Family & Community Support Systems, LLC

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APPLICATION FOR SERVICES

Referral Date: ________ Requested Start Date: ________ Start Date: _________ ID Number_______________

☐ Mentoring ☐ Supervised Visitation ☐ Customized Service ☐ Intensive In-Home-PO

☐ Intensive In-Home-Medicaid Client's Medicaid Number (12 digits): ______________________

Date of FCSS Initial Face-to-Face Contact with Client/Family: _______________________

Client: __________________________________ Social Security #: __________________ D.O.B: ____________

Resident Address:____

Phone Number: _______________________________ Reside with: ☐ Mother ☐ Father ☐ Other: _______________

Race: __________ Sex: ________ Language Preference: _______________ Handicaps: ______________

FCSS Assigned Worker:____________________________________

OTHER PEOPLE RESIDING IN THE HOME:

Name: _________________________ Age: ______ Relationship to Client: _________________________
Name: _________________________ Age: ______ Relationship to Client: _________________________
Name: _________________________ Age: ______ Relationship to Client: _________________________
Name: _________________________ Age: ______ Relationship to Client: _________________________
Name: _________________________ Age: ______ Relationship to Client: _________________________

REFERRING AGENCY

Referring agency: _____________________________ Agency requesting Reports/Updates? ___Yes ___No

Contact name: _______________________________Work number: ________________ Fax #: ________________

Address: ____

If PO, funding approval obtained: ☐ yes ☐ no Billing information if different: _______________________________

PRESENTING CONCERNS:

☐ Academic Problems ☐ Aggressive ☐ Alcohol Use ☐ Anxieties

☐ Bullies/Teases ☐ Communication Problems ☐ Depression ☐ Destruction of property

☐ Distorted Thinking ☐ Drug Use ☐ Eating Disturbances ☐ Encopresis/Enuresis

☐ Hallucinations ☐ Homicidal ☐ Hyperactivity ☐ Impulsive

☐ Lying ☐ Neglect ☐ Physical Abuse ☐ Poor Peer Relations

☐ Psychiatric needs ☐ Runaway ☐ Self Injurious ☐ Sexual Abuse

☐ Sexual Perpetrator ☐ Sexual Promiscuity ☐ Sleep Disturbances ☐ Suicidal ☐ Theft

☐ Truancy ☐ Withdrawn

☐ Other: ____

Please list the previous services client has received:

Diagnosis of Client (DSM IV – given by what therapist?):

Current Medications:

Medical History (include allergies, current condition):

History of Communicable Diseases:

History of Substance Abuse:

EDUCATIONAL PLACEMENT:

School: _______________________________________ Grade: ___________ IEP? ____Yes ____ No

Guidance Counselor/School Contact: ___________________________________ Phone: ________________

PERMANENCY PLAN

Permanency Plan if not placed in permanent placement: ____

Expected Date of Achievement: __________

CONTACTS IF CLIENT IS A MINOR

	Name	Phone Number	2nd Phone Number
Mother:	___________________________	____________________	____________________
Father:	___________________________	____________________	____________________
Legal Guardian:	___________________________	____________________	____________________
DSS Worker:	___________________________	____________________	____________________
Probation Officer:	___________________________	____________________	____________________
Other:	___________________________	____________________	____________________
Other:	___________________________	____________________	____________________

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*****Referring Agency Must Complete This Section Before Submitting Application to FCSS*****

Please list the goals you would like for FCSS to focus on with this client for the first 30-60 days of service. These goals will be considered in writing the ISP.

1)

2)

3)

4)

Client's Strengths:

Client's Needs and Preferences:

Name of FCSS staff member completing the screening: ____

Method of screening: ____________________ Date of screening: ____________________

Recommendations resulting from the screening: ____

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For Director Use Only:

Disposition of the Client: ______Admitted _______Not Admitted (state reason)

Hours Requested by Vendor and Funding Approved:

Hours per week:__________ Hours per month: __________ Rate per hour: _________

Original Purchase Order Information:

Start Date: ______________ End Date: _____________ Total Funding: _________________

Signature of Director: ____________________________ Date: ________________________