Family Centered Services and Supports Application- FY19

Service Coordination Dedicated Dollars
Updated 1.29.19

Date of request for FCSS funding: ____/____/_____ SC Liaison: ________________________________

Type of request: ☐ Individual ☐ Family

Youth Information:

Youth's Last Name: _______________________ **Youth's First Name**:_________________________

Youth's DOB :______________ **Youth's Gender** ____Female ____Male

Race/Ethnicity: (Check all that apply) _______ Asian ______ Black or African American

_______ Caucasian _______ Hispanic/Latino_______ Native Hawaiian or Other Pacific Islande

_______ Multi-racial _______ Other, Please Specify_________________________________

Address: ____ Apt _________

City __________________ Zip Code______________ Phone:_________________________

Legal Custodian Name & Relationship: ____

Address/Phone, If Different then above: ____

*Parental Home ____Yes ____No Relative Home ____Yes ____ No

**Child/Youth cannot be in out-of-home care at the time of FCSS services.*

Other household members who will also benefit from FCSS Dollars:

First Name	Last Name	DOB/Age	Relationship
First Name	Last Name	DOB/Age	Relationship
First Name	Last Name	DOB/Age	Relationship
First Name	Last Name	DOB/Age	Relationship
First Name	Last Name	DOB/Age	Relationship

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Referring Agency/Representative:

Name:_________________________ Position/Agency: _______________________

Address: ____________________________________ City ______________ Zip Code__________

Phone#:_______________________ Fax #: ______________________

Email Address____

Indicate System Involvement: (Family must have multi-system involvement to receive FCSS)

☐ Bright Beginnings	☐ MH/AOD Provider	☐ JFS	☐ Juvenile Court	☐ ODYS
☐ PEP Connections	☐ CCDCFS/TSOC	☐ CCBDD	☐ CCDCFS/MST	☐ Other_________
☐ CSEA	☐ School District:		☐ Neighborhood Collaborative:	

Do these systems participate on the child's multi-system team? ☐ Yes ☐ No

Please check all needs that the FCSS family has at intake in the following categories, whether or not those needs are being addressed.

☐ Developmental Disabilities	☐ Child Abuse	☐ Child Neglect	☐ Mental Health	☐ Alcohol/Drug
☐ Unruly	☐ Delinquent	☐ Physical Health	☐ Special Education	☐ Bright Beginnings
☐ Poverty	☐ Autism Spectrum Disorder		☐ Primary Care Physician	

Please identify the number of times each service or support that will be accessed using FCSS funds that was written into the IFSCP.

_____Non-Clinical In Home Parent /Child Coaching	_____Non-Clinical Parent Support Groups	_____Parent education
_____Transportation	_____Respite Care (Including Summer Camp)	_____Parent Advocacy
_____Social/Recreational Activities/Supports	_____Safety/Adaptive Equipment	_____Mentoring
_____Service Coordination	_____Structured Activities to Improve Family Functioning	
Other , Please Specify*____ *Requires approval from State FCFC Representative*		

Is the family involved with a Parent Advocate? ☐ Yes ☐ No
If the family does not have a Parent Advocate, is a Parent Advocate desired? ☐ Yes ☐ Offered/Denied

Does the youth have a primary care physician? ☐ Yes ☐ No

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Services or Supports Requested:

#	**Detailed Description of Service or Support (i.e. Boxing Lessons, sports equipment, Ceiling lift, etc.)**	**Name of Provider** (Please indicate contact person)	**Provider Address**	**Provider Phone Number**	**Amount**	**Service Date**		**IFSCP& ROI Attached**
						Begin	**End**	
1								
2								
3								
Total Cost of FCSS Request:								

**Please provide a copy of the IFSCP and ROI with FCFC added, and also a W-9 for the Provider.*

OFFICE USE ONLY:

1. ☐ Approved ☐ Denied Reason for Denial ____________________________

2. ☐ Approved ☐ Denied Reason for Denial ____________________________

3. ☐ Approved ☐ Denied Reason for Denial ____________________________

Signature ____ **Date**________________________

For requests over $2000.00 Family limit require management approval:

☐ Approved ☐ Denied Reason for Denial ____

Management Signature ____ **Date**_________________________