



# Perry County Family and Children First Council

## Approval for FCSS Services

Child Name: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Referral to PCFCFC: \_\_\_\_\_ Source of Referral: \_\_\_\_\_

**Date of last team meeting:** \_\_\_\_\_

**Date of most recent CANS assessment:** \_\_\_\_\_

**Date to re-evaluate (90 days past CANS):** \_\_\_\_\_

*Behavioral issues: (Check all that apply)*

<input type="checkbox"/> Biting	<input type="checkbox"/> Clingy	<input type="checkbox"/> Cruelty to Younger Children
<input type="checkbox"/> Destructive to property	<input type="checkbox"/> Thumb sucking	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Encopresis/Enuresis	<input type="checkbox"/> Excessive Crying	<input type="checkbox"/> Explosive Outbursts
<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Hair pulling	<input type="checkbox"/> History of Violence
<input type="checkbox"/> Hurts animals	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Withdrawn/Fearful
<input type="checkbox"/> Jealous/selfish	<input type="checkbox"/> Lying	<input type="checkbox"/> Manipulative
<input type="checkbox"/> Truancy	<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Running Away
<input type="checkbox"/> Self-abusive	<input type="checkbox"/> Sexually acting out	<input type="checkbox"/> Short Attention Span
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Smoking/tobacco use	<input type="checkbox"/> Stealing
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Suicidal/Homicidal	<input type="checkbox"/> Swearing
<input type="checkbox"/> Talking back	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Threatening
<input type="checkbox"/> Others : <input type="checkbox"/> Please give brief explanation as applicable: _____ _____ _____ _____ _____ _____ _____		

**Services for Approval to support family plan/goals:****Service:****Explanation:**

<input type="checkbox"/> Respite Care	Name of Provider:
<input type="checkbox"/> Mileage Reimbursement	
<input type="checkbox"/> Non-Clinical In-Home Parent/Child Coaching	Name of Provider:
<input type="checkbox"/> Safety/Adaptive Equipment	
<input type="checkbox"/> Social/Recreational Needs	
<input type="checkbox"/> Other, please specify	

**Any additional relevant notes for team to consider during approval of services:**


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**Perry FCFC Coordinator**

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**Date**


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**Approval of Monthly Coordination Service Team**  
(minimum of three (3) team member signatures)

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**Date**

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**Received:**

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**Perry FCFC, Fiscal**

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**Date**