FAPT Referral/Update Form ☐ Fredericksburg City ☐ Spotsylvania County ☐ Stafford County

FAPT Date:		SSN:		DOB:		Age:	
Case Manager:				Agency:	<SELECT ONE>		
Child's Name:		Gender: <SELECT>	Race: <SELECT ONE>			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:	

[Revised: 06/07/2011]

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):

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

Detail any legal issues and/or court involvement:

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:	Target Dates:
1.	
2.	
3.	
4.	
5.	
6.	

Detail long term outcomes expected:

FAPT Referral Form – Page 4	Name:		DOB:	

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

Agency/Service	Start Date	End Date	Outcome

Current Services Requested

Vendor	Service	Unit Type	# of Units	Frequency	Rate	Start Date	End Date
		<SELECT>		<SELECT>			
		<SELECT>		<SELECT>			
		<SELECT>		<SELECT>			
		<SELECT>		<SELECT>			
		<SELECT>		<SELECT>			

Discharge Plan:		Anticipated Discharge Date:	

Progress Toward Short Term Goals (Listed on Page 3)

1.

2.

3.

4.

5.

6.

Case Manager's Signature:		Date:	

[Revised: 06/07/2011]