Pathways to Well-Being

CHILD AND FAMILY TEAM MEETING REFERRAL FORM

WHEN: Completed any time there is an identified need for a Child and Family Team (CFT) meeting for a youth in a mental health treatment program

ON WHOM: Any child/youth involved with Behavioral Health Services and a CFT meeting is requested

COMPLETED BY: BHS Provider

MODE OF COMPLETION: Form fill and submitted by fax to CFT Meeting Facilitation Program: (858) 335-3949

REQUIRED ELEMENTS: All elements of the CFT Meeting Referral Form:

Elements on Page 1:

- Agency Involvement: check appropriate boxes (all known that apply)
- Name of person making referral/completing form
- Name of referring agency
- Date of referral/form completion
- Due date of meeting (if required by Pathways To Well-Being mandated timelines)
- Referring party preference for meeting date(s) and time(s) (Priority given to youth/family schedule)

Part A:
BHS Provider only completes the following:

- Enter PSW/PO name and phone number if known
- Enter PSW/PO Supervisor name and phone number if known
- BHS Provider Program Name
- Enter BHS Provider Contact Phone
- Enter Family's primary language
- Enter Cultural considerations (Military, other cultural consideration such as values, beliefs, lifestyle, traditions, historical trauma, race, ethnicity, language, religion/spirituality, sexual orientation, gender identity expression, and/or learned behavior of a group passed on from generation to generation)

Part B:
Reason for referral: BHS Providers only consider the following:

- At Risk of Removal: (Is youth at risk for loss of current placement?)
- Change of Placement: (Is there a plan to move youth away from current living situation?)
- Pathways to Well-Being Eligible for Enhanced Services: Select Yes or No
- Mental Health Treatment Needs: (e.g., exploring additional services, warm hand-off, change in treatment focus)
- Team member request for Child and Family Team Meeting: (Any team member can make request to provider for facilitating a CFT meeting when needed)
- Other: (e.g., change in Client Plan, significant event impacting youth/family functioning)

CFT's first meeting: Select Yes or No (Is this the first CFT meeting for this youth with this provider?)

Current case status and desired meeting outcomes/goals*:* (Enter what provider would like to have addressed and accomplished at CFT meeting based upon reason for referral as listed above)

Focus Child(ren) information: (Enter Name, date of birth, caregiver name, and phone number of youth open to provider program who is the focus of the CFT meeting)

- Enter parent/guardian name, relationship, and phone number

Elements on Page 2:

Alerts: enter all known that must be reviewed prior to scheduling a CFT meeting.

Note: If any of the following items are checked, Facilitator must clear attendee with the PSW/PO before inviting to CFT meeting: history of violent behavior, history of current use of alcohol/substances, behavioral health concerns, domestic violence, current restraining order, and alleged perpetrator of sexual abuse

CFT Participants/ Required Members: List all other required members and other potential participants requested by the Provider to be invited

BILLING: Billing for gathering of information for the CFT Meeting Referral Form shall only occur when connected to a direct client service