

FCCP Organization 1 <input type="checkbox"/> Northern (NRI) 2 <input type="checkbox"/> Urban Core (UC) 3 <input type="checkbox"/> East Bay (EB) 4 <input type="checkbox"/> Washington Kent (WK)	Agency Site Code Agency Name	RI FCCP Intake Report	Family ID # <i>(mother's social security number)</i> RIFIS ID # <i>(this number is auto-assigned)</i>
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RIFIS DEMOGRAPHICS: TARGET CHILD/YOUTH INFORMATION

Name	DOB	[MM/DD/YYYY]
Street	Gender	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female
Town/City & State	Zip	Social Security No.
CHILD/ YOUTH RACE (Check all that apply)		CHILD/ YOUTH ETHNICITY (Check all that apply)
1 <input type="checkbox"/> African American/Black	Hispanic Origin 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes	
2 <input type="checkbox"/> American Indian/ Alaskan Native	If yes, identify cultural/ethnic background (check all that apply)	
3 <input type="checkbox"/> Asian	1 <input type="checkbox"/> Mexican/ Mexican American	4 <input type="checkbox"/> Dominican
4 <input type="checkbox"/> Caucasian/White	2 <input type="checkbox"/> Puerto Rican	5 <input type="checkbox"/> Central American
5 <input type="checkbox"/> Native Hawaiian/ Pacific Islander	3 <input type="checkbox"/> Cuban	6 <input type="checkbox"/> South American
6 <input type="checkbox"/> Other 7 <input type="checkbox"/> Declined to provide	7 <input type="checkbox"/> Other Hispanic origin	
CHILD/ YOUTH PRIMARY LANGUAGE (check one)		
1 <input type="checkbox"/> English	5 <input type="checkbox"/> Chinese	9 <input type="checkbox"/> Khmer
2 <input type="checkbox"/> Spanish	6 <input type="checkbox"/> Creole	10 <input type="checkbox"/> Sign Language
3 <input type="checkbox"/> Portuguese	7 <input type="checkbox"/> Russian	11 <input type="checkbox"/> Other (specify)
4 <input type="checkbox"/> Hmong	8 <input type="checkbox"/> French	Is translator needed? 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes

RIFIS DEMOGRAPHICS: FAMILY INFORMATION

Family Composition	Number of adults residing in home (including caregivers)
	Number of children (18 and under) residing in home (including target child)
	Number of children (18 and under) receiving services through the FCCP (including target child)
What is the family structure for the target child/youth's primary residence?	
1 <input type="checkbox"/> Married couple 2 <input type="checkbox"/> Unmarried couple 3 <input type="checkbox"/> Single female 4 <input type="checkbox"/> Single male 99 <input type="checkbox"/> Unable to determine	
Does the family currently reside in permanent housing? 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes	
Is either caregiver currently incarcerated? 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes	
If yes – Identify which caregiver: 1 <input type="checkbox"/> Caregiver #1 2 <input type="checkbox"/> Caregiver #2	
Does family have a DCYF Caseworker (includes child protective services or family services unit caseworker or probation officer)?	
1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes	

RIFIS FCCP OPEN/CLOSE: FCCP REFERRAL & INTAKE INFORMATION

FCCP Referral (Date & Time)	[MM/DD/YYYY]	[HR : MIN]	1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM
FCCP Open Date & Time	[MM/DD/YYYY]	[HR : MIN]	1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM
First Contact Date	[MM/DD/YYYY]		
First Face-to-Face Date with Target Child	[MM/DD/YYYY]		
First Face-to-Face Date & Time with Family	[MM/DD/YYYY]	[HR : MIN]	1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM
If not able to make face-to-face contact, indicate date & time of attempted contact(s)	[MM/DD/YYYY]	[HR : MIN]	1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM
	[MM/DD/YYYY]	[HR : MIN]	1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM
	[MM/DD/YYYY]	[HR : MIN]	1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM
Response Priority:			
1 <input type="checkbox"/> Routine Referral 2 <input type="checkbox"/> CPS Emergency 3 <input type="checkbox"/> CPS Urgent 4 <input type="checkbox"/> CPS Routine 5 <input type="checkbox"/> Crisis (without DCYF CPS Involvement)			

