PROJECT THRIVE

REFERRAL PACKET

Program Description:
Our Project Thrive program is a unique program to assist adolescents and young adults develop and master the skills they need to flourish as adults. The program is offered weekly and covers topics from career planning to emotional regulation to social skills and personal care. To be eligible for this free program, youth must be between the ages of 12 and 21 and have a qualifying developmental disability (Autism, IQ of 70 or below, Down Syndrome, Cerebral Palsy, Prader-Willi Syndrome, Spina Bifida). Caregivers are also encouraged to participate in a separate concurrent caregiver portion of Project Thrive, to ensure they have the tools to help their adolescents and young adults grow and thrive! **Prior to making a referral, please contact the caregiver to ensure services are wanted in the home.**

Please email the following in your packet and email the completed packet to Leigh Ann Drew at LADrew@FI-Florida.org.

The completed packet should include:

- Referral Form (included below)
- Family Initiative Release Form (included below)
- Documentation showing need for one of the following:

  Social Skills: _____
  Independent Living Skills: _____
  Adaptive Skills: _____

- Current Diagnosis: _____
- Current Medications: _____
- Additional medical diagnoses/concerns: _____
  _____
- Other services/providers (i.e., OT, PT, speech therapies, etc.): _____
  _____
  _____

Family Initiative

REFERRAL FORM

Referral Date: _____ FSFN Case ID #: _____

CWCM Name: _____ Phone: _____ Email: _____

Supervisor: _____ Phone: _____ Email: _____

Family Name(s): _____ FSFN ID #: _____

Family Relation (circle one): Foster Relative Non-Relative Pre-Adoption

Address: _____

Home Phone: _____Cell: _____ Email: _____

Family has agreed to referral: ☐

Identified Child:_____ DOB: _____ Child Medicaid #: _____

Permanency Goal (circle one): Reunification Adoption Permanent Guardianship APPLA

Length of time at current location: _____ Previous # of Placements: _____

Qualifying Diagnosis (circle all that apply):

Autism IQ of 70 or Below Down Syndome Cerebral Palsy Prader-Willi Syndrom Spina Bifida

Additional Concerns: _____

_____

_____ _____

Signature of Case Manager **Signature of Supervisor**

For Family Initiative Use Only

Date Referral Received: _____ Date of Initial Contact: _____ Date of Initial Visit: _____