HEALTH SYSTEMS

FIT Continued Enrollment Staffing Form

Provider Name: _____ **Date**: _____

Consumer Information:	
Name:	
DOB:	SSN:
Treatment Details:	
Date of FIT Admission:	
Estimated length of continued treatment: ◉ 1 Month ○ 2 Months ○ 3 months	
Tentative Discharge Date:	
Current FIT Treatment Plan Goals and Progress:	

Goal:	○ Completed ◉ Not Completed
Goal:	○ Completed ◉ Not Completed
Goal:	○ Completed ◉ Not Completed

Evidence Based Practices (EBP) Utilized during FIT Treatment:

☐ Cognitive-Behavioral Therapy ☐ Wraparound ☐ Motivational Interviewing ☐ Dialectical Behavior Therapy ☐ Trauma Focused Cognitive Behavioral Therapy ☐ Solution Focused Brief Therapy ☐ EMDR ☐ WRAP ☐ Other_____

Client Symptoms Requiring Continued FIT Treatment:

Family's Level of Engagement During FIT Treatment:

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Challenges/Barriers During FIT Treatment:
Specific FIT Interventions that Will be Implemented:
Current FIT Discharge Plan Recommendations: ☐ Outpatient Therapy ☐ Case Management ☐ Behavioral Analyst ☐ Psychiatric Services ☐ Residential ☐ ☐ Other_____
Additional Information:

[Please submit all FIT Continued Enrollment Staffing Forms to your Network Manager and Erica Machnic, Child Welfare Integration Manager via encrypted email.**]**

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Contact Information:			
Agency Representative (Enter Name of Contact Person)	Phone	Fax	Email
LSF Health Systems Network Manager	904-900-1075	904-900-1628	NM:
LSF Health Systems Erica Machnic, Child Welfare Integration Manager	904-624-2309	904-900-1628	erica.machnic@lsfnet.org
Provider Contact Name:			
Parent/Guardian Name (if applicable):			

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Provider Representative Signature

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LSF Health Systems Signature