REFERRAL SOURCE: (check one)		
1 <input type="checkbox"/> Self-referral (child/youth)	11 <input type="checkbox"/> Law Enforcement	21 <input type="checkbox"/> Domestic Violence Shelter
2 <input type="checkbox"/> Caregiver or Family	12 <input type="checkbox"/> Community Mental Health Center	22 <input type="checkbox"/> Infant-Toddler Home Visiting Program
3 <input type="checkbox"/> Family Organization (RIPIN, PSN)	13 <input type="checkbox"/> Outpatient Mental Health Agency	23 <input type="checkbox"/> School System or Educational Agency
4 <input type="checkbox"/> DCYF Child Protect. Inv. Indicated	14 <input type="checkbox"/> Social Service Agency	24 <input type="checkbox"/> Early Care Provider (please specify)
5 <input type="checkbox"/> DCYF Child Protect. Inv. Information Service Referral	15 <input type="checkbox"/> Outpatient Alcohol/Drug Treatment Prgrm	25 <input type="checkbox"/> Early Head Start Program
6 <input type="checkbox"/> DCYF Intake Information Service Referral	16 <input type="checkbox"/> Inpatient Alcohol/Drug Treatment Prgrm	<input type="checkbox"/> Head Start Program
7 <input type="checkbox"/> DCYF Family Service Unit	17 <input type="checkbox"/> Physician/Medical Care Provider	<input type="checkbox"/> Early Intervention (Part C)
8 <input type="checkbox"/> DCYF Probation	18 <input type="checkbox"/> Partial Day Organization	<input type="checkbox"/> Preschool Special Education Program (Part B)
9 <input type="checkbox"/> DCYF Juvenile Corrections (RITS)	19 <input type="checkbox"/> State/General Hospital/Other Psychiatric Organization	<input type="checkbox"/> Other Early Care & Educ. Prgrm/Provider (incl. private child care/providers)
10 <input type="checkbox"/> Court/Corrections (except RITS)	20 <input type="checkbox"/> Homeless Shelter	25 <input type="checkbox"/> Other FCCP Organization
27 <input type="checkbox"/> Community Action Program	28 <input type="checkbox"/> Other (specify)	

RIFIS FCCP OPEN/CLOSE: FCCP INTAKE DECISION (check one)		
1 <input type="checkbox"/> Open		
2 <input type="checkbox"/> Deferred from service – family not eligible (NOTE: if this box is checked, please indicate nature of any referrals below)		
4 <input type="checkbox"/> Family declined service		
5 <input type="checkbox"/> FCCP declined to serve family (NOTE: if this box is checked, FCCP must contact DCYF to report reason)		
If family is not referred to FCCP, please indicate the nature of any referrals made for the family: (Check up to three referrals)		
1.	2.	3.
1 <input type="checkbox"/> After-school program	17 <input type="checkbox"/> Foster care	33 <input type="checkbox"/> Sexual abuse counseling
2 <input type="checkbox"/> Audiology	18 <input type="checkbox"/> Head Start	34 <input type="checkbox"/> Sexual offender counseling
3 <input type="checkbox"/> Basic needs/Financial support services	19 <input type="checkbox"/> Housing services	35 <input type="checkbox"/> Skills training
4 <input type="checkbox"/> Case mgmt service/ service coordination	20 <input type="checkbox"/> Intensive home-based case mgmt serv.	36 <input type="checkbox"/> Special educational services
5 <input type="checkbox"/> Counseling/therapy (child)	21 <input type="checkbox"/> Intensive home-based clinical services	37 <input type="checkbox"/> Specialized childcare
6 <input type="checkbox"/> Counseling/therapy (family)	22 <input type="checkbox"/> Legal Services	38 <input type="checkbox"/> Specialized instruction
7 <input type="checkbox"/> Counseling/therapy (parents)	23 <input type="checkbox"/> Maternal & child health services	39 <input type="checkbox"/> Specialized preschool
8 <input type="checkbox"/> Crisis intervention	24 <input type="checkbox"/> Medical consultation	40 <input type="checkbox"/> Specialized summer camp
9 <input type="checkbox"/> Day treatment	25 <input type="checkbox"/> Medication & monitoring	41 <input type="checkbox"/> Speech & language
10 <input type="checkbox"/> Diagnosis, evaluation & assessment	26 <input type="checkbox"/> Nutritional consultation	42 <input type="checkbox"/> Social/recreational
11 <input type="checkbox"/> Domestic violence services (perpetrator)	27 <input type="checkbox"/> Other in-school support	43 <input type="checkbox"/> Therapeutic foster care
12 <input type="checkbox"/> Domestic violence services (victim)	28 <input type="checkbox"/> Parent aide supports	44 <input type="checkbox"/> Time bank
13 <input type="checkbox"/> Drug abuse counseling (child)	29 <input type="checkbox"/> Parent education	45 <input type="checkbox"/> Transition services (DLT, ORS, DDD)
14 <input type="checkbox"/> Drug abuse counseling (parent)	30 <input type="checkbox"/> Peer Support	46 <input type="checkbox"/> Transportation
15 <input type="checkbox"/> Early intervention program	31 <input type="checkbox"/> Residential treatment	47 <input type="checkbox"/> Vocational Services
16 <input type="checkbox"/> Family Stabilization	32 <input type="checkbox"/> Respite	48 <input type="checkbox"/> Other (specify):

