STATE OF RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH & FAMILIES

Behavioral/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 behavioral/mental health of the applicant. In order that we may expedite the processing of the application, we ask that a Behavioral/Mental Health Professional complete this form at your earliest convenience and return it to: **DCYF Licensing 101 Friendship St. 4th Fl. Providence, RI 02903 Attn:** _____

Date of Referral:

An application to be a foster parent has been received from: _____

Applicant's Name

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

_____ _____

Signature *Date*

101 Friendship St. Providence, RI 02903
Fax (401) 528-3650