ELIGIBILITY FOR PROGRAM PARTICIPATION

FAMILY TREE PROGRAM

Instructions: Use this form **prior to registration** to identify eligible program participants. You must complete all sections of this form.

Primary Contractor: CCD Counseling	Contract #: 24555273
Service Provider (if not CCD Counseling):	
Primary Caregiver First Name:	Primary Caregiver Last Name:
Target Child First Name:	Target Child Last Name:
* Child's Age:	

☐ Yes ☐ No **Has the target youth ever been adjudicated?**

What is the family hoping to achieve through counseling?

Is this a long-term presenting problem?

☐ Yes ☐ No ☐ Maybe

Has the youth been formally diagnosed? If so, what is the diagnosis?

☐ Yes ☐ No _____

Has the youth seen a therapist before? If so, when?

☐ Yes ☐ No _____

What is the current stage of readiness for change for the following?
(Precontemplation, Contemplation, Planning, Action, Maintenance)

Primary Caregiver _____
Target Youth _____
Secondary Caregiver _____
Other Family Members _____

If services are provided, what key components will be utilized (Check all that apply)

☐ Strengthening coping skills
☐ Restoring family stability
☐ Building resiliency in youth
☐ Enhancing parental protective factors

Eligibility Determination

In order to be eligible for the FAYS Program, children and youth between the ages of 0 to 17 can be enrolled.

☐ This family is eligible for the FAYS Program

☐ This family is not eligible for the FAYSProgram. They will be referred to other services.

Intake Staff Name:	1st Session Date:

FAMILY TREE PROGRAM
ACTION PLAN

YOUTH NAME: _____ AGE: _____ INTAKE DATE: _____
PRIMARY CAREGIVER: _____ RELATIONSHIP TO YOUTH: _____
LOCATION OF SESSION: ○ OFFICE ○ HOME ○ SCHOOL ○ OTHER _____
CONCERN IDENTIFIED: _____

CORE SERVICES TO BE PROVIDED

- ☐ INITIAL INTAKE
- ☐ FAMILY COUNSELING SESSIONS
- ☐ INDIVIDUAL COUNSELING SESSIONS
- ☐ YOUTH CLASSES- POSITIVE ACTION
- ☐ PARENT CLASSES- STEP

FAMILY STRENGTHS AND RESOURCES

_____
_____
_____
_____

HEALTH OF RELATIONSHIP SCALE:

Unhealthy 1 2 3 4 5 6 7 8 9 10 Healthy

FAMILY IDENTIFIED GOALS (EX. YOUTH WANTS TO…)	MEASURABLE TASKS (WHO'S GOING TO DO WHAT?)	TARGET DATE	CURRENT STAGE OF READINESS (**Pr, C, Pl, A, M**)
1.			
2.			
3.			
4.			

My signature below indicates: 1. I have participated in the development of this plan, 2. I agree to do my part to accomplish these goals, 3. I understand that I may withdraw from this agreement at any time, and 4. I have received a copy of this plan.

Youth signature: _____ Date: _____

Parent signature: _____ Date: _____

Staff signature: _____ Date: _____

ACTION PLAN WAS NOT SIGNED DUE TO: _____ NEXT APPOINTMENT: _____

FAMILY TREE PROGRAM
SESSION__1___

YOUTH:_____ DATE OF SESSION:_____

START TIME:_____ END TIME:_____ REFERRALS PROVIDED:

SERVICE BILLED: ○ 1.5 HOUR: INTAKE (00)
○ 1 HOUR: INDIVIDUAL (01)
○ 1 HOUR: FAMILY (03)

WHO WAS PRESENT DURING SESSION:_____

WHO WAS NOT PRESENT DURING SESSION:_____

SUMMARY:

_____

THERAPIST SIGNATURE

FAMILY TREE CHECKLIST

CCD ID#:_____

Youth Name:_____ Intake Date:_____

☐ Re-Open (Former Family Tree/FAYS Client) with Original Intake/Closure Dates:_____

Family Tree Registration Packet (13 pages total – Place in chart top to bottom)	**COMPLETED**
Family Tree Checklist	
Completed Case Note #1	
Action Plan — ***Give Client Copy of Action Plan***	
Program Schedule/Parameters Form	
Authorization for Release of Confidential Information	
As Needed Social Security Refusal Form	
Registration Form (5 pages)	
Eligibility For Program Participation (1 page)	

SURVEYS COMPLETED	**DATE**
Protective Factors Pre Survey (complete at Intake)	
Protective Factors Post Survey #1 (complete at session 5/discharge if earlier than session 5)	
Program Experience Survey #1 (complete at session 5/discharge if earlier than session 5)	
Protective Factors Post Survey #2 (complete at discharge/session 10)	
Program Experience Survey #2 (complete at discharge/session 10)	

Sessions: #1_____ #2_____ #3_____ #4_____ #5_____
#6_____ #7_____ #8_____ #9_____ #10_____

Youth Skills: #1_____ #2_____ #3_____ #4_____ #5_____ #6_____ #7_____

Parent Skills: #1_____ #2_____ #3_____ #4_____ #5_____ #6_____ #7_____

Discharge Summary Date _____

Follow Up Report Date _____

THERAPIST_____ CASE MANAGER_____ AUDITOR_____

✓=MEETS REQUIREMENTS **0= DOES NOT MEET REQUIREMENTS** **N/A= NOT APPLICABLE**

Sessions 40 Minutes Or More		All Blanks Filled In		All Surveys Completed	
Family Services Provided Or Explanation Why Not		Family Attended Classes Or Explanation Why Not		Seen By Therapist Weekly Or Documented Why Not	
Progress Notes For All Services And Correct Service Was Billed		Action Plan & Case Notes Include Family Identified Goals And Tasks		Closure/Discharge Completed (All Blanks Completed)	
Case Notes Signed By All Or Explanation Why Not					

AUDITORS COMMENTS ONLY: _____

_____

_____