Application for
Integrated Behavior and Family Therapy Intervention Program

A program funded through a Family Support Grant from OPWDD

Integrated Behavior and Family Therapy Intervention Program

This program provides integrated intervention services to individuals and their families when a behavioral problem has been identified. The focus of the intervention is twofold: first, is to provide a Behaviorist to help identify the problem and then develop a behavioral plan to meet the needs of the behavior. Second, we provide a Family Therapist to provide education and support to the family members to sustain the individuals Behavior Plan. This program is designed to create sustainable changes to the individual and family.

ADDITIONAL INFORMATION

1.) This program is available to individuals between the ages of five (5) and twenty one (21) years old
2.) The individual and family must reside in Albany, Schenectady, or Southern Saratoga counties
3.) Complete the requested information in each section carefully and completely.
4.) In order to best meet the needs of the individual, we will need you to attach:
    - Previous or Current Behavioral Intervention Plans (if applicable)
    - Most recent IEP
    - Most recent ISP
    - Most recent psychological/psychiatric evaluation (if applicable)
    - OPWDD Determination of Eligibility letter

CONTACT INFORMATION

Toni Wakefield, Director of Family Support Services

Phone: 518-372-2814

Fax: 518-374-3652

Email: twakefield@familyandchildservice.com

Mailing Address: Family and Child Service of Schenectady
1007 Maryland Ave
Schenectady, NY 12308
Attention: Toni Wakefield, Director of FSS

Family & Child Service of Schenectady

OFFICE USE ONLY

Date Received _____

Start Date _____

Behaviorist _____

Family Therapist _____

INTEGRATED BEHAVIOR & FAMILY THERAPY INTERVENTION PROGRAM (IBFTIP)

APPLICATION/REFERRAL

Name of Applicant: _____

Address: _____

STREET

_____

CITY **STATE** **ZIP CODE** **COUNTY**

Phone Number: _____ **or** _____

Date of Birth: _____

Medicaid #: _____ **TABS #:** _____

Developmental Disability: _____

Additional Diagnosis's: _____

Medicaid Service Coordinator Information:

Name: _____ **Phone:** _____ **Ext:** _____

Agency Name: _____

Agency Address: _____

STREET

_____ _____ _____

CITY **STATE** **ZIP CODE**

Email Address: _____

Has the individual received behavioral services in the past? Yes ☐ **No** ☐

If yes, name and number of provider: _____

Reason for needing service again? _____

Current Services receiving: _____

Is the applicant currently enrolled in Self Directed Services? Yes ☐ **No** ☐ **Pending** ☐

If yes, please attach Self Direction budget.

Broker Contact Information:

_____

Parent / Guardian (s):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Siblings:

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Others living in household:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Justification for Referral of Integrated Behavior & Family Therapy Intervention Program

If more space is needed please attach a separate sheet.