[**FAPT Date:**](#FAPTdate) **select date** [**Current CANS Date**](#Current_CANS_Date)**: select date** **Requesting New Service:** [ ]  **Yes** [ ]  **No**

|  |
| --- |
|  **Youth Information:**  |
| **Client Name:** (first middle last) | [**FAPT** **Client ID #**](#ClientID)**:** (\_) | **[DOB:](#BirthDate)**   (date) | **Age:**  | (age) | **Grade:** (\_) |
| **[Mental Health Diagnosis](#Mental_Health_Diagnosis_Medication) (DSM5)**: [ ] **No** [ ] **Yes; If yes, list diagnosis:** Click or tap here to enter text. |
| **Medications:** [ ] **No** [ ] **Yes**; **If yes list medications** (Include medication type, and dosage frequency): Click or tap here to enter text. |
| **Youth in Foster Care:** [ ] **No** [ ] **Yes** | **Custody Date:** select date | **Current Foster Care Goal**: Choose an item. |
| **Special Education:** [ ] **No** [ ] **Yes** | **Con-Current Foster Care Goal:** Choose an item. |
| **Youth’s Current Placement/Residence:** Choose an item. | **Probation:** [ ] **No** [ ] **Yes** | **CHINS (Services)** [ ] **No** [ ] **Yes**  | **CHINS (Supervision)** [ ]  **No** [ ] **Yes** |

|  |
| --- |
| **Case Management Information:** |
| **Case Manager:** (first last) | **Referral Source:** (agency) | **Services Requested Court Ordered:** [ ] **No**  [ ] **Yes** | **Date of Court Order:** **select date** |
| **[Are Services Requested Result of Emergency Placement/Services](#Emergency_Placement_Dir):** [ ] **No** [ ] **Yes** | **Start date of Emergency Placement/Services:** (date) |
| **Who are the treatment team members and what is their relationship to youth/family?** Click or tap here to enter text. |

|  |
| --- |
| **[Reason for Referral/Presenting Problems:](#Reason_for_Referral)** |
| Click or tap here to enter text. |

|  |
| --- |
| **[Alternative Funding Resources](#Alternative):***Please select the one(s) the youth currently is eligible/covered by:* |
| **Title IV-E:** [ ]   [ ] **Pending** | **Medicaid:** [ ] [ ] **Pending** | **FAMIS:** [ ]  [ ] **Pending** | **Not Eligible for Insurance:** [ ] **Uninsured:** [ ]  | **Other Insurance:** [ ] (health insurance carrier) |
| **Which alternative funding sources were considered before seeking CSA funds for the requested service** (check all that apply): [ ]  Medicaid [ ]  Title IV-E [ ]  Federal Adoption Assistance [ ]  Mental Health Initiative [ ]  Respite Grant [ ]  Independent Living [ ]  State Adoption Assistance [ ]  Private Insurance [ ]  Family Preservation & Support [ ]  Other |
| **Choose why alternative funding sources were not utilized for requested service (in boxes below):** |
| **SERVICE REQUESTED** | **REASON** |
| Choose an item. | Choose an item. |
| Click or tap here to enter text. | Click or tap here to enter text. |

| [**Treatment Hi****story:**](#Treatment_History)*Please provide youth’s prior treatment history (within past 12 months and all significant services relevant to request) and brief outcome summary* |
| --- |
| **Type of Treatment** | **Dates** | **Outcome Summary** |
| Click or tap here to enter text. | Date | Click or tap here to enter text. |

| [**Family Input:**](#Family_Input) |
| --- |
| **Goal:** (What is the family’s overall desired outcome?) |
| **Strengths:** (In the family’s words.) |
| **Natural Supports:** (Who does the family identify as their support system?) |
| **Needs**: (In the family’s words.) |

| **[Strengths](#Strengths)(As evidenced by the CANS Assessment):** *Select only ratings of “0” and “1” within the CANS* |
| --- |
| (select CANS Strengths/Resiliency) | (comment) |

