



The Children's Aid Home Programs
of Somerset County, Inc.
Functional Family Therapy
REFERRAL FORM

Referral Date _____

CHILD INFORMATION

Child Last Name	First	MI	D.O.B.	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (Street Address, City, State, Zip Code)	County	Telephone Number(s)	SS Number		
	Race		Place of Birth		
Current School District / Address / Phone (if available)	Primary Language Spoken		Grade		

Referral Source (Name of person/agency who referred child):

Phone Number of Referral Source:

Reason for Referral (Be specific – Use additional sheets if necessary):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Runaway | <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Conduct Problems |
| <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Delinquency | <input type="checkbox"/> Verbal Aggression | <input type="checkbox"/> Theft |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> School Suspensions | <input type="checkbox"/> Property Destruction | |

Please Describe:

Current Service Providers / Involved Parties (Use additional sheets if necessary.):

Name of Service Provider	Worker	Address (Street Address, City, State, Zip)	Dates of Placement	Type of Svc/Placement
1.				
2.				
3.				
4.				

Past Placements and/or Service Providers (Use additional sheets if necessary.)

Name of Service Provider	Address (Street Address, City, State, Zip Code)	Telephone	Provider Type
1.			
2.			

Past Placements and/or Service Providers (Use additional sheets if necessary.)

Name of Service Provider	Address (Street Address, City, State, Zip Code)	Telephone	Provider Type
3.			
4.			

HOME DEMOGRAPHICS

Does the child reside with natural parents? YES NO	If no, current living arrangement:	Relationship to youth:
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Others in the home and relationship to youth:

INSURANCE INFORMATION**(PLEASE ATTACH A COPY OF THE CHILD'S INSURANCE**

Is child covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MA/Access <input type="checkbox"/> BC/BS <input type="checkbox"/> UPMC <input type="checkbox"/> Gateway <input type="checkbox"/> Other (Specify)
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Primary Behavioral Health Care Provider / Number(s):	Secondary Behavioral Health Care Provider / Number(s):
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PARENT INFORMATION

Mother's Last Name	First	Middle	Birth Date	Age
Address (Street Address, City, State, Zip Code)			Marital Status	Telephone
Father's Last Name	First	Middle	Birth Date	Age
Address (Street Address, City, State, Zip Code)			Marital Status	Telephone

Functional Family Therapy Overview:

Functional Family Therapy (FFT) • Targets at-risk youth ages 11-18 and their families (must have caretaker)

- Focuses on family relations and communication; builds on strengths as motivation for change
- Home based intervention
- Length of treatment: average 12 -14 sessions for most cases
- Caseload 10 per therapist
- Phases of Treatment: Engagement & Motivation, Behavior Change and Generalization
- Weekly Team Supervision

Behaviors include:

- Youth with anti-social behavior
- Aggressive, conduct disorder
- Drug Use, school behavior, referrals, truant and drop-out.
- Family Conflict

PLEASE DO NOT WRITE BELOW THIS LINE (staff use only)

<input type="checkbox"/> Accepted (reason):
<input type="checkbox"/> Denied (reason):