

Application for Family Assessment & Planning Team (FAPT)

Parent(s)/Custodian(s):	
Mailing Address:	
Phone Number(s):	
E-Mail:	

Child's Name:		Date of Birth:	_____.
Social Security #:		Gender:	
Child's School:		Current Grade:	

FAMILY INFORMATION

CHILD'S MOTHER:		Phone:	
Address, if different than above:			
CHILD'S FATHER:		Phone:	
Address, if different than above:			
OTHER CUSTODIAN:		Relationship:	
In Household? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone:	

OTHER HOUSEHOLD MEMBERS (i.e. siblings):

NAME	AGE	RELATIONSHIP TO CHILD

INSURANCE/ FINANCIAL INFORMATION *attach a copy of child's insurance card

Insurance Company:		Identification Number	
Medicaid:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Medicaid Number:	
Waiver:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Applied/ denied <input type="checkbox"/> Waitlist <input type="checkbox"/> NA	Case Manager:	
Social Security Disability Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
Supplemental Security Income:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
Is the child adopted?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Type/ Date:	_____.

REASON FOR REFERRAL TO FAPT (provide as much detailed information as possible):

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Current working DIAGNOSIS:	
Completed by:	Date: _____.

CURRENT MEDICATION/ DOSE	CURRENT MEDICATION/ DOSE	CURRENT MEDICATION/ DOSE

SERVICES AND OTHER AGENCIES INVOLVED

DEPARTMENT OF SOCIAL SERVICES (DSS)

VIEW/TANF Self-Sufficiency Worker:	<input type="checkbox"/> NA
Eligibility Worker Name:	<input type="checkbox"/> NA
Has the child been involved with CPS?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Explain:</i>
Has the child been in Foster Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Explain:</i>

COURT INVOLVEMENT NA

Past court involvement (<i>attach disposition</i>)	<input type="checkbox"/> NA
Current charges	<input type="checkbox"/> NA
Future Court Date	<input type="checkbox"/> NA
Probation Officer Name	Phone:

SPECIAL EDUCATION SERVICES NA IEP 504

Date of Eligibility:	Identified Disability(ies):
Guidance Counselor:	Phone:

COMMUNITY SERVICES BOARD *Is the family known to Hanover CSB?* Yes No

Dates of Service:	Frequency:
Youth:	Parent:
Case Manager:	Therapist:

MENTAL HEALTH: *Does the child have a private provider (current or prior)?* Yes No

Agency Name:	Therapist:
Dates of Service:	Phone:
Frequency:	Outcome:

MEDICATION MANAGEMENT/ PSYCHIATRIST: NA

Agency Name:	Doctor:
Dates of Service:	Outcome:

ASSESSMENTS/EVALUATIONS COMPLETED ON YOUR CHILD (Include in packet**)**

NAME/ TYPE	DATE COMPLETED:	COMPLETED BY:

INTENSIVE IN-HOME (IIH) YES NO/NA

Agency Name:	Worker Name:
Dates of Service:	Outcome:

THERAPEUTIC DAY TREATMENT (TDT) YES NO/NA

Agency Name:	Worker Name:
Dates of Service:	Outcome:

SUBSTANCE ABUSE SERVICES YES TYPE: NO/NA

Agency Name:	Worker Name:
Dates of Service:	Outcome:

ACUTE/ CRISIS YES NO/NA

Agency:	Dates:
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OTHER CURRENT OR PRIOR SERVICES YES NO/NA

Type:	Agency:	Dates/ Outcome:
Type:	Agency:	Dates/ Outcome:
Type:	Agency:	Dates/ Outcome:

Please attach copies of reports, treatment plans and discharge summaries of services identified. Attach additional pages as needed.

In order to be eligible for funding through CSA, a child, shall meet the criteria specified in the *COV § 2.2-5212* and follow the policies and procedures established by the Hanover CPMT. A child shall meet all of the criteria specified in sections 1 through 3 to meet the statutory definition of a "child in need of services." *COV §16.1-228*

DOES THE CHILD OR YOUTH HAVE EMOTIONAL AND/OR BEHAVIORAL PROBLEMS THAT:

1.	Have persisted over a <u>significant period of time</u> or, though only in evidence for a short period of time, are of such a <u>critical nature</u> that intervention is warranted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, provide details and supporting documentation:

2.	Are <u>significantly</u> disabling and are present in several community settings such as home, in school, or with peers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, provide details and supporting documentation:

3.	Require services or resources that are <u>unavailable or inaccessible</u> , or that are beyond normal agency services or routine collaborative processes across agencies, or <u>requires coordinated interventions</u> by at least two agencies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, provide details and supporting documentation:

"The child is currently in, or is at imminent risk of entering, purchased residential care; <u>and</u> requires services or resources that are beyond normal agency services or routine collaborative processes across agencies; <u>and</u> requires coordinated services by at least two agencies."	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, provide details and supporting documentation:

The above information is complete and accurate to the best of my knowledge. Yes No

Completed by: _____ Relationship: _____ Date: _____

Please submit completed application and related attachments to the Hanover County CSA Office.

Fax 804-365-4110 E-mail csa@hanovercounty.gov In person: 12304 Washington Hwy Ashland VA 23005

CSA staff will contact you within 5 business days to discuss the status of application.