REQUEST #_____ (To be filled in by HSPD)

MONTGOMERY COUNTY HSPD Service Coordination

REFERRAL / SERVICES APPROVAL FORM

FAMILY-Centered Services and Supports FCSS Request

ACTIVE FCFC SERVICE COORDINATION CASE:

- **Family Service Plan Meeting Date:**
- **FCSS funding identified as a need**

Lead Agency Requesting Family-Centered Supports & Services between 7/1/20 and 6/30/21:

Staff Contact:

Agency:

Phone: **Fax:**

Email:

Child Needing Family Supports

Initial Request ☐ **Continuation Request** ☐

Child Name:

Date of Birth:

Age: ☐ **0-3 years** ☐ **4-9 years** ☐ **10-13 years** ☐ **14-18 years** ☐ **19-21 years**

Address:

Legal Custodian Name & Relationship:

Phone:

Parental Home: ☐ **Yes** ☐ **No** **Relative Home:** ☐ **Yes** ☐ **No**

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

FCSS funds are for child/youth with needs in 2 or more systems. Please check needs:

☐	**Developmental Disabilities**	☐	**Delinquent**
☐	**Child Abuse**	☐	**Physical Health**
☐	**Child Neglect**	☐	**Special Education**
☐	**Mental Health**	☐	**Poverty**
☐	**Alcohol/Drug**	☐	**Help Me Grow**
☐	**Unruly***	☐	**Autism Spectrum Disorder**

***If child is deemed unruly, a process will be put in place to include methods to divert the child from the juvenile court system.**

1. **Does the child/youth have a primary care physician?** ☐ **Yes** ☐ **No**

Describe how the child/youth has needs in multiple systems:

Funding Requested:

2. Name of Service needed for the Child/Youth:

ELIGIBLE SERVICES CODES:
001 – Non-clinical in-home parent/child coaching
002 – Non-clinical parent support groups
003 – Parent education
004 - Mentoring
005 - Respite care (including summer camp)
006– Transportation
007– Social/recreational supports
008 – Safety and adaptive equipment
009 – Structured activities to improve family functioning
010 – Parent advocacy
011 – Service coordination
012– Other

Identified Need (See below)	Service Code (See above)	Description of Service	Quantity	Unit Cost	Total Cost
				Total Request	

***If you need to request additional items, attach a separate sheet.**

Coding for Identified Needs: For each funding request, select the need addressed from the list below.

A. Developmental Disabilities
B. Child Abuse
C. Child Neglect
D. Mental Health
E. Alcohol/Drug
F. Unruly*
G. Delinquent
H. Physical Health
I. Special Education
J. Poverty
K. Help Me Grow - Early Intervention
L. Autism Spectrum Disorder

***If child is deemed unruly, a process will be put in place to include methods to divert the child from the juvenile court system.**

3. Service Provider(s) Requested:

4. Duration Requested: From through

(Initial request will be considered for a maximum of 3 months per state fiscal year.

5. Is the child at risk of removal from the home? ☐ **Yes** ☐ **No**

6. How will this requested service reduce the risk of removal?

7. Was a Family Advocated offered to you? ☐ **Yes** ☐ **No**

APPROVALS

Family and Children First Council (FCFC) FUNDS WILL BE UTILIZED FOR AN ACTIVE CASE IN FCFC SERVICE COORDINATION.

Agency Signature:_____ Date:

The above signed acknowledges that any modification (increase or decrease) to this request must be submitted to the Human Services Planning & Development Department (HSPD) via the FCSS Modification Form with any supporting documentation attached.

The above signed also acknowledges that failure to comply with HSPD requirements to submit invoices within 30 days of the end of the service month will result in the unspent balance of this request being released for other FCSS requests in the county._____(initial)

HSPD Approval: Date:

Approval Emailed/Faxed to Lead Agency: Date: