Community Partnership for Children
protecting children . . . fostering family stability

BAYS
Inspiring Youth & Families

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Circuit 7 FFT Referral Form

Referral Date:

Date Received (for internal use):

County of Service: Volusia ☐ Flagler ☐ Putnam ☐

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: / /

Ethnicity: _____

Sex (Circle): Male Female Transgender

Preferred Pronouns (Circle):

He/Him She/Her They/Them

Diagnosis (Required): _____

Guardian:

Name: _____

Ethnicity: _____

Relation to Youth: _____

Telephone Number: _____

Email Address: _____

Service Preference:

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:

Case Manager: _____ Email/Phone: _____

Juvenile Probation Officer: _____ Email/Phone: _____

Child Protective Investigator: _____ Email/Phone: _____

Other: _____ 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

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

   If answered no, please explain:

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

   If answered no, please explain:

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

   If answered no, please explain:

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

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

Reason for Referral:
Please explain the dynamics of the family, behaviors 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:			
DCF Documents	School Records	Mental Health Records/Evals	Substance Abuse Evaluation
Psychological/Psychiatric Evaluation	Arrest Reports	Other: _____	

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

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INTERNAL USE ONLY

Referral Status (Please Indicate):

Accepted ☐ Ineligible/Rejected ☐ Waitlist ☐

Referral Reviewed By: _____ Date: _____

Referral Assigned To: _____ Date: _____