

[illegible]

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:

Perry FCFC Coordinator

Date

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

Date

Received:

Perry FCFC, Fiscal

Date

Approved by Council 1/20/2026