|  |
| --- |
| **Discharge Planning** |
| **Current Requested Service(s):** *(please add ALL)* | **Proposed Stepdown Date for Current Requested Service(s):** | **Aftercare Service(s):** *(What is in place after requested service(s) ends?)* |
| Choose an item. | Click or tap to enter a date. | Click or tap here to enter text. |
| **Summarize discharge planning efforts:** Click or tap here to enter text. |

|  |
| --- |
| **CSA SERVICE REQUEST AND ACTION PLAN** |
|  |
| **[Youth’s Long Term Goal](#Goals) *(s):*** |
| ***Goal 1:*** Choose an item. | ***Goal 2:*** Choose an item. | ***Goal 3:*** Choose an item. |
|  |
| **CANS DOMAIN** | **CANS NEED** | **SHORT TERM GOAL/OBJECTIVE**S **TO BE ACCOMPLISHED BY SERVICE/PROVIDER** | **SERVICE** | **[# UNITS](#Units)** | **[START DATE](#Start)** | **REQUESTED SERVICE DATES****FROM TO** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| (select Domain/Module) | Choose an item. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  (date) |  (date) (date) |
| **Progress:** Click or tap here to enter text. |

| [**FAPT Recommendations**](#FAPT_Recom)***,* Follow-up, Action Plan: (To be completed by FAPT Facilitator)** |
| --- |
| **RETURN FAPT DATE:**  |

| [**Consideration of UR Findings**](#UR_Find)***:*** **UR addendum attached?** [ ] **Yes** [ ] **No** |
| --- |
| (How are UR findings incorporated into the service plan?) |

|  |  |
| --- | --- |
| **Pre-FAPT participation and consent of youth, parent/guardian, and treatment team members:** | **FAPT (Family and Assessment Planning Team) Participation and Consent:** |
| The undersigned have had the opportunity to participate in the development of the Individual Family Services Plan (IFSP), including the goals, objectives, and services contained within.  | The undersigned had the opportunity to participate in the development of this Individual Family Services Plan (IFSP). We understand the IFSP and, unless otherwise indicated above, agree with its implementation. Those who disagree with any or part of the IFSP will be given a FAPT Disagreement Form to complete..***\*\*Information discussed during this meeting is confidential and protected. By signing below, you agree not to disclose any information obtained in this meeting to a third party without prior written consent and/or unless required to do so by law\*\****  |
| **[Signature](#Signatures)** | **Date** | **Agency/Role** | **Signature** | **Date** | **Agency/Role** | **Agree/Disagree** |
|  **🞎 By Phone** |  | Case Manager |  **🞎 By Phone** |  | Child Welfare | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  | Parent(s) |  **🞎 By Phone** |  | Behavioral Health | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  | FC Parent(s) |  **🞎 By Phone** |  | JDRC | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  | Youth |  **🞎 By Phone** |  | APS | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  | Vendor |  **🞎 By Phone** |  | Parent Representative | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  | Vendor |  **🞎 By Phone** |  | Private Provider Rep. | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  | GAL |  **🞎 By Phone** |  | FAPT Facilitator/CSA Coordinator **(circle one)** | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  |  |  **🞎 By Phone** |  | Case Manager | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  |  |  **🞎 By Phone** |  | Utilization Review | 🞎 Agree 🞎 Disagree |
|  **🞎 By Phone** |  |  |  **🞎 By Phone** |  | GAL | 🞎 Agree 🞎 Disagree |
|  |  **🞎 By Phone** |  | Youth | 🞎 Agree 🞎 Disagree |
|  |  **🞎 By Phone** |  | Parent(s) | 🞎 Agree 🞎 Disagree |
|  |  **🞎 By Phone** |  | Vendor | 🞎 Agree 🞎 Disagree |
|  |  **🞎 By Phone** |  |  | 🞎 Agree 🞎 Disagree |
|  |  **🞎 By Phone** |  |  | 🞎 Agree 🞎 Disagree |
|  |  **🞎 By Phone**  |  |  | 🞎 Agree 🞎 Disagree |

