|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE REFERRED:** Click to enter a date. | | **NC-JOIN NUMBER:** | | | | | | |
| **\*ELIGIBILITY CRITERIA** | | | | | | | | |
| Youth must be Level II Probation, Post Release Supervision, OR Level I with an approved risk/needs  Youth must not be involved in other Family Counseling Services.  Youth must have the intellectual capacity to benefit from FFT.  Long Term Family must agree to be involved in FFT services.  Parent/Legal guardian must be involved in FFT services and have been advised that this referral has been made.  Family has been advised that participation is required as a condition of the youth’s Probation order. | | | | | | | |  |
| **YOUTH INFORMATION** | | | | | | | | |
| *(First) (Middle Initial) (Last)*  **YOUTH’S NAME:** | | | | | | | | |
| *(Street) (City) (State) (Zip Code)*  **ADDRESS:** | | | | | **COUNTY:** | | | |
| *(Month/Day/Year)*  **DATE OF BIRTH:**   /  / | **AGE:** | **GENDER:** Choose an item. | | | | | **RACE:** Choose an item. | |
| **SPANISH SPEAKING THERAPIST REQUESTED:** Choose an item. | | | | **HISPANIC/LATINO:** Choose an item. | | | | |
| **SCHOOL GRADE:**       **NAME OF SCHOOL:** | | | | | | | | |
| **PARENT/GUARDIAN INFORMATION** | | | | | | | | |
| *(First) (Last)*  **PARENT/GUARDIAN NAMES:** | | | | | | | | |
| **RELATIONSHIP TO YOUTH:** | | | | | | | | |
| **CURRENT LIVING ARRANGEMENT:**  Choose an item. | | | | | | | | |
| **HOME PHONE:** (   )   -     **CELL PHONE:** (   )   -     **WORK PHONE:** (   )   - | | | | | | | | |
| **JUVENILE JUSTICE INFORMATION** | | | | | | | | |
| **LEGAL STATUS:** Choose an item. **YASI PRE-SCREEN SCORE:**  **FACILITY OPERATIONS SOCIAL WORKER:**  **YASI PRE-SCREEN RISK LEVEL:** Choose an item. **YASI STATIC RISK LEVEL:** Choose an item.  **YASI NEEDS LEVEL:**  Choose an item. **YASI STRENGTH LEVEL:** Choose an item. | | | | | | | | |
| **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 fax referral form to AMIkids at (910) 939 -1701 along with the Family Data Sheet, YASI Assessment, Mental Health Assessments, and Court History to include a list of arrests, charges and adjudications. A representative with AMIkids will confirm receipt within 24 hours and provide the referral status.