Charlottesville – Albemarle Family Treatment Court (FTC)
Initial Eligibility Referral Form

Parent Full Name (First, Middle, Last):_____**SSN:**_____ **DOB:**_____

Mailing Address:_____ **Zip Code:**_____

Parent's Phone(s): Cell:_____ **ALT:**_____ **Court Case Number:** _____

Parent's Email: _____ Parent's Race: _____

Child's Name:_____ **Placement:**_____ **D.O.B.:**_____ **SSN:**_____

Child's Name:_____ **Placement:**_____ **D.O.B.:**_____ **SSN:**_____

Child's Name:_____ **Placement:**_____ **D.O.B.:**_____ **SSN:**_____

Child's Name:_____ **Placement:**_____ **D.O.B.:**_____ **SSN:**_____

Child's Name:_____ **Placement:**_____ **D.O.B.:**_____ **SSN:**_____

DSS Worker:_____ **DSS plans to pay for services, if appropriate?** Y N

Participant will begin treatment once assessed/assigned by Region Ten and DSS funding letter is received? Y N

Participant has insurance? Y N **Name of insurance(s)**_____

Are there domestic violence issues in this case? Y N **Housing Issues?** Y N **Other?**_____

Current Driver's License? Y N OR **Suspended License?** Y N **Has parent had prior termination of parental rights?** Y N

GAL:_____ **Phone:**_____

Therapist/Agency:_____ **Phone:**_____

Mom's Attorney:_____ **Phone:**_____

Dad's Attorney:_____ **Phone:**_____

Other Providers/Agencies:_____

I. PRESUMPTIVE QUALIFYING CHARACTERISTICS:

___ There is a Civil Petition for: (Circle one) abuse /neglect custody protective order CHINS services or supervision ; AND,

___ Individual is the primary caregiver of a child at risk of or removed from the home, and is known to have a substance abuse issue.

Collateral information (i.e., legal involvement, police involvement, other indicators that will help assess level of need):_____

_____

Check appropriate line(s) for this referral:

___ Individual tested positive for drugs. Drug(s)/Date(s):_____

___ Individual states that s/he is a drug user. Drug(s) of choice:_____

___ Individual's family, friends, attorney, etc. state that s/he is a drug user. Behaviors witnessed:_____

_____

___ Individual is a voluntary participant

___ Does the individual participate in a methadone/suboxone maintenance program.

II. DISQUALIFYING CHARACTERISTICS:

___ Individual is not a resident of the City of Charlottesville or County of Albemarle, Madison, Greene, Louisa, Nelson, or Fluvanna.

___ Individual is under the age of 18 years.

___ Individual has been convicted of an offense which constitutes felony assault or felony bodily wounding resulting in serious bodily injury where the victim of the offense was a child of the individual, or a child who resided with the individual, or another family member who resided with the individual at the time of the offense.

___ Individual has been convicted of an offense which constitutes sexual assault where the victim of the offense was a child of the individual, or a child who resided with the individual, or another family member who resided with the individual at the time of the offense.

___ Individual has been convicted of an offense which constitutes murder or voluntary manslaughter, or a felony attempt, conspiracy, or solicitation to commit any such offense where the victim of the offense was a child of the individual, or a child who resided with the individual, or another family member who resided with the individual at the time of the offense.

___ Individual is incompetent, or is suffering from an unstabilized mental disorder, or has demonstrated a failure to follow a medical regime of treatment for a mental disorder.

___ Individual has functional or cognitive impairments that would inhibit effective participation in the program.

___ Individual suffers from advanced terminal illness.

___ Other:_____

Brief narrative of how case was referred to DSS:

_____

_____

_____

_____

_____

_____

_____

_____

Where is this case in terms of the time line for the dependency matters? FTC is generally 12 months.

_____

_____

_____

Please attach IFSP or Authorization Date: _____

Preparer's Signature/Agency/Title:_____

Email:_____ **Phone:**_____ **Date:**_____

Email completed form and info to: Ms. Leslie A. Pryor, FTC Coordinator Leslie.Pryor@regionten.org **Phone:** (434) 906 – 4730

PLEASE BE REMINDED THAT FTC IS A VOLUNTARY PROGRAM

_____

Date Received:_____ **Eligible for Consideration:** Y___ N___ **Date of Assessment:**_____ **Date of Eligibility:**_____

Date Reviewed for Eligibility:_____ Accepted / Rejected **If rejected, rationale for rejection:**_____

updated 2/27/2023