RIFIS FCCP OPEN/CLOSE: AGENCY INTAKE INFORMATION		
Agency Referral Date & Time	[MM/DD/YYYY]	
Agency Intake Start Date & Time	[MM/DD/YYYY]	[HR : MIN] 1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM
Has family received FCCP services previously?	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes 99 <input type="checkbox"/> Unknown	
If Yes, which agency provided the FCCP services?		

RIFIS AGENCY INTAKE: BASIC FAMILY INFORMATION	
SOURCES OF INFORMATION USED TO COMPLETE THIS FORM (Select all that apply)	
1 <input type="checkbox"/> Caregiver (child's caregiver in a family, household environment)	3 <input type="checkbox"/> Youth
2 <input type="checkbox"/> Staff-as-Caregiver (staff person who has acted as the child's day-to-day caregiver for the majority of the past 6 months)	4 <input type="checkbox"/> Case record review

RIFIS AGENCY INTAKE: PRIMARY FAMILY PAYMENT SOURCES

<input type="checkbox"/> Active Military/CHAMPUS	<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private: Tufts
<input type="checkbox"/> Federal Grant Funding	<input type="checkbox"/> Other	<input type="checkbox"/> Private: United
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Personal Resources	<input type="checkbox"/> RITE Care
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private: Blue Cross	<input type="checkbox"/> RITE Share

RIFIS AGENCY INTAKE: FUNDING/BILLING CATEGORY

<input type="checkbox"/> Behavioral Health (SED)	Date: [MM/DD/YYYY]
<input type="checkbox"/> Early Childhood Development	Date: [MM/DD/YYYY]
<input type="checkbox"/> Family Stabilization	Date: [MM/DD/YYYY]
<input type="checkbox"/> Not Applicable	Date: [MM/DD/YYYY]

RIFIS FAMILY RELATIONS: CAREGIVER #1 & #2 INFORMATION

CAREGIVER #1 INFORMATION			
Name			Relation to Child/Youth (Check one)
Street			1 <input type="checkbox"/> Parent 6 <input type="checkbox"/> Relative Foster Parent
Town/City & State	Zip		2 <input type="checkbox"/> Step-parent 7 <input type="checkbox"/> Non-relative Foster Parent
Tel (H/W)			3 <input type="checkbox"/> Adoptive Parent 8 <input type="checkbox"/> Legal Guardian
DOB	[MM/DD/YYYY]		4 <input type="checkbox"/> Grandparent 9 <input type="checkbox"/> Other (specify)
Gender	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female		5 <input type="checkbox"/> Other Relative
CAREGIVER #1 RACE (Check <u>all</u> that apply)		CAREGIVER #1 ETHNICITY (Check <u>all</u> that apply)	
1 <input type="checkbox"/> African American/Black		Hispanic Origin 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes	
2 <input type="checkbox"/> American Indian/ Alaskan Native		If yes, identify cultural/ethnic background (check all that apply)	
3 <input type="checkbox"/> Asian		1 <input type="checkbox"/> Mexican/ Mexican American	4 <input type="checkbox"/> Dominican
4 <input type="checkbox"/> Caucasian/White		2 <input type="checkbox"/> Puerto Rican	5 <input type="checkbox"/> Central American
5 <input type="checkbox"/> Native Hawaiian/ Pacific Islander		3 <input type="checkbox"/> Cuban	6 <input type="checkbox"/> South American
6 <input type="checkbox"/> Other 7 <input type="checkbox"/> Declined to provide		7 <input type="checkbox"/> Other Hispanic origin	

