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| **Date of Request:** |
| **Child Name:** Click or tap here to enter text. **Age:** Click or tap here to enter text. |
| **Guardian Name:**Click or tap here to enter text. **Phone:** Click or tap here to enter text. |
| **Request Made By:** Click or tap here to enter text. **Phone:** Click or tap here to enter text. |
| **Agency:** Click or tap here to enter text. **Agency Address:** Click or tap here to enter text. |

1. **Description of Request: Please include dates and helpful information:**

Click or tap here to enter text.

1. **Choose type of service from the drop-down list here: ------**
2. **Please list other agencies that are involved as well as any friends or family members that could be a support for the family. (family, friends, pastor, coach, counselor, caseworker)**

Choose an item. **Name:** Click or tap here to enter text. **Phone #:** Click or tap here to enter text.

Choose an item. **Name:** Click or tap here to enter text. **Phone #:** Click or tap here to enter text.

1. **How does this request relate to family plan?**

Click or tap here to enter text.

1. **What other community resources have been explored for this request?**

Click or tap here to enter text.

1. **Estimated Cost of Service: $** Click or tap here to enter text.
2. **Vendor/Payment Information: Name/Address/Phone:**

Click or tap here to enter text.

**With each referral the Service Team will meet to discuss systemic issues regarding system of care, case review, out of home placements, service gaps, child and family issues, local mental health assessments, problem solving, and strategizing.**

**(Below for FCFC use only)**

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| FCSS Funds to be Utilized.  Service Coordination Team: Approved:  Denied:  Date: Click or tap to enter a date.  Reason if Denied: Click or tap here to enter text.  SFSC Funds to be Utilized.  Service Coordination Team: Approved:  Denied:  Date: Click or tap to enter a date.  Reason if Denied: Click or tap here to enter text.  Coordinator Signature: Click or tap here to enter text. |