# NCG Functional Family Therapy (FFT) Referral Form

REFERRAL DATE: REQUESTED START: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **YOUTH:** \_\_\_\_\_\_  **AGE:** \_\_\_\_\_\_ **DOB:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER: \_\_\_\_\_\_  RACE/ ETHNICITY: \_\_\_\_\_\_\_\_\_ Language Spoken in the Home: \_\_\_\_\_\_\_\_\_

YOUTH RESIDES WITH: RELATIONSHIP: Guardian? \_\_\_\_\_\_

CELL # HOME # \_\_\_\_\_\_\_\_ WORK # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUTH’S CURRENT PHYSICAL ADDRESS:

 CITY: ZIP: \_\_\_\_

OTHERS IN THE HOME AND RELATIONSHIP:

REFERRAL HAS BEEN DISCUSSED WITH THE FAMILY? Choose an item.

Is the family willing and able to engage in FFT? Select Yes or no THEIR RESPONSE?\_\_\_\_\_\_\_\_\_\_

Youth Specifics Please select True or False for the following statements:

|  |  |
| --- | --- |
| select one | The Youth is living in the community or is ready to return to home within the next 30 days. |
| select one | Youth has severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism. *Note: youth on the higher end of the autism spectrum may be served.* |
| select one | Youth needs sexual offender treatment as a primary need. *Note: FFT may work with families that that have begun or completed treatment with a CSOTP or youth who’s sexualized behaviors is secondary to other externalizing behaviors.* |
| select one | The family is not receiving any other form of family therapy or parent coaching services from another provider that are expected to continue for the duration of FFT treatment.  |

Background

PRIOR SERVICES:

CURRENT SERVICES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other agency involvement: *Select and describe all historical or current agency involvement.*

Select CPS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select DSS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select CSB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select CSU \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select SPED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IEP: Click or tap to enter a date.

**FFT Priority Criteria Checklist**

Check ALL criteria that are relevant to the Youth being referred.

|  |  |  |  |
| --- | --- | --- | --- |
| Past 3 Months | Past Year | Criteria | Describe Frequency/Intensity/location(i.e. daily, 1 time, weekly/ at home, community etc.) |
|[ ] [ ]  **At risk of out-of-home placement** |   |
|[ ] [ ]  Physical Aggression |   |
|[ ] [ ]  Substance Abuse/Use |   |
|[ ] [ ]  Negative Peer Associations |   |
|[ ] [ ]  Theft |   |
|[ ] [ ]  Verbal Aggression |   |
|[ ] [ ]  Property Destruction/Vandalism |   |
|[ ] [ ]  Runaway |   |
|[ ] [ ]  Truancy |   |
|[ ] [ ]  School Failure/ Suspensions |   |
|[ ] [ ]  Family Conflict/ Discord |   |

Briefly, provide additional information regarding youth’s **CURRENT** EXTERNALIZING behaviors that put him/her at risk for out-of-home placement:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CSA Details

CSA FIPS Code: YOUTH OPEN TO CSA: \_\_\_\_\_\_\_\_\_\_\_ MANDATE: Choose an item.

REFERRAL AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-MAIL: \_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_

[ ]  FAPT REQUESTED DATE: \_\_\_\_\_\_\_\_\_

 [ ]  CPMT APPROVED DATE: \_\_\_\_\_\_\_\_\_\_\_

NEXT FAPT DATE: \_\_\_\_\_\_\_ TIME: LOCATION: \_\_\_\_\_\_\_\_

Attach all requested information for a new referral:

[ ]  Release of information

[ ]  FACE SHEET

[ ]  POSO or Funding Approval

[ ]  FAPT approved Service Plan and meeting notes

[ ]  Recent CANS

[ ]  Recent assessments or evaluations

**E-mail referral packet to** **RSCNorth@ebanetwork.com**

**Referrals may also be called into the NCG Call Center: *1-877-566-9624.***

To staff a case with the local FFT Supervisor, please contact:

Kendall McCarthy, LPC, FFT Supervisor, Site Director
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