RIFIS FAMILY RELATIONS: OTHER DEMOGRAPHIC INFORMATION FOR CAREGIVER #1

CAREGIVER #1 PRIMARY LANGUAGE (Check one)

1 <input type="checkbox"/> English	5 <input type="checkbox"/> Chinese	9 <input type="checkbox"/> Khmer
2 <input type="checkbox"/> Spanish	6 <input type="checkbox"/> Creole	10 <input type="checkbox"/> Sign Language
3 <input type="checkbox"/> Portuguese	7 <input type="checkbox"/> Russian	11 <input type="checkbox"/> Other (specify)
4 <input type="checkbox"/> Hmong	8 <input type="checkbox"/> French	Is translator needed? 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes

CAREGIVER #1 EDUCATION LEVEL (Check one)

CAREGIVER #1 EMPLOYMENT STATUS (Check one)

1 <input type="checkbox"/> 8 th Grade or Less	6 <input type="checkbox"/> College Graduate (2-year program)	1 <input type="checkbox"/> Part Time (20 hrs or less/week)
2 <input type="checkbox"/> Some High School	7 <input type="checkbox"/> College Graduate (4-year program)	2 <input type="checkbox"/> Full Time (Over 20 hrs/week)
3 <input type="checkbox"/> High School Graduate/ GED	8 <input type="checkbox"/> Advanced Degree (e.g., RN, MA, MS, Ph.D., MD)	3 <input type="checkbox"/> Disabled
4 <input type="checkbox"/> Trade School/Vocational Training	9 <input type="checkbox"/> Other (specify)	4 <input type="checkbox"/> Unemployed
5 <input type="checkbox"/> Some College		5 <input type="checkbox"/> Retired
		6 <input type="checkbox"/> Not in workforce (e.g., student)

CAREGIVER #2 INFORMATION		Is there a second caregiver? 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes	
Name		Relation to Child/Youth (Check <u>one</u>)	
Street		1 <input type="checkbox"/> Parent	6 <input type="checkbox"/> Relative Foster Parent
Town/City & State	Zip	2 <input type="checkbox"/> Step-parent	7 <input type="checkbox"/> Non-relative Foster Parent
Tel (H/W)		3 <input type="checkbox"/> Adoptive Parent	8 <input type="checkbox"/> Legal Guardian
DOB	[MM/DD/YYYY]	4 <input type="checkbox"/> Grandparent	9 <input type="checkbox"/> Other (specify)
Gender	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	5 <input type="checkbox"/> Other Relative	
CAREGIVER #2 RACE (Check <u>all</u> that apply)		CAREGIVER #2 ETHNICITY (Check <u>all</u> that apply)	
1 <input type="checkbox"/> African American/Black		Hispanic Origin 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes	
2 <input type="checkbox"/> American Indian/ Alaskan Native		If yes, identify cultural/ethnic background (check all that apply)	
3 <input type="checkbox"/> Asian		1 <input type="checkbox"/> Mexican/ Mexican American	4 <input type="checkbox"/> Dominican
4 <input type="checkbox"/> Caucasian/White		2 <input type="checkbox"/> Puerto Rican	5 <input type="checkbox"/> Central American
5 <input type="checkbox"/> Native Hawaiian/ Pacific Islander		3 <input type="checkbox"/> Cuban	6 <input type="checkbox"/> South American
6 <input type="checkbox"/> Other 7 <input type="checkbox"/> Declined to provide		7 <input type="checkbox"/> Other Hispanic origin	

