State of Rhode Island

Rhode Island Department of Children, Youth and Families

Mental Health History Form/Provider Reference

As being a foster parent is frequently a physically and emotionally demanding job, the Department of Children, Youth and Families is interested in the mental health of the applicant. In order that we may expedite the processing of the application, we ask that a Mental Health Professional complete this form at your earliest convenience and return it to:

DCYF Foster Care Licensing
101 Friendship Street; Providence, RI 02903

Date of Referral: _____

An application to be a foster parent has been received from: _____
Applicant's Name

<table>
<tr><td colspan="3">What is your history with this patient?</td><td colspan="2">☐ New Patient</td><td>☐ Returning patient</td></tr>
<tr><td colspan="6">Has the patient disclosed or are you aware of any:</td></tr>
<tr><td colspan="2">…current mental health diagnosis?</td><td colspan="2">…history of substance abuse?</td><td colspan="2">…history of mental illness?</td></tr>
<tr><td>☐ Yes</td><td>☐ No</td><td>☐ Yes</td><td>☐ No</td><td>☐ Yes</td><td>☐ No</td></tr>
<tr><td colspan="6">What is your impression of the applicant's mental health? If you answered "yes" to any of the above, please use this space to explain:</td></tr>
<tr><td colspan="4">To your knowledge, is the patient currently prescribed or taking any medications (including medicinal marijuana)?</td><td>☐ Yes</td><td>☐ No</td></tr>
<tr><td colspan="6">If yes, please list:</td></tr>
<tr><td colspan="4">Do you consider the patient mentally and emotionally competent to be a foster parent?</td><td>☐ Yes</td><td>☐ No</td></tr>
<tr><td colspan="6">If no, please explain:</td></tr>
<tr><td colspan="6">Any additional comments:</td></tr>
<tr><td colspan="6">Print Mental Health Professional Name & Address:</td></tr>
</table>

_____ _____
Signature *Date*

Please note: The DCYF form #007B, "Authorization to Obtain Confidential Information" shall be forwarded to the medical professional along with this form.