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| **YOUTH INFORMATION:** |
| Autism Spectrum Disorder: | [ ]  Yes [ ]  No | Special Education Eligible:  | [ ]  Yes [ ]  No |
| Child DSM Diagnosis: | [ ]  Yes [ ]  No | Active in Probation or Diversion: | Click to select item. |
| Child Mental Health Meds: | [ ]  Yes [ ]  No | Currently being served by Foster Care/ CPS or have in the last year: | Click to select item. |
| Race: | Caucasian/White | Hispanic Origin: | [ ]  Yes [ ]  No |
| **INSURANCE INFORMATION** |
| Medicaid Status: Does youth have Medicaid? Choose an item. *If yes, for each service requested below indicate whether Medicaid is being used and if not, why:*[ ] Service not covered by Medicaid. [ ] Medicaid being used or requested.[ ] Medicaid service inappropriate/unavailable. Why? Click or tap here to enter text. |
| **Insurance Status:** Does youth/family have private insurance?[ ]  Yes [ ]  No*If yes, please explain why insurance is not being utilized for requested service(s):* Click or tap here to enter text. |
| **FOR NEW REQUESTS:** |
| 1. **Please summarize the needs (as aligned with current CANS scores) of the youth/family that has led to your team’s request for a FAPT meeting:**
* **1a. Please provide the top 3 concerns as ranked by the parent/guardian.**
* **1b. Please provide the top 3 concerns as ranked by the youth (if available)**

**How will placement address the identified needs and concerns listed above?** |
| 1. **What therapeutic interventions are currently being utilized/have been utilized in the past year?**

**Have they been implemented fully as to fidelity and duration?*** **2a. What goals are the youth/family currently working on in treatment?**
* **2b. What progress/outcomes have been achieved?**
1. **Please list any assessments or evaluations that have been completed in the past two years and provide copies:**
 |
| **FOR EXTENSION REQUESTS:**  |
| 1. **Is progress being made toward the youth’s and family’s identified needs that led to placement? Please describe.**
2. **Are there issues or needs that have been identified that are not being addressed?**

**3.** **Parents are required to visit their child at least monthly. Please provide the dates of visits here:** **4. Case managers are required to visit their child at least quarterly. Please provide the dates of visits here:**  |
| **FOR ALL REQUESTS** |
| 1. **What is the discharge plan for the youth? Please include potential interventions to be implemented *prior* to discharge.**

**5a. What are barriers to this plan and how will the team address those barriers?** |
| **Will any members of your team require language interpretation assistance at the FAPT meeting?** Select an item  *If yes, please be aware it is your responsibility to secure this service.* |

**Signatures**

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Case Manager’s Name |  | Case Manager Signature |  | Date |
|  |  |  |  |  |
| Supervisor’s Name |  | Supervisor’s Signature |  | Date |