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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 |