



Hillcrest

Behavioral Health Services

THERAPEUTIC FOSTER CARE

PASS REQUEST

TO BE COMPLETED BY FCS PARENT

Youth _____ Pass Dates _____

TFC PARENT WILL OBTAIN THE FOLLOWING INFORMATION FROM THE ADULT RESPONSIBLE FOR THE YOUTH WHILE ON PASS.

Adult Responsible: Name _____
Address _____
Phone _____

Address of Destination: Name _____
Address _____
Phone _____

Purpose of Pass _____

What activities are planned? _____

Will they be supervised? Yes or No (please circle)

Transportation arrangements _____

FCS Parent Signature _____ Date _____

TO BE COMPLETED BY CASEWORKER

Pass: Approved or Disapproved (please circle) Date _____

Comments _____

Caseworker Signature _____

TO BE COMPLETED BY FCS STAFF

Pass: Approved or Disapproved (please circle) Date _____

Comments _____

FCS Staff Signature _____