Stafford County FAPT Referral/IFSP

FAPT Date:		SSN:		DOB:		Age:	
Case Manager:				Agency:			

Child's Name:		Gender:	Race:	Hispanic?
				Yes No
Address:		City:	State:	Zip:
Apt. #:			VA	

School:		Grade:		Parental Agreement	Yes No

IEP Category: ☐ N/A	☐ Autism ☐ Deaf-Blindness ☐ Develop. Delay	☐ Emotional Disability ☐ Hearing Impair./Deaf ☐ Learning Disability	☐ Intellectually Disabled ☐ Multiple Disabilities ☐ Orthopedic Impair.	☐ Other Health Impair. ☐ Severe Disabilities ☐ Traumatic Brain Inj.	Oasis #: JTS #: STI #:	

Mother's Name:			Phone:	
Address:		City:	State:	Zip:
Apt. #:			VA	
Employer:			Phone:	
Address:		City:	State:	Zip:
Suite #:				

Father's Name:			Phone:	
Address:		City:	State:	Zip:
Apt. #:			VA	
Employer:			Phone:	
Address:		City:	State:	Zip:
Suite #:				

Legal Custodian(s):			Phone:	
Address:		City:	State:	Zip:
Apt. #:			VA	
Employer:			Phone:	
Address:		City:	State:	Zip:
Suite #:				
Relationship to child:				

Household Members	Relationship to Child	Age (*siblings*)	In the home?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Was the child/family assessed a parental co-payment/child support?	Yes No to be determined	Does the child have a diagnosis of PDD, Asperger's, or Autism?	Yes No
Amount per month:	$	Does the family receive Public Assistance?	Yes No
Is child enrolled in Medicaid?	Yes No	If yes, list type(s) of assistance:	
If no, list insurance carrier:			
Does the child have a DSM-IV mental health diagnosis?	Yes No	Does child take prescription medication for a mental health problem?	Yes No
If yes, list diagnosis/diagnoses:		If yes, list medications:	

FAPT Referral Form – Page 2	Name:		DOB:	

Case Status/Update (Narrative of past and ongoing events to include family history, presenting problems, strengths, and needs of the child and family):

Service Request:

Is the FAPT meeting court ordered?	☐ Yes ☐ No	Is the child on probation?	☐ Yes ☐ No

Detail any legal issues and/or court involvement:

Mitigating Circumstances:

Detail any medical and/or mental health issues:

FAPT Referral Form – Page 3	Name:	DOB:

CANS Information	*Date of most recent CANS:*	

List Child's Strengths:
1.
2.
3.
4.
5.
6.

List Child's Needs:
1.
2.
3.
4.
5.
6.

List short term goals youth:	Target Dates:
1.	
2.	
3.	
4.	
5.	
6.	

List short term goals family:	Target Dates:
1.	
2.	
3.	
4	
5.	
6.	

Name:	DOB:

Previous Service Information – List CSA and Non-CSA Funded Services (Include Past and Present)

Agency/Service	Start Date	End Date	Outcome

Discharge Plan/Goal:		Anticipated Discharge Date:	

Progress Toward Short Term Goals Youth: (Listed on Page 3)

1.
2.
3.
4.
5.
6.

Progress Toward Short Term Goals Family: (Listed on Page 3)

1.
2.
3.
4.
5.
6.

Case Manager's Signature:		Date:	