FAPT Date: **Client Name:**

Winchester CSA
Referral Form

Child's Name:				
Date of FAPT:		**Case Worker:**		
Forms	**Required**	**Yes**	**No**	**Comments**
CANS	Yes	☐	☐	
Consent to Exchange Information SA Consent	Yes	☐	☐	
FAPT Invitation Letters	Yes	☐	☐	
Eligibility Determination FC Prevention Determination	Initial	☐	☐	
Parental Co-Pay Screening Form & Parental Co-Pay Agreement	Initial	☐	☐	
Brochure	Initial	☐	☐	
Provider Reports	At Review	☐	☐	
Residential & Private Day only:				
State Testing Identifier Number (STI)	Required	☐	☐	
IACCT Report/CON	Required	☐	☐	Date of IACCT Referral:
Magellan Consent to Exchange	Required	☐	☐	
In-Home Services Referral Only:				
IV-E Candidacy Determination Form From OASIS	Required	☐	☐	
Prevention Plan (From OASIS)	Required	☐	☐	
CANS (Renewed every 90 days)	Required	☐	☐	

FAPT Date: **Client Name:**

Initial Referral ☐ Review ☐

Child Demographic Information:			
Client Name:	**Client SSN #:**	**DOB:**	**Age:**
Gender: ☐ **Male** ☐ **Female**	**Race:** (select)	**Ethnicity:** (select)	
Address:			
Siblings: (name/age)			
Title IV-E: ☐ **Yes** ☑ **No**	**Medicaid:** ☐ **Yes** ☐ **No** **If yes, MCD #:**	**FAMIS:** ☐ **Yes** ☐ **No**	
Other Insurance: ☐ **Yes** ☐ **No** ☐ **If yes, what type?**			
Date of most recent CANS:			
Grade: (select)	**School:**	**504 Plan:** ☐ **Yes** ☐ **No**	
STI # (congregate care only):	**Disability:**	**IEP:** ☐ **Yes** ☐ **No**	
Educational History:			

Family Demographic Information:		
Mother Name:	**Father Name:**	**Caretaker Name:**
Address:	**Address:**	**Address:**
Phone:	**Phone:**	**Phone:**
Ethnicity: (select)	**Ethnicity:** (select)	**Ethnicity:** (select)
Race: (select)	**Race:** (select)	**Race:** (select)
SSN #:	**SSN #:**	**SSN #:**
Medicaid: (select) **Medicaid #:** **Other:**	**Medicaid:** (select) **Medicaid #:** **Other:**	**Medicaid:** (select) **Medicaid #:** **Other:**
Legal Custody: (select)	**Legal Custody:** (select)	**Legal Custody:** (select)

FAPT Date: **Client Name:**

Others Involved: (name/relationship)

Case Management Information:	
Case Manager:	**Referral Source:** WDSS
Case Manager Email:	**Case Manager Phone:**

Reason for Referral: (Must include presenting issue, child/family history, previous interventions/outcomes, interests, and reason for referral for CSA funding)

Evaluations/Diagnosis/Medication
Evaluations: (Include name/date of assessment and results.)
Diagnosis: (DSM-5)
Medications: (Include medication type, dosage, frequency, and prescribing doctor.)

FAPT Date: **Client Name:**

Family Input:
Goal: (What is the family's overall desired outcome?)
Strengths: (In the family's own words.)
Natural Supports: (Who does the family identify as their support system?)
Needs: (In the family's words.)

Strengths & Needs (As evidenced by the most recent CANS Assessment):	
List up to top 4 strengths of the family.	List up to top 4 needs of the family.

FAPT Date: **Client Name:**

Goals *are overreaching outcomes that the family and team desire for the desire for the child and family. Although goals are broad they guide team decision making and are generally, but not always tied to agency specific goals for the child/family.*

Objectives *are specific measurable steps that can be taken to meet the goal. Objectives should be concrete, tangible, and measurable steps which directly address the needs as they are reflected by the CANS Assessment.*

Goals and Objectives should be SMART (Specific, Measurable, Attainable, Relevant, and Time-bound).

Goal(s)	
(What is the long-term goal for this child/family?)	
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)

Goal(s):	
(What is the long-term goal for this child/family?)	
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)
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(measurable short-term objective)	(progress towards objective)

FAPT Date: **Client Name:**

Goal(s):	
(What is the long-term goal for this child/family?)	
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)
Objective	***Progress***
(measurable short-term objective)	(progress towards objective)

FAPT Date: **Client Name:**

Discharge Plan/Progress Toward Discharge	
Discharge to: (What is the next step in the plan?)	**Proposed Discharge Date:** (select date)
Summarize discharge planning efforts: (services, community resources, educational plan, etc.)	

Additional Information
(Brief background, court history, previous CPS involvement, other pertinent information)

Progress Since Last FAPT
(Progress, utilization of provided services, changes to services needed, etc.)

FAPT Date: **Client Name:**

Caseworker							CSA Coordinator				
Client Name	Service	Provider	Frequency/ Duration of Service	Approval Dates From	To	New Service (Y/N)	UR %	Service Rate	Total Cost	Funding Source	CSA Expend Code

FAPT Date: **Client Name:**

Caseworker							CSA Coordinator				
Client Name	*Service*	*Provider*	*Frequency/ Duration of Service*	*Approval Dates From*	*To*	*New Service (Y/N)*	*UR %*	*Service Rate*	*Total Cost*	*Funding Source*	*CSA Expend Code*

Funding Approval - Internal	
X _____	X _____
Case Manager	Case Manager's Supervisor

Funding Approval – FPMT and CPMT Chairs		
Signature	**Date**	**Role**
		FAPT Chair
		CPMT Chair

FAPT Date: **Client Name:**

Participation and consent of youth and parent/guardian			
The undersigned have had the opportunity to participate in the development of the Individual Family Services Plan (IFSP), including the goals, objectives, and services contained within.			
Signature	**Date**	**Role**	**Agree/Disagree**
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree

Participation and consent of the Family Assessment and Planning Team (FAPT)			
The undersigned had the opportunity to participate in the development of this Individual Family Services Plan (IFSP). We understand the IFSP and, unless otherwise indicated below, agree with its implementation			
Signature (Participated)	**Date**	**Agency**	**Agree/Disagree**
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree
			☐ Agree ☐ Disagree

Next FAPT Review		
Date:	**Time:**	**Location:**

FAPT Date: **Client Name:**

FAPT Minutes:

CSA Office Use Only
Copayment Status:
Date CSA Office Received:
Mandate Type: (select)