|  |  |
| --- | --- |
| **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 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).