|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE REFERRED:**   /  / | | **NC-JOIN NUMBER:** | | | |
| **\*ELIGIBILITY CRITERIA** | | | | | |
| Youth must be Level II Probation or Pending Post Release Supervision  Youth must not be involved in other Counseling Services  Youth must have the intellectual capacity to benefit from FFT  Parent/Legal guardian must be involved in FFT services  Parent/Guardian has been advised that this referral has been made.  Parent/Legal Guardian & Youth have been advised that participation  is required as a condition of the youth’s Probation order.  *\*If the youth referred does not meet the above eligibility criteria, then FFT services can not be provided.* | | | | | |
| **YOUTH INFORMATION** | | | | | |
| *(First) (Middle Initial) (Last)*  **YOUTH’S NAME:** | | | | | |
| *(Street) (City) (State) (Zip Code)*  **ADDRESS:** | | | | **COUNTY:** | |
| *(Month/Day/Year)*  **DATE OF BIRTH:**   /  / | **AGE:** | | **GENDER:** (Click here to select one option.) | | |
| **RACE:** (Click here to select one option.) | | | | | |
| **CURRENT LIVING ARRANGEMENT:**  (Click here to select one option.) | | | | | |
| **PARENT/GUARDIAN INFORMATION** | | | | | |
| *(First) (Middle Initial) (Last)*  **PARENT/GUARDIAN’S NAME:**  **OTHER CUSTODIAN:** | | | | | |
| **RELATIONSHIP TO YOUTH:** | | | | | |
| **HOME PHONE:** (   )   -     **CELL PHONE:** (   )   -     **WORK PHONE:** (   )   - | | | | | |
| **JUVENILE JUSTICE STATUS** | | | | | |
| **LEGAL STATUS:**  (Click here to select one option.)  **DELINQUENCY POINTS:**  **CURRENT RISK ASSESSMENT SCORE:**  (Click here to select one option.)  **CURRENT NEEDS ASSESSMENT SCORE:**  (Click here to select one option.)  **SCHOOL GRADE \_\_\_\_\_** **NAME OF SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **REFERRAL REASON** | | | | | |
| **REFERRAL REASON:** *Clearly explain the reason for the youth referral for Functional Family Therapy Services.* | | | | | |
| **AVAILABILTY OF THERAPEUTIC SERVICES** | | | | | |
| Is the youth eligible or do they have access to similar services in their area?  (Examples include: Multi-Systematic Therapy (MST), Intensive In-Home Therapy) | | | | | Yes  No |
| **JUVENILE COURT COUNSELOR INFORMATION** | | | | | |
| **COURT COUNSELOR’S NAME:** | | | **TELEPHONE NO:** (   )   - | | |
| **COURT COUNSELOR’S EMAIL ADDRESS:** | | | | | |

Please initially e-mail **only** this referral form to [Wayne.Smith@ncdps.gov](mailto:Wayne.Smith@ncdps.gov) for processing. Upon notification of acceptance, you will be asked to provide the following documentation to AMIkids: Phone number(s)/contact information for the family, **Family Data Sheet**, and Mental Health Assessment(s).