**Supervisor Review of IFSP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_**

**CPMT Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Decision:** 🞎 Agree 🞎 Pend

**Individual Family Services Plan (IFSP) Instructions**

An IFSP is central to service planning and documents the Family Assessment and Planning Team (FAPT) process. This record incorporates the results of the mandatory uniform assessment, input of youth and family, evaluation results, diagnostic/medication information, goals/objectives, services, and the treatment-focused discussion of the FAPT.

In keeping with the intent of CSA and system of care principles, the IFSP for the child and family should strive to include creative, non-traditional services and natural supports, as well as more formal types of services. The System of Care principles of the CSA emphasize least restrictive treatment and services which meet identified needs and are designed based on the unique strengths and needs

of that child and family. Strength-based, as opposed to needs-based, planning is optimal.

**General Instructions:**

Field information can be entered by clicking in the area enclosed in parentheses which will yield a

text, calendar, or drop-down field.

* Enable “content” when opening the document.
* Only use the SharePoint version
* Print button-use this button to print only the IFSP without the instructions page. If you wish to also print instructions, use normal Word print button.

**Section Specific Instructions:**

Although most sections of this document are self-explanatory, section-specific guidance is included below to assist in the forms completion.

**[FAPT Date:](#FAPT_Date)**

Click in this field and select scheduled FAPT date on the calendar. In the case of new referrals type “TBD”

**[Current CANS Date:](#CANS_Date)**

Click in this field and select the “CANS Completion” date on the calendar. Do not use the “assessment date” [CANS Policy](https://arlingtonva.sharepoint.com/sites/dhs/POSManual/Attachments/CPMT%20Manual/CANS%20policy%20CPMT.pdf%22%20%5Co%20%22CANS%20POLICY)

[**Client ID Number:**](#Client_ID)

Be sure to use the client ID number which is generated in DMC. For new cases that do not have a number enter “TBD”

**[Date of Birth:](#DOB)**

You must select the date of birth of the client as well as enter the current Age in the next space. Each time you re-open the document for update, you should validate the age and correct it if necessary.

**[Mental Health Diagnosis/Medication](#Mental_Health_Diagnosis):**

Include as much information as possible in this section as it will assist the team in service planning. Current diagnostic information should be cited per DSM-5, and include where the diagnosis came from (who gave the child the diagnosis).

**[Emergency Placement](#Emergency_Placement):**

If you have received approval for service to begin as an emergency prior to FAPT, complete this section. Most often used for placement of youth in foster care.

[**Reason for Referral**](#Reason) **:**

CSA services are always child and family specific and specifically designed to meet the needs of an individual child and family.

Describe the presenting problem(s), identify behaviors and symptoms that warrant the requested service and explain the goals of the treatment.

This section is designed to capture specific information related to the history of the case, including how it became known to CSA, service history, and the rationale for current services. It is important to be a specific as possible in the section as it will provide perspective and direction in determining the efficacy of current services and case progress. Please include any relevant assessments: psychological, educational, sociological, VEMAT, YASI, and/or Casey Life Skills.

**[Alternative Funding Resources:](#Alternative_Funding_Resources)**

Identify all applicable funding sources and explain in detail why they are not being used

To create additional lines, left click on the plus sign

**[Treatment History:](#Treatment_History_tbl)**

Please provide youth’s prior treatment history (within past 12 months and all significant services relevant to request/beginning with most recent) and brief outcome summary (examples include individual therapy, intensive outpatient therapy, group home placements, residential treatment placements, partial hospitalization, family therapy, medication management, Intensive In-home or other in-home service, acute psychiatric hospitalization). \*\*To create additional lines, left click on the plus sign

**[Family Input:](#Family_Input_tbl)**

Per statute [(COV § 2.2-5208)](http://law.lis.virginia.gov/vacode/title2.2/chapter52/section2.2-5208/), Community Policy and Management Teams (CPMT) are responsible

for developing policies and procedures which provide for family participation in all aspects of

assessment, planning and implementation of CSA services. This section allows for the inclusion of

the family’s goals, strengths, needs, and supports as they see them. It is important to use the family’s

words in this section as it is meant to be a direct representation of their engagement in the FAPT/

service planning process.

