Partnership
FOR CHILD HEALTH

KIDS HOPE ALLIANCE
The Jacksonville Partnership
for Children, Youth & Families

C4 Functional Family Therapy Referral Form

Referral Date:	Date Received (for internal use):

Referrals will be sent back to the referring party if the referral is not completed in its entirety

Youth:

Name: ___________________________

Preferred Name: ___________________

Age: _____

Date of Birth: ____/ ____/ ________

Sex: Male ___ Female ___ Transgender ___

Male to Female _____ Female to Male _____

Preferred Pronouns:

He/Him ___ She/Her ____ They/Them ____

Ethnicity: ____________________

Telephone Number: ______________

Guardian:

Name: ____________________________

Ethnicity: ____________________

Relation to Youth: _____________

Telephone Number: _____________

Email Address: __________________

Service Preference:

Virtual Office Home

Additional Information:

Home Address: ______________________________________ Zip Code: ____________

Youth School: ______________________________ Grade: __________

Special Education (Y/N): _________

If yes, please specify: ____

Medicaid/Insurance: ___________________________

Referring Party:

Name/Title: ______________________________________

Organization: ______________________________

Email/Telephone: __________________________

Has the family consented to services prior to submission of referral? (Y/N): ____________

Confidential Information

Other Interested Parties:

Diversion Case Manager: ____________________ Email/Phone: ____________________

Juvenile Probation Officer: ____________________ Email/Phone: ____________________

State Attorney: ____________________ Email/Phone: ____________________

Public Defender: ____________________ Email/Phone: ____________________

If referrals were made to other agencies/organizations/resources, please indicate:

Agency(s) (e.g. Child Protection, Community)	Professional (e.g. OT, Psychologist)
1.______________________________	______________________________
2.______________________________	______________________________
3.______________________________	______________________________

FFT Criteria/Eligibility

Refer to the FFT information sheet or contact the Site Director for questions regarding service eligibility

Question	Yes	No
1. Does the youth have a formal caretaker/guardian?		

If answered no, please explain:

Question	Yes	No
2. Is the family currently receiving/participating in other services for behavioral Health, mental health or and/or substance abuse?		

If answered yes, please explain:

Question	Yes	No
3. Does the youth have a diagnosed or undiagnosed neurodevelopmental condition that would interfere with his/her ability to benefit from FFT?		

If answered yes, please explain:

Question	Yes	No
4. Has the youth been classified as a sexual offender?		

If answered yes, please explain and indicate if the youth has completed psychosexual treatment:

Reason for Referral:
Please explain the dynamics of the family, behaviours exhibited by the youth, and any other pertinent information that should be known by the FFT clinician:

Delinquency History:
Please explain the youth's current involvement with the delinquency system to include history of offenses, YSL, and current delinquency status:

Documents Included With Referral Submission:

☐Facesheet ☐School Records ☐Mental Health Records/Evals ☐Substance Abuse Evaluation

☐Psychological/Psychiatric Evaluation ☐Arrest Reports ☐Other: ____________

Please email referral and all supporting documentation to: bfcjacksonville@bayskids.org

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INTERNAL USE ONLY

Referral Status (Please Indicate):

Accepted ☐ Ineligible ☐ Waitlist ☐

Referral Reviewed By: ____________________________________ Date: __________

Referral Assigned To: ____________________________________ Date: __________