Family Centered Services and Supports Termination-FY19

FCFC Service Coordination

Date of Termination for FCSS funding: ___/___/____

Type of request: ☐ Individual ☐ Family

FCSS Youth Information:

Youth's Last Name: _____ Youth's First Name:_____

Youth's DOB:___/___/____ Address: _____ Apt _____

City _____ Zip Code_____

Person Completing Form:

Liaison:_____ Agency: _____

1. Were the services of a Parent Advocate used at any time during FCSS services and supports delivery?	☐ Yes ☐ No
2. Was the child/young adult who had no primary care physician at intake connected to a primary care physician during the service coordination process?	☐ Yes ☐ No
3. If child/youth was not connected to a primary care physician, please indicate reason(s) the connection was not made.	
4. Did any youth who received FCSS funding subsequently end up in an out-of-home placement?	☐ Yes ☐ No If Yes, Number of Youth _____
5. Did the youth or family exit Service Coordination (i.e. FCSS service or support) during SFY19?	☐ Yes If yes, please answer #4. ☐ No
6. If you answered yes above, please rate the youth/family's who exited Service Coordination (the FCSS service or support) successfully in SFY19.	☐ Completed 75%-99% of IFSCP goals ☐ Completed 100% of IFSCP goals

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