**[Strengths:](#Strengths_Tbl)**

This is the section where the child and family’s strengths and needs are captured. Information included in this section should come directly from the Child and Adolescent Needs and Strengths Assessment (CANS). Although it is possible for a child/family to have several strengths, it is not necessary to list each and every one. Instead, focus on the key strengths ratings of “0” and “1” which will be addressed during service planning.

**[Discharge Plan/Progress Toward Discharge:](#Discharge_Tbl)**

Regardless of service type, discharge planning is a necessary part of service provision, which must begin on the first day of treatment.

Discharge plans should consider the unique needs of each child and family and clearly identify the step-down level of care. This section of the IFSP documents the existence and consideration of the discharge planning process so that discharge needs can be addressed on an ongoing basis.

**[Goals/Objectives:](#Goals_Tbl)**

This section is one of the most important in the IFSP. The goals and objectives should be informed

by the identified strengths and needs, and guide the direction and choice of services. Objectives

are the specific measurable steps which are necessary to achieve the overall goal.

Although the goal is likely not to change with every FAPT meeting, objectives should be based on the

child and family’s progress over the past reporting period.

Use SMART goals (specific, measurable, attainable, realistic, and timely)

When documenting progress, be specific in documenting progress toward the objective. The purpose of this section is to ensure that services are adequately meeting the child and family’s needs and moving the case toward the overall goal. If the service not on the list, contact the CSA Coordinator for consultation. Remember, there are some needs that are “background needs”, such as adjustment to trauma, which direct the course of treatment. These are exactly the type of need which should be included in this section as they will tie directly to service provision and the child/family overall goal. Target needs should match the CANS and align with treatment request. \*\*To create additional goals, left click on the plus sign

**[Units:](#Units_Tbl)**

Type in the requested number of hours, days or months

**[Start Date:](#Start_Date)**

For a new referral type “N/A.”

For concurrent/return reviews select the start date on the calendar (the date services began).

**Requested Service Dates:**

Put in the dates that reflect the timeframe you are requesting for services. If FAPT approves a different timeframe the FAPT Facilitator will amend the dates accordingly in FAPT.

**[FAPT Recommendation:](#FAPT_Recom_Tbl)**

Recommendation, follow up and action plan to be completed FAPT facilitator

**[Consideration of UR Findings:](#UR_Find_Tbl)**

To be completed by FAPT facilitator and UR Utilization review (UR) is a component of a comprehensive Utilization Management approach and is

the process of reviewing individual cases to determine if the appropriate treatment plan and services are in place based upon the client’s current level of need. Utilization Review can be conducted through chart review, onsite visits to treatment programs, and state sponsored UR. It is also

allowable for UR to be conducted in the course of the FAPT process. For localities who wish to do this, there is a UR addendum to the IFSP which can be used to document the UR process. Regardless of how UR happens, the results of case review should be considered as a part of the

FAPT process. This documents FAPTs consideration of UR results in service planning.

**[Signatures:](#Signatures_Tbl)**

If the youth or parent/guardians disagree with the proposed plan for any reason, they are welcome to submit rationale for their dissenting opinion in the space provided. Additionally, they, or any other FAPT member can attach documentation explaining why they do not agree with the proposed plan and any other rationale they deem appropriate. Treatment team members will sign and complete the left column of form prior to FAPT. The right column will be signed and completed during the FAPT meeting.