APPLICATION FOR FAMILY THERAPY - INTENSIVE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
WEST CENTRAL HUMAN SERVICE CENTER
SFN 369 (10-2010)

Clear Fields

Family Therapy - Intensive
(Intensive In-Home Services)

The purpose of Family Therapy - Intensive Services is to provide therapy to families who have at least one child in the home at imminent risk of being placed out of the home. The therapy modalities will include assessment, family therapy, marital therapy, individual therapy, and crisis intervention. The therapy modalities will occur in the family's home, the child's school, or within the family's community. Initially, families commit to frequent and intense therapy services, with services slowly decreasing in frequency and intensity as the family begins to accomplish the treatment goals they set for themselves. This service may or may not also include Parent Aide Services.

Parent Aide Services

Parent Aide Services is a service to encourage, teach and assist parents to develop independence and self-reliance within their community by helping parents to identify formal and informal resources or supports in their community. This may include teaching parenting skills, budgeting, and household management.

DISCLAIMER: Please be aware that should we be able to offer Family Therapy - Intensive services to your family, we will require that ALL firearms be safely secured and in locked storage.

PROVIDER INFORMATION - If the family is being referred by another social service/mental health agency, the worker should fill out the following:

Primary Client Name		Telephone Number	
Address	City	State	Zip Code
Custodian		Telephone Number	

1. Describe the focus of working with the family (what has worked - what doesn't work).

2. Risk Factors (Check any that pertain)

- ☐ Child Abuse/Neglect
- ☐ Law Violations (domestic violence)
- ☐ Physical/Developmental Disabilities
- ☐ Substance Abuse
- ☐ Rules Violations
- ☐ Parent/Child Discord
- ☐ Severe Mental Illness
- ☐ Prior Placement
- ☐ Other

3. Referral Reasons

- ☐ Child Abuse/Neglect
- ☐ Services Required
- ☐ Court Ordered (JC/DJS or Social Service Case Management)
- ☐ Services Recommended
- ☐ Reunification
- ☐ Other

4. Does the family have a history of domestic violence?
☐ No ☐ Yes

Does the family have a history of addiction?
☐ No ☐ Yes - List Who

Does the family have a history of abuse?
☐ No ☐ Yes - List Who (Victim/Perpetrator)

5. Do you want to introduce the family therapist to the family or do you want the family therapist to meet the family on their own?

6. Describe who is on the team and your perception of how well the family works with helping agencies.

FAMILY INFORMATION (Please have family complete.)

Checklist of behaviors occurring in the home by child (Check ALL that apply.)

☐ Hitting	☐ Biting	☐ Not Communicating	☐ Staying Out All Night	☐ Defiant
☐ Kicking	☐ Talking Back	☐ Demanding	☐ Poor Choice in Friends	☐ Truancy
☐ Door Slamming	☐ Spitting at People	☐ Refusing to do Chores	☐ Stealing	☐ Blames Others
☐ Running Away	☐ Pulling Hair	☐ Lying	☐ Fire Setting	☐ Destruction of Property
☐ Hurting Animals	☐ Yelling/Screaming	☐ Refusal to Follow Curfew	☐ Impulsive	☐ Sexual Concerns
☐ Hurting Self	☐ Uncontrollable Behavior	☐ Doesn't Listen to Direction	☐ Disruptive	☐ Other (Explain)
☐ Hurting Others	☐ Whining	☐ Alcohol/Drug Use	☐ Hostile	_____

Check who is involved with the family

☐ County Social Services	☐ Individual Therapist	☐ Parent Aide	☐ Probation Officer
☐ Division of Juvenile Services	☐ Headstart	☐ Neighborhood Network	☐ Tutor
☐ Juvenile Court	☐ Residential Treatment Center	☐ Serious Mental Illness Case Manager	☐ Other (Explain)
☐ Addiction Counselor	☐ Group Home	☐ Care Coordinator	_____
☐ Psychiatrist	☐ Foster Family	☐ Developmental Disabilities Case Manager	
☐ Psychologist	☐ Mentor/Case Aide		

Check the problems you have with parenting your child

☐ Disagree on Discipline Style	☐ Not Enough Support From Others	☐ Physical Disability
☐ Current Substance Abuse Problems	☐ Power Struggles with Children	☐ Unemployment
☐ Overwhelmed	☐ Difficulty Being Consistent	☐ Other (Explain)
☐ Household Rules	☐ Past/Current Mental Health Issues	_____

Date	Referred By		Referral Agency Telephone Number	
Family Street Address		City	State	Zip Code
Current Street Address		City	State	Zip Code
Family Telephone Number	Has family received In-Home Services in the past? ☐ No ☐ Yes - When	Has family received Medical Assistance? ☐ No ☐ Yes	Is anyone in the family a current West Central HSC client? ☐ No ☐ Yes	

PARENTS:

NAME	AGE	BIRTHDATE

Mother's Work Telephone Number	Father's Work Telephone Number	Race

CHILDREN:

NAME	SEX	AGE	BIRTHDATE	GRADE

Current physical and legal custody of your child/children is with:
Describe who is at risk of being placed out of the home or who is in need of being reunified and why.
Describe your child's past and current legal history.
Describe your family's goal in receiving Intensive In-Home Services.