

## **FACIT REFERRAL AND INTAKE PROCESS**

*The FACIT Program provides mental health services to students who are experiencing behavioral or emotional needs that are interfering with their ability to succeed in school. These behaviors include but are not limited to physical and/or verbal aggression, threatening behaviors, harm to self, failing grades, non-compliance, mental health diagnosis, failure to follow instructions, etc.*

### **Referral Process**

1. Establish a school contact person who is knowledgeable regarding student's performance and needs and is willing and able to work collaboratively on a weekly basis with the FACIT staff.
2. Obtain parental consent to release information to CCSA/FACIT.
3. Complete FACIT referral form and submit to Kay Thuecks at CCSA, 333 E. Washington Street, Suite 2100, West Bend, WI 53095.
4. Kay will review the referral for appropriateness and ascertain if the referred student is receiving other services through Washington County. If appropriate, Kay will forward the referral to the FACIT Program Coordinator.
5. The referral will receive a high, moderate or low priority ranking based on information provided. Factors examined will include behaviors displayed by student in school, risk factors, academic performance, mental health diagnosis, past hospitalization/institutionalization, and involvement or access to other mental health services, etc.
6. If the program has an opening, the highest ranked student will be assigned to a FACIT therapist who will proceed with the intake process. In no space is available, the identified school contact person will be informed that the student will be placed on the program waiting list.

### **Intake Process**

*Note: Due to the nature of FACIT's school based program, FACIT therapists often have limited times available in their schedules to meet with students. Although FACIT considers academic concerns, a number of students will miss academic classes to attend FACIT therapy appointments. If you do not want this student to miss academic classes to attend therapy sessions, please address this concern with the FACIT therapist when s/he contacts you to schedule an intake meeting. The therapist can provide you with a list of the times s/he is available to meet with the referred student. If the therapist's schedule cannot accommodate to the specific needs of the referred student, FACIT staff will recommend that the school refer the student to an outpatient therapist who is available to work with the student outside of school hours*

1. The FACIT therapist will contact the identified school contact person from the referral form and request the school host an intake meeting. The school contact person and FACIT therapist will determine together possible meeting dates and times.
2. The school contact person will invite the student, parents/guardians, and other pertinent individuals to attend the intake meeting
3. The school contact person will confirm the date, time and location with the FACIT therapist and other pertinent individuals.

4. At the intake meeting, the FACIT therapist will explain the program and invite the student and the parents/guardians to participate.
5. If the student and family are interested in participating in the FACIT program, the student, parents/guardians, and the school contact person will identify student needs and develop specific goals with the FACIT therapist for enhanced school performance.
6. The FACIT therapist will establish the degree to which the parents/guardians want to be involved in their child's treatment (i.e. monthly phone call, face to face meetings, and/or family therapy).
7. FAC IT staff will obtain parental consent and releases.
8. The school contact person and the FACIT therapist will determine a regular day, time and location for the weekly individual therapy to occur.
9. The FACIT therapist and the school contact person will establish a regular weekly time to communicate regarding the student's performance and progress.
10. Services begin.

**FACIT REFERRAL FORM**

Missing information on this form will result in a delay of processing. FACIT staff will return the form so that missing information can be provided.

**Referral Source**

Name of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

School Contact Person Name: \_\_\_\_\_ Phone: \_\_\_\_\_

School Administrator Authorization (if needed): \_\_\_\_\_

**Identifying Information:**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

Gender: M F Grade: \_\_\_\_\_ School: \_\_\_\_\_

School Address: \_\_\_\_\_ School Phone #: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Parents/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone: (h) \_\_\_\_\_ (h) \_\_\_\_\_

(w) \_\_\_\_\_ (w) \_\_\_\_\_

**Reason for Referral:**

Describe the student's behaviors that have resulted in this referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the student's strengths and weaknesses:

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If the student is in special education, please circle which distinction(s):

DD, S/L, ED, LD, CD, PDD, Section 504 ADD/H, Other: \_\_\_\_\_

Circle Yes or No, if Yes, please include a copy of the following:

|                           |        |
|---------------------------|--------|
| Psychological Evaluation: | Yes/No |
| Social Work Evaluation    | Yes/No |
| IEP:                      | Yes/No |
| M-Team Evaluation:        | Yes/No |
| Section 504 Evaluation:   | Yes/No |

In your opinion are there significant family issues that are interfering with the student's performance at school? If so, please explain.

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In your opinion are there significant community issues that are interfering with the student's performance at school? If so, please explain.

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In your opinion are there significant mental health issues that are interfering with the student's performance at school? If so, please explain.

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To your knowledge, is the student receiving any other mental health services?

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What specific behaviors would have to be improved in order for the student to be discharged from FACIT services? Please clearly define expected behavioral/emotional goals and outcomes.

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Additional Comments

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**School Data\***

In the past **three months**, how many days was the student (if you are unable to gather data from a 3 month period – please indicate length of time that is measured \_\_\_\_\_):

suspended? in-school suspensions \_\_\_\_\_ out of school suspensions \_\_\_\_\_ (*number of days suspended*)

absent? excused \_\_\_\_\_ unexcused \_\_\_\_\_ (**not including suspensions**)

involved in police intervention at the school? \_\_\_\_\_

involved in a classroom behavioral intervention (i.e. sent out of class, sent to office, sent home for the day, completed O.I. form, time out, consequence imposed/loss of privilege etc. )?

\_\_\_\_\_

please describe intervention: \_\_\_\_\_

please estimate % of time during a typical day that the primary school staff person spends dealing with this student's behavior (including direct intervention, calls to parents, staffings, paperwork etc.) \_\_\_\_\_%

Number of academic subjects the student is in? \_\_\_\_\_

Of those, how many is the student passing? \_\_\_\_\_ Dates grades received? \_\_\_\_\_

*\*Collection of this data is vital to program evaluation. Please fill out completely and accurately regarding the student's performance in the last 3 months. It will be compared to performance at discharge and 6 months after discharge from FACIT.*

You will be notified within 10 days of the status of your referral

**Please return this form to: Kay Thuecks, Mental Health/AODA Coordinator  
CCSA  
333 E. Washington St., Suite 2100  
West Bend, WI 53095**