Family Assessment and Planning Team
Referral Form

Locality: ☐ Williamsburg ☐ James City County ☐ York (199) ☐ Poquoson (735)

Referring Agency: ☐ DSS ☐ CSB ☐ CSU ☐ Schools ☐ CSA Office

☐ Direct Parent Referral

Case Manager: **Number:** **Email:**

☐ Foster Care ☐ Foster Care Prevention ☐ CHINS
☐ Wraparound Services for Student with Disability

Name of Child	DOB	Sex	SSN	CSA Case #	Race

Current Caregiver /Placement of Child *Note relationship to child if not biological parent.	
Address	**Telephone**

Biological Parents of Child	
Mother:	Father:
DOB:	DOB:
Address:	Address:
Phone:	Phone:
Marital Status: Name of significant other, if not bio father:	Marital Status: Name of significant other, if not bio mother:
☐ Child currently resides with mother OR Last known date of contact with child:	☐ Child currently resides with father OR Last known date of contact with child:

Legal guardian(s), if applicable:	
Name:	Name:
DOB:	DOB:
Address:	Address:
Phone:	Phone:
Relationship to child:	Relationship to child:
Date of placement with guardian:	Date of placement with guardian:

Sibling	**DOB**	**Does sibling currently reside with child?**
		☐ **Yes** ☐ **No – Caregiver:**
Sibling	**DOB**	**Does sibling currently reside with child?**

		☐ **Yes** ☐ **No – Caregiver:**
Sibling	**DOB**	**Does sibling currently reside with child?**
		☐ **Yes** ☐ **No – Caregiver:**

Has the child ever been placed out of the home? ☐ **No**, skip to next section

☐ **Yes,** check all that apply and include dates of placement:

☐	Relative Name: Relationship:	☐	Detention Name: Dates:
☐	Foster/Group Home Name: Dates:	☐	Crossroads Dates:
☐	Residential Treatment Center Name: Dates:	☐	DJJ Juvenile Corrections Facility Name: Dates:
☐	Psychiatric Facility Name: Dates:	☐	Post D Name: Dates:

Has there been a termination of Parental Rights?

☐ **No** ☐ **Yes –** Date: **Court**:

School	**Grade**	**Special Ed**		**Classification**
		☐ **No**	☐ **Yes**	

Medicaid: ☐ **Yes** ☐ **No** **Other insurance:** ☐ **No** ☐ **Yes, list:**

IV-E Eligible: ☐ **Yes** ☐ **No** ☐ **Pending**

Physician's Name: **Date of Last Physical:**

Is the child under the care of a psychiatrist?

☐ **No** ☐ **Yes; Name & Phone number:**

- Current diagnoses:
  Axis I:
  Axis II:
  Axis III:
  Axis IV:
  AxisV:

- Current medications: *Include name, dosage/frequency, and date prescribed

Is the child on probation or parole? ☐ **No** ☐ **Yes; Name of JPO:**

- Please list most significant and/or current legal violations and dates of charges for the child.

Presenting Problem (s)/Reason for Referral

☐	Developmental disability	☐	Serious emotional disturbance	☐	Delinquency/Court involvement
☐	Physical abuse	☐	Sexual abuse (victim)	☐	Sexual abuse (perpetrator)
☐	Traumatic brain injury	☐	ADHD	☐	Aggressive behavior ☐Verbal ☐ Physical
☐	Physical disability/chronic health problem	☐	IEP/School-related issues	☐	Autism
☐	Emotional abuse	☐	Acting-out behavior (i.e. running away)	☐	Substance abuse
☐	Mental retardation	☐	Pregnancy/parenthood	☐	Truancy
Other (please specify):					

- Detail the specific circumstances leading to this referral.

- Are there any issues with maintaining the child in his/her current placement? ☐ No
  ☐ Yes, please describe:

- Describe how the overall functioning of the family influences the identified child:

Community Services - Indicate all services that the child/family has received:

Provider Name	Dates of service	Services	Outcome of Services
Comments:			

Date of CANS:

What are the primary needs of the child, based on the CANS?

1)
2)
3)
4)

What are the centerpiece strengths of the child, based on the CANS? ***May also** *include additional strengths not listed on CANS*

1)
2)
3)
4)

What service(s) are you requesting?

Need (Based on CANS)	Service Type	Provider	# of Units	Type of Unit (per hour, day, week, etc.)	Rate per Unit	Total Cost	Dates of Service Include range

Please list any services or resources currently in place or that will be in place to build upon the strengths of the child and/or family.

Short-term and Long-term Goals

- What are the short-term outcomes/goals desired? Include target dates for completion.

- What are the long-term outcomes and objectives / goals desired? Include target dates for completion.

Family's Perception *To be completed jointly with the parent(s)/legal guardian(s).

- What strengths does your child have? What is your child successful at?

- What strengths does your family have? What is your family successful at?

- What are the most important changes that need to happen now for your child?

- What are the most important changes that need to happen now for your family?

- What services can best help your child and your family make these changes you think are most important?

THE UNDERSIGNED PARENT/CAREGIVER AND FAPT PRESENTER PREPARED THIS CHILD AND FAMILY ASSESSMENT CONJOINTLY.

_____ _____
Parent/Caregiver Date

_____ _____
Case Manager Date

_____ _____
Case Manager Supervisor Date

The following is attached to this referral:

☐ Signed FAPT consent from the parent/legal guardian
☐ Court order, if applicable
☐ Psychological, Psychiatric, Treatment Reports, or Social History
☐ Completed CANS
☐ Child Data Set Form