# Chesterfield/Colonial Heights
# Comprehensive Services Act
# FAPT Plan for Youth in Therapeutic Foster Care

FAPT Date: Case manager:

Name: Date of Birth: Medicaid #

Vendor: Dates of Service: to

**1. Explain the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities.**

**2. Describe the Potential for reunification**

**3. Detail the short term and long-term treatment objectives**

**4. What types of interventions and therapeutic modalities are needed to achieve the plan's objectives**

FAPT Signatures-Confirmation of Medical Necessity☒