RIFIS FAMILY RELATIONS: OTHER DEMOGRAPHIC INFORMATION FOR CAREGIVER #2		
CAREGIVER #2 PRIMARY LANGUAGE (Check <u>one</u>)		
1 <input type="checkbox"/> English	5 <input type="checkbox"/> Chinese	9 <input type="checkbox"/> Khmer
2 <input type="checkbox"/> Spanish	6 <input type="checkbox"/> Creole	10 <input type="checkbox"/> Sign Language
3 <input type="checkbox"/> Portuguese	7 <input type="checkbox"/> Russian	11 <input type="checkbox"/> Other (specify)
4 <input type="checkbox"/> Hmong	8 <input type="checkbox"/> French	Is translator needed? 1 <input type="checkbox"/> no 2 <input type="checkbox"/> yes
CAREGIVER #2 EDUCATION LEVEL (Check <u>one</u>)		CAREGIVER #2 EMPLOYMENT STATUS (Check <u>one</u>)
1 <input type="checkbox"/> 8 th Grade or Less	6 <input type="checkbox"/> College Graduate (2-year program)	1 <input type="checkbox"/> Part Time (20 hrs or less/week)
2 <input type="checkbox"/> Some High School	7 <input type="checkbox"/> College Graduate (4-year program)	2 <input type="checkbox"/> Full Time (Over 20 hrs/week)
3 <input type="checkbox"/> High School Graduate/ GED	8 <input type="checkbox"/> Advanced Degree (e.g., RN, MA, MS, Ph.D., MD)	3 <input type="checkbox"/> Disabled
4 <input type="checkbox"/> Trade School/Vocational Training	9 <input type="checkbox"/> Other (specify)	4 <input type="checkbox"/> Unemployed
5 <input type="checkbox"/> Some College		5 <input type="checkbox"/> Retired
		6 <input type="checkbox"/> Not in workforce (e.g., student)

RIFIS ASSESSMENTS AND FORMS: RISK/CRISIS PLANNING COMPLETED			
Risk Management Plan (Date & Time)	[MM/DD/YYYY]	[HR : MIN] 1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM	<input type="checkbox"/> Not Applicable
Initial Crisis Plan (Date & Time)	[MM/DD/YYYY]	[HR : MIN] 1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM	<input type="checkbox"/> Not Applicable

RIFIS INTAKE 1A, SECTION 1: FCCP ELIGIBILITY CRITERIA	
Age	1 <input type="checkbox"/> Under 18 2 <input type="checkbox"/> 18-21
Identify rationale for eligibility if 18-21	
Inclusionary Criteria: Child/Youth meets at least one of the following criteria (check <u>all</u> that apply) <input type="checkbox"/> Family is at risk for child abuse, neglect, and/or dependency or DCYF involvement <input type="checkbox"/> Child/youth meets criteria for a serious emotional disturbance (SED) or diagnosis under the DSM-IV or DC:0-3 <input type="checkbox"/> Child/youth is concluding a sentence at the RITS or is leaving Temporary Community Placement (TCP)	

RIFIS INTAKE 1A, SECTION 2: PRESENTING CONCERNS

TARGET CHILD/YOUTH PRESENTING CONCERNS (Check up to 5 reasons)

1.	2.	3.	4.	5.
Child/youth:			6. Other:	
1 <input type="checkbox"/> Alcohol/drug use			7 <input type="checkbox"/> Recreational needs	
2 <input type="checkbox"/> Criminal/delinquent behavior			8 <input type="checkbox"/> Peer relationship concerns	
3 <input type="checkbox"/> Developmental disability/delay			9 <input type="checkbox"/> School concerns	
4 <input type="checkbox"/> Health concerns/disability			10 <input type="checkbox"/> Speech/language concerns	
5 <input type="checkbox"/> Maltreatment (abuse or neglect)			11 <input type="checkbox"/> Stressful life events	
6 <input type="checkbox"/> Mental health/behavioral health concerns			12 <input type="checkbox"/> Other (specify)	

CAREGIVER/FAMILY PRESENTING CONCERNS (Check up to 5 reasons)

1.	2.	3.	4.	5.
Caregiver/family:			6. Other:	
1 <input type="checkbox"/> Alcohol/drug use			9 <input type="checkbox"/> Work-related concerns	
2 <input type="checkbox"/> Criminal/delinquent behavior			10 <input type="checkbox"/> Stressful life events	
3 <input type="checkbox"/> Developmental disability			11 <input type="checkbox"/> Housing/shelter needs	
4 <input type="checkbox"/> Health concerns /disability			12 <input type="checkbox"/> Other basic needs (e.g., food, clothing, transportation)	
5 <input type="checkbox"/> Mental health concerns			13 <input type="checkbox"/> Family in crisis (as defined in practice standards)	
6 <input type="checkbox"/> Respite needs			14 <input type="checkbox"/> Family access to services	
7 <input type="checkbox"/> Family relationship concerns			15 <input type="checkbox"/> Other (specify)	
8 <input type="checkbox"/> Family/domestic violence				

