believe are needed services, and what the family has expressed as needed to assist them:

Referring Agency: _____

Worker: _____

Phone #: _____

Child's Name: _____

Date of Birth: _____

Age: _____ M F

Client has Medical Assistance/PMAP YES NO, If yes, PMI # _____

Date and Place of Last Placement and or Hospitalization _____

Diagnosis _____

Psychiatrist/Medical Doctor _____

Medications _____

Involved Agencies, including Name and Contact Information:

Probation/Truancy: _____

County Child Protection: _____

Special Education/School Attending: _____

Guardian Ad Litem (GAL): _____

Other: _____

Parent(s): _____ Phone: _____
Address: _____ City: _____
Zip: _____ County: _____

Foster Parent(s): _____ Phone: _____
Address: _____ City: _____
Zip: _____ County: _____

County Human Services Guardian: _____ Phone: _____
Address: _____ City: _____
Zip: _____ County: _____

*Please include a valid Release of Information for the county Human Services Agency along with any relevant court documentation. Referrals will not be processed without this documentation.

*ITFC understanding: the family is only contacted by HVMHC if the *referring agency person* has briefly explained to the family that this service is available, and that the family acknowledges wanting a provider from Hiawatha Valley Mental Health Center (HVMHC) to contact them to further explain service options.

Signature of referral source: _____ Date: _____

If you have questions or a family has questions about ITFC, please call
Andy Bohlman, LICSW at (507) 961-8368.

Please return this form to:
Sally Poepping
Hiawatha Valley Mental Health Center
Fax: (507) 474-9471
SallyP@hvmhc.org