

FIT Client Information 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:		Ī	Completed	Not Completed			
Goal:		Ī	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							
cognitive behavioral merapy							
Client Symptoms Requiring Continued FIT Treatment:							
Family's Level of Engagement During FIT Treatment:							
ramily's Level of Engagement During FIT Treatment:							



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.**]



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

Provider Representative Signature	LSF Health Systems Signature