RIFIS INTAKE 1A, SECTION 3: ADDITIONAL FAMILY INFORMATION

FAMILY CASH INCOME SOURCES (Check all that apply)

FAMILY NON-CASH INCOME SOURCES (Check all that apply)

<input type="checkbox"/> Employment earnings	<input type="checkbox"/> Other retirement/pension	<input type="checkbox"/> Food stamps
<input type="checkbox"/> Unemployment benefits	<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> Medicaid/RITE Care
<input type="checkbox"/> TANF/TANF "child only"/FIP	<input type="checkbox"/> Foster care payments	<input type="checkbox"/> Housing subsidy/public housing
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	<input type="checkbox"/> Income from spouse/family/friends (including alimony or child support)	<input type="checkbox"/> Heating Assistance
<input type="checkbox"/> Social Security Retirement (OASI)	<input type="checkbox"/> Other cash income	<input type="checkbox"/> WIC (Women, Infants, & Children Program)
<input type="checkbox"/> Veterans Association (VA Pension)	<input type="checkbox"/> No cash income	<input type="checkbox"/> Other non-cash income
		<input type="checkbox"/> No non-cash income

RIFIS INTAKE 1B, SECTION 4: TARGET CHILD/ YOUTH LIVING SITUATION

(Indicate number of days in each setting during past 90 days – TOTAL DAYS MUST EQUAL 90)

Date Completed: [MM/DD/YYYY]		
___ Independent living with friend	___ Supervised independent living	___ Group emergency shelter
___ Two biological parents	___ Relative foster care	___ Residential treatment
___ Biological mother	___ Non-relative foster care	___ Medical hospital
___ Biological father	___ Specialized foster care (includes therapeutic foster care)	___ Drug/Alcohol rehabilitation center
___ School dormitory		___ Inpatient psychiatric hospital
___ Home of a relative	___ Individual home emergency shelter	___ Juvenile detention/youth corrections
___ Adoptive home	___ Group home	___ Adult correctional facility
___ Home of a family friend	___ Vocational center	

RIFIS INTAKE 1B, SECTION 5: DIAGNOSTIC EVALUATION

Does the child/youth have a DSM-IV diagnosis?
 1 No 2 Yes 3 Pending 4 Unknown

Additional Information

1. Duration of Identified Diagnosis (check one)	1 <input type="checkbox"/> Longer than 1 year	2 <input type="checkbox"/> Potential for longer than 1 year	
2. Risk Status for Out-of-Home Placement (check one)	1 <input type="checkbox"/> Currently in out-of-home placement	2 <input type="checkbox"/> At risk for out-of-home placement	
3. Presence of functional impairments (check all that apply)	1 <input type="checkbox"/> Home	2 <input type="checkbox"/> School	3 <input type="checkbox"/> Community
4. Is child in need of multi-agency service?	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	

RIFIS INTAKE 1C, SECTION 6: TARGET CHILD/YOUTH EDUCATIONAL INFORMATION

TYPE OF EDUCATIONAL PLACEMENT (Check One)	CURRENT GRADE IN SCHOOL (Check <u>one</u> – if summer indicate rising grade)	
1 <input type="checkbox"/> Early childhood educational setting (not including day care)	1 <input type="checkbox"/> Preschool	10 <input type="checkbox"/> Eighth grade
2 <input type="checkbox"/> Regular educational placement	2 <input type="checkbox"/> Kindergarten	11 <input type="checkbox"/> Ninth grade
3 <input type="checkbox"/> Special day school	3 <input type="checkbox"/> First grade	12 <input type="checkbox"/> Tenth grade
4 <input type="checkbox"/> Home-bound instruction	4 <input type="checkbox"/> Second grade	13 <input type="checkbox"/> Eleventh grade
5 <input type="checkbox"/> Residential school	5 <input type="checkbox"/> Third grade	14 <input type="checkbox"/> Twelfth grade
6 <input type="checkbox"/> Vocational school	6 <input type="checkbox"/> Fourth grade	15 <input type="checkbox"/> High School Graduate (or GED)
7 <input type="checkbox"/> Self-contained special education	7 <input type="checkbox"/> Fifth grade	16 <input type="checkbox"/> Enrolled in 2-year college program
8 <input type="checkbox"/> Other special educational placement	8 <input type="checkbox"/> Sixth grade	17 <input type="checkbox"/> Enrolled in 4-year college program
9 <input type="checkbox"/> Not enrolled in school/preschool	9 <input type="checkbox"/> Seventh grade	99 <input type="checkbox"/> Unknown
10 <input type="checkbox"/> Other (specify):		

