Monthly or Exit Summary Report **Attachment D**

Today's Date:_____ Next Update Due:_____ EXIT Date:_____
Date of Presentation: _____ Release Expires:_____
Childs Name: _____ D.O.B.: _____ Age: _____
Agency: _____
Lead Service Coordinator: _____
Person Completing Report_____
Please Mark as Appropriate: Needs at Intake:
____ Developmental Disabilities ___ Child Abuse ___ Child Neglect ___ Mental Health ____ Alcohol/Drug ___Unruly ___Delinquent
____ Primary Care Physican ___Poverty ___Special Education ____Help Me Grow ___Mentoring ____Autism Spectrum Disorder ___ Physical Health
Does child have an IEP?_____ Does child have Primary Care Physican? _____ If Yes, who:_____
Services and Supports: Dates of Service This Update: _____
Non-clinical in-home Parent/Child Coaching: _____
Non-clinical parent support groups:_____
Parent education :_____ Youth/Young Adult Peer Support: _____
Respite care (includes summer camp):_____
Transportation:_____
Social/recreational supports:_____
Safety and adaptive equipment:_____
Structured activities to improve family functioning:_____
Parent advocacy: _____
Service Coordination:_____ Mentoring: _____
List Completed Tasks/Action Items: _____
_____
_____
_____
Next Steps: _____
_____
_____
_____
Open Issues & Comments:: _____
_____
_____
Did Family Exit FCFC Service Coordination in FY17? _____ Date family exited FCFC Service Coordination: _____
If family Exited Service Coordination in FY17 please complete following questions:
Did family accomplish their service coordination goals: Yes_____No_____ 75%-99% of goals met_____ 100% of goals met_____
How did accomplishing goals improve family functioning? _____

To be COMPLETED monthly OR at date of EXIT. Form may be faxed or emailed ATTN: Teresa Alt at 419-522-4375 or teresa.alt@jfs.ohio.gov