1007 MARYLAND AVE.
SCHENECTADY NY 12308
PHONE #: 518-372-2814
FAX #: 518-374-3652

Family & Child Service of Schenectady, Inc.'s

INTEGRATED BEHAVIOR & FAMILY THERAPY INTERVENTION PROGRAM (IBFTP)

IBFTIP is a Family Support Service funded program. The IBFTIP is designed for individuals and their families when a behavioral problem has been identified. The program provides integrated intervention services. The service is provided to individual's between the age of five (5) and twenty one (21) years old. This program is available to Individuals who reside in their family home and live in Albany, Schenectady or Southern Saratoga Counties.

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.

The following materials are required when applying for services:

- **IBFTI application**
- **current ISP**
- **behavior plans and/or psychological evaluation (if applicable)**
- **OPWDD Eligibility Determination**

The Integrated Behavior & Family Therapy Intervention Application should be sent to:

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

Family & Child Service of Schenectady

1007 Maryland Ave.
Schenectady, NY 12305
PHONE #: 518-372-2814
FAX #: 518-374-3652

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 #:** _____

Disability: _____

_____

_____

Medicaid Service Coordinator Information:

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

Agency Name: _____

Agency Address: _____
STREET

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

Email Address: _____

OFFICE USE ONLY

Date received _____

Start date _____

Behaviorist _____

Family Therapist _____

Parent / Guardian (s):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Siblings:

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Justification for Referral of Integrated Behavior & Family Therapy Intervention Program

(Please fill in below)

If more space is needed please attach a separate sheet.