School district responsible for child/youth

Name of school child/youth is attending

Is child/youth involved in an early intervention program?
 1 No 2 Yes 99 Unknown

Are there identifiable school-related concerns about the child/youth in the following areas:

a. Learning problems	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown
b. Behavior problems	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown
c. Attendance	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown
d. Other concerns	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown
Has the child/youth had a special education evaluation?	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown
Does the child/youth have an Individual Educational Plan (IEP)?	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown
Does the child/youth have a 504 accommodation plan?	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown
If the child/youth is 14 or older is there a Transitional Plan in the IEP?	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown

RIFIS INTAKE 1C, SECTION 7: TARGET CHILD/ YOUTH LEGAL SYSTEM INVOLVEMENT INFORMATION

Has child/ youth ever been...				If yes, age of first occurrence
a. arrested by the police for breaking the law	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown	_____
b. convicted of a crime or offense in court	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown	_____
c. in a detention center	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown	_____
d. incarcerated	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown	_____
e. on probation	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown	_____
f. on parole	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	99 <input type="checkbox"/> Unknown	_____

RIFIS INTAKE 1C, SECTION 8: ADDITIONAL INFORMATION FOR TARGET CHILD/ YOUTH INFORMATION

Has child/youth had a psychiatric hospitalization within the 6-months prior to this intake? 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes 99 <input type="checkbox"/> Unknown
Does child/youth have a medical home (place where caregivers usually take him or her for health care) or a primary care provider? 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes 99 <input type="checkbox"/> Unknown

RIFIS: DIAGNOSIS DETAIL

Has a diagnostic evaluation been completed with the target child? 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes 99 <input type="checkbox"/> Unknown	
IF YES, was this evaluation completed during the FCCP Intake/Engagement period? 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes 99 <input type="checkbox"/> Unknown	
Date of most recent multi-axial diagnostic evaluation	[MM/DD/YYYY]
Who completed the diagnosis?	1 <input type="checkbox"/> Child Psychiatrist 2 <input type="checkbox"/> General Psychiatrist 3 <input type="checkbox"/> Child Psychologist 4 <input type="checkbox"/> General Psychologist 5 <input type="checkbox"/> Licensed Independent Clinical Social Worker 6 <input type="checkbox"/> Primary Care Physician 7 <input type="checkbox"/> Other 99 <input type="checkbox"/> Unknown

Axis I: Clinical Disorders		
Axis Ia:	Diagnostic code	DSM name
Axis Ib:	Diagnostic code	DSM name
axis Ic:	Diagnostic code	DSM name
Axis Id:	Diagnostic code	DSM name

Axis II: Personality Disorders and Mental Retardation		
Axis 2a:	Diagnostic code	DSM name
Axis 2b:	Diagnostic code	DSM name
Axis 2c:	Diagnostic code	DSM name
Axis 2d:	Diagnostic code	DSM name

Axis III: General Medical Condition (ICD-9-CM name):		
Axis 3a:	Diagnostic code	Name
Axis 3b:	Diagnostic code	Name
Axis 3c:	Diagnostic code	Name
Axis 3d:	Diagnostic code	Name

Axis IV: Psychosocial and Environmental Problems (check <u>all</u> that apply)		
<input type="checkbox"/> Problems with primary support group	<input type="checkbox"/> Occupational problems	<input type="checkbox"/> Problems with access to health care services
<input type="checkbox"/> Problems related to social environment	<input type="checkbox"/> Housing problems	<input type="checkbox"/> Problems related to interaction with legal system
<input type="checkbox"/> Educational Problems	<input type="checkbox"/> Economic problems	<input type="checkbox"/> Other psychosocial/environmental problems

Axis V. (GAF, CGAS)	GAF	CGAS
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Name of person completing this form (print)	_____
Signature	_____
Today's Date	[MM/DD/YYYY]
Telephone	