|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Agency/PASSE submitting referral & contact information:** | **Agency requested to provide services and email address for referrals:** | | | | | | | | | |
| Centers for Youth & Families ([FCT@thecentersar.com](mailto:FCT@thecentersar.com))  Connected Families ([FCTReferrals@abcfm.org](mailto:FCTReferrals@abcfm.org) )  The Guidance Center ([FCT@wacgc.org](mailto:FCT@wacgc.org))  Impact Counseling ([admission@impactcounselingclinic.com](mailto:admission@impactcounselingclinic.com))  SPARC ([sparcreferrals@thesparcnetwork.net](mailto:sparcreferrals@thesparcnetwork.net))  St. Francis Ministries ([arfctreferrals@st-francis.org](mailto:arfctreferrals@st-francis.org))  Youth Advocate Program ([yaparkansasiihsreferrals@yapinc.org](mailto:yaparkansasiihsreferrals@yapinc.org)) | | | | | | | | | |
| **Date of Referral:** | | | **County of residence:** | | | | | **PASSE assigned to identified child:** | | |
| **PASSE Care Coordinator name, phone, email information:** | | | | | | | | | | |
| **Care Coordinator’s supervisor name, phone, email (if known):** | | | | | | | | | | |
| **Emergency Referral** (24-hour follow-up with referral source)  **Regular Referral** (48-hour follow-up with referral source) | | | | | | | | **Date of most recent BH Independent Assessment for identified child:** | | |
| **Caregiver** | First: | | Last: | DOB: | | Phone #: | | Alt. Phone #: | Relationship: | |
| **Caregiver** | First: | | Last: | DOB: | | Phone #: | | Alt. Phone #: | Relationship: | |
| **Children**  **(Identified child with BH needs listed first)**  **List any additional children/care-givers in Notes Section below** | **First:** | | | **Last:** | | | | **DOB:** | | **School :** |
| **Identified child’s Medicaid ID number:** | | | | | | **PASSE ID number (if known):** | | | |
| **Current outpatient BH provider:** | | | | | | | | | |
| First: | | | Last: | | | | DOB: | | School: |
| First: | | | Last: | | | | DOB: | | School: |
| First: | | | Last: | | | | DOB: | | School: |
| First: | | | Last: | | | | DOB: | | School: |
| **Family Address** |  | | | | | | | | | |
| Family should meet all minimum criteria | At least one child between the ages of 4-17 with an identified BH need for FCT service | | | | A caregiver available to participate in FCT services | The need to facilitate a successful reunification if the child(ren) are already placed out of the home, or to avoid out of home placement for the child(ren). | | | | |
| **Type of case for family:**  prevention of removal  Reunification  Pre/Post Adoption  Post Residential  Other (please describe): | | | | | | | | | | |
| **Preferred Primary language:**  **Interpreter Services needed:  Yes  No**  Comments about family’s need for an interpreter, member-specific, etc.: | | | | | | | | | | |
| **Referral Behaviors:**  Please review this list below and add information by any of items which you indicate are present for this family, such as which family member is involved, frequency and last incident. If something is not applicable, please include N/A.  Serious family conflict putting the child(ren) at risk:  Concerns or problems regarding caregivers and overall family support systems (for example – Caregiver is unable or unwilling to perform parenting role, conflict between caregivers resulting in family instability, serious caregiver behavioral health issues [mental health, substance use, or co-occurring]):  Mental Health Issues:  Serious behaviors including substance abuse, physical aggression, running away, truancy, fire setting:  Defiant/Oppositional behaviors:  Suicidal/Homicidal/Psychotic behaviors:  Juvenile Justice Involvement including unruly/delinquent:  Youth displaying problem sexual behaviors (Must include information to describe specific problem behaviors, access to previous or potential victims, problem sexual behavior assessment outcomes, specialized treatment, and current safety plan.):  Youth in adoptive placements in danger of disruption:  Trauma impacting the family:  Concerns/problems regarding caregiver/family support:  Youth returning home from residential placement (bypassing step-down programs):  Substance Use problems (which member(s), impact on family functioning):  Repeated acute hospitalizations (please describe where, when, & why briefly):  Other (please describe): | | | | | | | | | | |
| **Notes (**please mark NA if not applicable**):**  If needed, please list any other family members:  Identify other agencies involved with the family:  Identify family strengths:  Note if any child is in foster care & give placement information:  Other pertinent (please describe): | | | | | | | | | | |
| **Signature:** | |  | | | | | | | | |