The Children's Services Act in Manassas

Family Assessment and Planning Team

9324 West Street, Manassas, VA 20110
Phone (703) 361-8277 x 2335
Fax (571) 921-8806

Community Policy and Management Team

REQUIREMENTS FOR SCHEDULING FAPT APPOINTMENT

Items That Must be Submitted to Scheduling Office:

1. **FAPT Transmittal form**
2. **CANS (must be a recent assessment that is no older than 30 days prior to FAPT appointment)**
3. **City of Manassas Consent to Release Information form signed by parent/guardian AND (if applicable) Court Order directing that case be brought to FAPT [paperwork will not be accepted without the signed Consent Form included]**
4. **FAPT case summation and service costs data forms**
5. **Progress and Incident report(s) (no older than 60 days)**
6. **Discharge summaries and any other relevant information that substantiates prior treatment/service efforts**
7. **Current rate sheet***
8. **Current Residential Academic Calendar [*for residential education funding requests*]***

Please request these documents from Service Provider(s)

Case Managers:

1. **Must have an unexpired certification to administer CANS. [Contact the CSA office at number shown above for instructions on obtaining certification.]**
2. **Must have a valid and signed *Request for Case Manager Account* form on file in the Manassas City CSA office. [Contact CSA office for necessary document]**
3. **Must contact Sharon Chambers at 571-377-6069 to request a FAPT appointment (all paperwork must be in to her office no later than 4:00pm on the Wednesday one week prior to the staffing date). Due to privacy regulations, paperwork must be faxed or emailed via encryption to Ms. Chamber's office. Please be sure to ask her for the correct fax number or email address.**
4. **Please note that cases will be rescheduled if all of the required paperwork is not submitted as instructed and/or if it is submitted late.**
5. **Please contact CSA office, at number shown above, with any questions.**

Revised 8/31/20

Children's Services Act *for* Youth & Families

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FAPT TRANSMITTAL FORM

Child/Youth Name:______________________________ DOB: ________________ **S.S.#:** ___________________ ***(required)***

Gender: M F *(please circle)* Race: ______________________ Hispanic: Y N *(please circle)*

Oasis Client ID# ______________________ *(for DSS cases only)*

Parent/Guardian Name(s):____

Home Address: ____

CANS Date: __________ Initial Assessment ____ Re-Assessment____ Discharge ____ *(check one)*

(Please submit a legible copy of entire CANS Report including all modules)

Does the child/youth have Medicaid insurance? Y N If yes, please provide Medicaid #: ______________________

Does the family have private insurance? Y N

If yes, please list the name of the private insurance: ____

Does child/youth have a mental health diagnosis? Y N

If yes, please state the diagnosis/(es): ____
____

Does the child/youth take prescription medications for a mental health problem? Y N

If yes, please list names of all medication(s):
____
____

Service Request Type: _____Home/Community-Based _____Residential

Is the Service Provider and/or facility, under consideration, Medicaid-certified? Y N

Agency: _______________________ Case Manager: _________________________________

Supervisor's Name: _________________________

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<u>FAPT CASE SUMMATION</u>

1. Briefly describe the **one primary issue** regarding this client that has been **present for the last 30 days.** Include examples that clearly show evidence of this issue.

____
____
____

2. Briefly describe the **top 1-3 issues** regarding this client that have been **present for 6 months or longer**.

____
____
____

3. What is the <u>long-term goal</u> for this client?

____
____
____

4. What <u>short-term objectives</u> will be pursued to aid in fulfilling the long-term goal stated above?

____
____
____

5. List the **strengths** that the client possesses. (*None is not an acceptable answer!*)

____
____
____

6. List the client's **needs.** (*Again, none is not an acceptable answer!*)

____
____
____

7. School - briefly discuss attendance, punctuality and academic performance and whether or not the client is on grade level. Be sure to include whether or not the client has an IEP and, if so, state the primary disability.

____
____
____

8. What <u>hobbies</u> does the client have and what <u>recreational pursuits</u> does the client engage in? How does the client spend his/her time? (***Include both positive and negative activities***)

____
____
____

9. Who are the people who **influence** this client? (*include both family members and non-family)*

10. Briefly discuss the **strengths** that the client's family possesses. (*For foster care clients include both biological and foster family*)

11. Briefly discuss the **weaknesses and obstacles** that impact this client's family unit. (*For foster care clients include both biological and foster family)*

12. List the service(s) that is/are being requested and briefly explain why/how this/these service(s) will benefit your client?

13. **If the request is for continued funding** please also answer the following questions:

A) What progress has been made with services received thus far?

B) What goals remain to be addressed?

C) Please discuss the extent to which parents and family have participated in services to date.

D) What community and external services will this client be connected to for on-going support?

14. Miscellaneous Comments: ___

SERVICE(S) COST DATA

Service Provider Name: ____

Business Address & Phone Number: ___________________________________
____

List the service(s) being requested and applicable rate(s):
____
____
____
____
____
____

What is the period of time for which the service(s) is/are being requested?

___1 month ___2 months ___3 months ____6 months (*DSS renewals only*)

Requested start date: ____________________

*****Please provide Provider's current rate sheet.***

***** For residential placements only, please ask Provider for current academic calendar and submit with this form..***

Case Manager's Signature: _________________ Date: ________________

Supervisor's Signature: ___________________ Date: ________________

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, ____ am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

____
(FULL PRINTED NAME OF CLIENT)

____
(CLIENT'S ADDRESS) (CLIENT'S BIRTHDATE) (CLIENTS SSN – OPTIONAL)

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:

Yes	No		Yes	No		Yes	No	
☒	☐	Assessment Information	☒	☐	Medical Diagnosis	☒	☐	Educational Records
☒	☐	Financial Information	☒	☐	Mental Health Diagnosis	☒	☐	Psychiatric Records
☒	☐	Benefits/Services Needed Planned, and/or Received	☒	☐	Psychological Records	☒	☐	Employment Records
			☒	☐	Medical Records	☒	☐	Criminal Justice Records

Other Information (write in):

I want: ____

____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And ALL of the following other agencies to be able to exchange this information, unless noted:

Public Schools
Police Department
3 Jurisdictions: City of Manassas
Health Department
Community Services Board
Prince William County
FAPT/CPMT/CSA Office (City of Manassas)
Department of Social Services
Manassas Park
Court Services Unit
Local and/or Statewide CSA offices/OCS as applicable

Are More Agencies Listed on Back? YES ☐ NO ☒

I want this information to be exchanged ONLY for the following purpose(s):

☒ Service Coordination and Treatment Planning ☐ Eligibility Determination

Other (write in): ____

I want information to be shared: (check all that apply)

☒ Written Information ☒ In Meetings or By Phone ☒ Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until: ____

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): ______________________________ Date: ______________
(CONSENTING PERSON OR PERSONS)

Person Explaining Form: ____
(Name) (Title) (Phone Number)

Witness (If Required): ____
(Signature) (Address) (Phone Number)

Updated 05/2023