|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 |