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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: | Click to select item. | Hispanic Origin: | [ ]  Yes [ ]  No |
| **STRENGTHS:** |
| **Please describe youth and family strengths:**  |
| **NEEDS:** |
| **Please specify the needs to be addressed by the services requested below (reference 2s and 3s on the CANS). Describe how these services will be used and by whom.**  |
| **MEDICAID STATUS:** Does youth have Medicaid?[ ]  Yes [ ]  No |
| **REQUESTED SERVICES:**  |
| **Emergency Services may begin prior to FAPT/UR authorization, provided the services are reviewed by the FAPT and approved within 14 calendar days.** |
| **Emergency Services for *DFS CYF* staff use only \****(for Foster Care/Foster Care Prevent requests only)* | **Start Date** | **End Date** |
|[ ]  Family Foster Care Maintenance | date. |  |
|[ ]  Family Partnership Services |  date. |  date. |
|[ ]  Home-based Services (50 hours and 60 days max) |  date. |  date. |
|[ ]  Respite (per policy guidelines) |  date. |  date. |
|[ ]  Second Story *(21 days max)* |  date. |  date. |
|[ ]  Treatment Foster Care and TFC case management (*60 days max)****\*Medicaid Status****:* Choose an item. |  date. |  date. |
| **Emergency Services—for *CSB* staff use only** | **Start Date** | **End Date** |
|[ ]  Leland House ***\*Medicaid Status****:* *Choose an item.****\*Does youth have private insurance:*** *Choose an item.* |  date. |  date. |
|[ ]  Leland House ICC & Community Based Services *(Leland House residents only)* |  date. |  date. |
| **Expedited Services – *services may not begin prior to authorization*** | **Start Date** | **End Date** |
|[ ]  ICC - Care Coordination and Family Peer Support Partner Services only *(60 days max)* |  date. |  date. |
|[ ]  Case Support |  date. |  date. |
|[ ]  Family Partnership Services *(requested via the CSA team-based planning coordinator; NOT for DFS case managers)* |  date. |  date. |
|[ ]  Family Peer Support Partners (FPSP) Services (6 months max.)***\*Please indicate provider:*** Click or tap here to enter text. |  date. |  date. |
| *For* ***ALL requests****, please submit this form along with a Team Based Planning Request form (new cases only), current consent, current CANS, and current eligibility determination form**For* ***Emergency Services****: supporting materials must be received no more than* ***2 calendar days*** *after the requested start date of services to ensure that the request can be reviewed by a FAPT within 14 days from the requested start of services. The FAPT cannot support the start date if the request is not reviewed within this 14-day timeframe.* |

**Signatures**

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