LUTHERAN Community Services NORTHWEST

Spokane County FOCIS Referral Form

Family Outreach Crisis Intervention Services (FOCIS Program):
Client is currently enrolled and active in Medicaid. Enrollment in Medicaid is required for FOCIS. Client must currently have an outpatient counselor they can return to when services with FOCIS has been completed. Services with FOCIS are high intensity, up to 12 hours per week, and limited to 30 days. There is, however, no limit to the number of times FOCIS can be accessed as long as the child qualifies for the services.

Date of Referral:			
Child/Youth Information			
Child/youth Name:		Date of Birth:	
Parent/Guardian:		Phone #:	
Address:			
Provider One #:			
Current School:		Phone #:	
Grade:		School District:	
Primary Medical Doctor:		Phone#:	
Current Psychiatric Diagnosis:			
Current Psychotropic Medications:			
Social Worker Name:			

Referring Agency Information			
Agency:		Phone #:	
Provider name:		CLIP/PCCA	☐ Yes ☐ No

Special Considerations

Risk factors (please check all that apply):

☐ Physical aggression	☐ Sexualized behavior	☐ Delusions/hallucinations
☐ Past suicide attempt	☐ Suicidal ideation	☐ Homicidal ideation
☐ Drug use/abuse	☐ Fire starting	☐ Animal abuse

Reasons for referral (e.g. risk factors, problem behavior, imminent issues)

Family Agreement

We understand that our family is being considered for referral to the _____program. This program is intended to divert from, or assist in stepping down from, psychiatric hospitalization. We understand that the _____ program is an **intensive, in-home**, **family counseling program**. Therapists typically meet with family members **3-5 times per week** (more if needed), for a total of **40 or more face-to-face contact hours over 4 weeks**. Therapists work with family members to develop a service plan that meets the needs of family members, and that decreases the likelihood of hospitalization. If approved for services, we agree to:

Be available for an intake session within 24 hours of approval;
Be available to meet with the assigned therapist (typically 3-5 times per week, as described above).
For FOCIS only: Agree to having a therapeutic aide (TA) to assist therapist with the applications of skills, interventions **<u>up to 12 hours per week in home</u>

Signature: _____ Date: _____
Parent

Signature: _____ Date: _____
Youth

Provider Agreement

As primary therapist/counselor requesting ancillary services I agree to actively participate in treatment and discharge planning. I will maintain regularly scheduled therapy sessions in conjunction with ancillary treatment goals, and to maintain regular contact with ancillary therapist.

Signature: _____ Date: _____

Provider: _____