Family Intensive Treatment (FIT)

Referral

Parent's Last Name:________________________________ **Parent's First Name**:________________________**MI**:____

Case #: _________________________ **DOB**____/_ __/____ **SSN**:________________ **Medicaid #**:__________

☐Male ☐Female

CPI/DCM Making Referral Name & Phone Number: ____

Parent's Phone Number :________________________ **County**:_______________________

Parent's Address: ____

Eligibility Criteria (required):

☐ Caregiver meets the diagnostic criteria for a substance abuse disorder

☐ A child in the family has been determined to be "unsafe" ☐ Primary goal of reunification (for out-of-home cases)

Additional Case Information: (check one):

☐ Has a child under **non-judicial** supervision

☐ Has a child under **judicial** supervision, **in-home** with a safety plan & case management

☐ Has a child under **judicial** supervision and placed in **out-of-home** care

Priority Criteria (check all that apply):

☐ Has a child(ren) aged 10 or under (child/children's ages are ___________________)

☐ Has a child with a mental and/or physical disability ☐ Has a mental health diagnosis ☐ Had a child born substance exposed

☐ Has previously been open to DCF case management ☐ Has previously participated in substance abuse treatment

☐ Has had a previous child removed from the home ☐ Has been reunified within the past 12 months

☐ Has no reliable transportation ☐ Is a young parent (under 21) ☐Baker Act / Marchman Act in past 60 days

☐ One parent incarcerated ☐ Parent not currently employed ☐ Single Parent Household ☐ No support system

☐Other risk factor(s): ____

Notes/Remarks (include information about previous diagnoses, treatment providers and programs, etc.):

____

____

Please return completed form to FIT Supervisor Meghan McCloskey, at meghan.mccloskey@discvillage.org
Call with any questions or concerns (850) 274-2418