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| --- |
| 1. Child’s Information |

***Child’s Name***:       Sex:  Male  Female

Address:

Social Security Number:

Age:       D.O.B:       Race:

Child lives with:  Mother  Father  Other:

Who has physical custody of Child?

Current Diagnosis:      Provided by:

Current Medications:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication: | Dosage/Frequency: | Treating Condition: | Prescribed by: |
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Current Service(s):

|  |  |  |
| --- | --- | --- |
| Agency: | Service Provided: | Date Initiated: |
|  |  |  |
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|  |  |  |
|  |  |  |

List Services Utilized in the Past:

|  |  |  |  |
| --- | --- | --- | --- |
| Agency: | Service Provided: | Dates of Service: | Termination Reason: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Has the Child been in Foster Care: Yes  No

Reason Child was in Foster Care:

Is Child adopted: Yes  No From What Locality:

Reason for CSA Referral (Service Requested & Description of behaviors/conditions within past 60 days):

|  |
| --- |
|  |

Describe Past Behaviors (Prior to 60 days with dates of incidents):

|  |
| --- |
|  |

Please List All Assessments/Evaluations Completed on your Child (\*\*Include in packet\*\*).

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Date Completed: | Completed by: | Attached (Yes/No): |
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| --- |
| 2. Family Information |

***Child’s Mother:***

Physical Address:

Phone:       E-Mail:

SS#:       D.O.B:       Race:

In Household: Yes  No

Employer:

***Child’s Father:***

Physical Address:

Phone:       E-Mail:

SS#:       D.O.B:       Race:

In Household: Yes  No

Employer:

***Other Legal Guardian:***      (Relationship:      )

Address:

Phone:       E-Mail:

In Household: Yes  No

Employer:

***Other Household Members:***

Name:       D.O.B:

Relationship to Child:

Name:       D.O.B:

Relationship to Child:

Name:       D.O.B:

Relationship to Child:

Name:       D.O.B:

Relationship to Child:

|  |
| --- |
| 3. Other Involved Agencies (Attach a separate sheet if needed) |

***DSS:***

VIEW/TANF Self-Sufficiency Worker Name:

Phone:       E-Mail:

Eligibility Worker Name:

Phone:       E-Mail:

***SCHOOL:***

Name:       Grade:       IEP: Yes  No

Identified Special Education Disability(ies):

Teacher Name:

Phone:       E-Mail:

Guidance Counselor/Home-school Coordinator Name:

Phone:       E-Mail:

***MENTAL HEALTH:***

Is the family known to Northwestern CSB?  Yes  No Case Manager:

Youth       Parent

Identified substance abuse issues:

***COURT:***

Past court involvement (charges and disposition):

Current charges:

Future Court Date:

Probation Officer Name:

Phone:       E-Mail:

***PRIVATE PROVIDERS:***

Mental Health Therapist Name:

Agency Name:

Dates of Service:       Type of Service:

Outcome:

In-Home Worker Name:

Agency Name:

Dates of Service:       Type of Service:

Outcome:

Other Private Provider Name:

Agency Name:

Dates of Service:       Type of Service:

Outcome:

Other Private Provider Name:

Agency Name:

Dates of Service:       Type of Service:

Outcome:

|  |
| --- |
| 5. Financial Information |

Private Insurance: Yes  No Primary Insured:

Insurance Company:       Phone Number:

Group Number:       Identification Number:

Medicaid: Yes  No  APPLIED HMO Name:

Medicaid Number:       HMO Phone Number:

EPSDT: Yes  No  APPLIED

Social Security Disability Insurance: Yes  No  APPLIED Who:

Supplemental Security Income: Yes  No  APPLIED Who:

|  |
| --- |
| 6. PreFAPT Determination (For CSA Use Only) |

Date Received:      PreFAPT Meeting Date:

Client Referred to:

Comments:

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| --- |
|  |

FAPT Signatures:

|  |  |  |  |
| --- | --- | --- | --- |
| Agency | Name | Signature | Date |
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