

Case Name:
 Date of initial Review:
 Date of last Review:
 Date of current Review:

York-Poquoson FAPT Utilization Review

Locality: York Poquoson

Referring Agency: DSS CSB CSU Schools

Case Manager: Phone Number: Email:

Foster Care Foster Care Prevention IEP CHINS Wraparound Svcs for Student with Disability

Name of Child	DOB	Sex	Social Security #	Race
Current Caregiver/Placement of Child *Note relationship to child if not biological parent.				
Address			Telephone	
School	Grade	Special Ed		Classification
		<input type="checkbox"/> No	<input type="checkbox"/> Yes	

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

IV-E Eligible: Yes No Pending

Current Diagnoses:			
Axis I			
Axis II			
Axis III			
Axis IV			
Axis IV			
Medication	Dosage	Frequency	Purpose

Progress on Long-term and Short-term Goals:

Long Term Goal #1:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

Long Term Goal #2:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

Long Term Goal #3:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

Long Term Goal #4:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

Short Term Goal #1:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

Short Term Goal #2:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

Short Term Goal #3:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

Short Term Goal #4:

Achieved Progress Made No Progress Made

Details:

Updated Target Date for Completion:

- **What efforts and progress has been made towards discharge from services?** *Please address the following areas: progress in treatment, client/family involvement in treatment (including any services that the parents/legal guardians are involved in), changes in medications or diagnoses, performance in the home, school and community (include any legal violations since last review).*
- **Are there any issues with maintaining the child in his/her current placement?** No
 Yes, please describe:

Date of CANS:

List the previous and current primary NEEDS of the child, based on the CANS:

Initial CANS	Previous CANS	Most recent CANS

List the previous and current centerpiece STRENGTHS of the child, based on the CANS: **May also include additional strengths not listed on CANS*

Initial CANS	Previous CANS	Most recent CANS

List all current services regardless of CSA funding: (i.e., medication management, groups, therapy, independent living, and education supports). **Put an asterisk next to CSA services you want to continue.*

Need (Based on CANS)	Service Type	Provider	Number of Units	Type of Unit	Rate per Unit	Total Cost (Funding Source)	Dates of Service

List any new service request that requires CSA funding:

Need (Based on CANS)	Service Type	Provider	Number of Units	Type of Unit	Rate per Unit	Total Cost (Funding Source)	Dates of Service

- Have issues/concerns arisen regarding the effectiveness of services by designated vendors? No
 Yes, please explain:
- In what manner has the service delivery been verified?

Case Manager Name & Agency

Date

Parent/Legal Guardian Signature

Date

Case Manager Supervisor

Date