Catholic Charities
Functional
Family Therapy

Date of Referral:_____

Type of Service Requested:
☐ FFT

Contact Information:

Name(person completing form) Agency:

Name of Children's Targeted Case Manager:

Office Location/Address:

Phone #: EXT: Cell Phone #:

Demographics of Child: (Child's name spelled as it appears on the MaineCare card)

First: Middle: Last: Gender: ☐ M ☐ F

DOB: SS #: Maine Care #: Race: (optional)

Child's Current Residence:

Street: Town:

ME Zip: Phone #: Cell Phone #:

Legal Guardian(s): Name & Mailing Address Phone #: Cell Phone #:	**Guardian(s) Custody:** Married ☐ Yes Sole ☐ Yes
Shared Custody: Name & Mailing Address Phone #: Cell Phone #:	Shared ☐ Yes fill in name/address DHHS ☐ Yes Own ☐ Yes

Child Primary Language: Caregiver's Primary Language:

Does this family utilize interpreters services ☐ Yes ☐ No

Name of Interpreter & Contact information:

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Primary Diagnosis:

Diagnosis Provided By: Date of DX:

Does child have developmental delays, Intellectual Disabilities, or Autism Spectrum Disorder*? ☐ Yes ☐ No

If yes, please comment on youth's ability to fully participate in a relational, talk-therapy model:

**Please note that referral will be assessed and youth may be deemed not appropriate for FFT Services.*

Primary Reason for referral (Please include primary symptoms, frequency, intensity, duration):

Which of the following behaviors does the child display: check all that apply

	Verbal Aggression		Threatening
	Physical Aggression		Truancy
	Active Defiance		School Work Refusal
	Property Destruction		Substance Use/Abuse
	Engaged with Negative Peers		Problem Sexual Behavior
	Oppositional Behaviors		Criminal Behaviors
	Risk of failure at school due to behaviors		Ongoing Family Conflict
	Serious Disrespect and Disobedience		Running Away
	Fire Setting		Self-injurious or Suicidal
	Abusive to Animals		Police Involvement
	Dangerous Impulsivity		Night terrors or sleep disturbance
	Child Isolated		Use of Crisis services
	Soil, smear feces or urinate in inappropriate places		Other: Please explain:

How are these behaviors affecting the family:

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Service History:

1. Is child currently placed in residential treatment or foster/kinship care ?
☐ Yes (If yes please explain) ☐ No

2. Has the child been involved in the Juvenile Justice System?
☐ Yes (If yes please explain) ☐ No JCCO: _____

3. Has the child been reviewed by the Intensive Temporary Residential Treatment team in the last 6 months?
☐ Yes (If yes please explain) ☐ No

4. Has the child utilized individual therapy?
☐ Yes (If yes please explain) ☐ No

5. Has the child utilized RCS 28 services?
☐ Yes (If yes please explain) ☐ No

Please list prior treatment received:

Current Services:

1. Is the youth at risk for out of home treatment or transitioning home from an out of home treatment?
☐ Yes (If yes please explain) ☐ No

2. Has the family had child protective involvement in the past 6 months?
☐ Yes (If yes please explain) ☐ No

3. Has the family had HCT, MST, or FFT in the last 6 months**?** ☐ Yes (IF yes, Please provided information regarding other services accessed, barriers to progress, what has change, and how service is anticipated to benefit family at this time) ☐ No

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Please list all current services:

What would child & parent like to see from treatment:

Release of Information ****If needed, but not required****

In order for Treatment to proceed the following Parental/Guardian Approval must be granted. (Please initial after each statement and sign below in Parent/Guardian section)

As the parent/guardian of this child (or self, when own guardian),

1. I agree with the proposed intensive in home child and family treatment service. _____
2. I agree to actively participate in this treatment that includes: family meetings, family therapies, individual therapy, as indicated._____
3. I agree to the release of the information contained within this application, but only to a receiving provider agency as part of the treatment planning process. _____
4. I have reviewed all information contained in this document and attest that it is true to the best of my knowledge. _____

My signature below indicates my approval of all the above-initialed statements.

Parent/Guardian: Date:

Once completed please email to fftreferralinfo@ccmaine.org or fax to 238-8626. It is highly recommended to attach the child's most recent diagnostic evaluation.

Questions? Please call 453-4367 and someone will be happy to assist you.