☐ Initial

☐ Review

KING GEORGE COUNTY INDIVIDUAL & FAMILY SERVICE PLAN OUTCOMES

Schools Only

FAPT Date: _____ **Case Manager**: _____

Name: _____

Mother: _____ **Father**: _____

DOB: _____ **Age**: _____

Sex: ☐Male ☐Female

Race: ☐**White/Caucasion** ☐**Asian** ☐**Black/African American** ☐**American Indian or Native Alaskan**
☐**Native Hawaiian or Pacific Islander** ☐**Hispanic** ☐**Multiracial**

Social Security #: _____ **CSA Case #:** _____
STI # _____

Address: _____ **Phone Number**: _____

Parent/Guardian Email: _____

School: _____ **Grade**: _____

◯YES ◯ NO Child has a DSM-IV mental health diagnosis Diagnosis: _____
◯YES ◯ NO Child takes a prescription medication for a mental health problem
Medication(s): _____

Recommended CSA Funded Service Requests:

Provider #1: _____ Service Provided: Counseling

Start Date: _____ End Date: _____

Rate Charged by Vendor: $ _____ Per: one time only

Total # of one time or requested for service period: _____

Total $_____ requested for service period

Provider #2: _____ Service Provided: Counseling

Start Date: _____ End Date: _____

Rate Charged by Vendor: $ _____ Per: one time only

Total # of one time or requested for service period: _____

Total $_____ requested for service period

Provider #3: _____ Service Provided: Counseling

Start Date: _____ End Date: _____

Rate Charged by Vendor: $ _____ Per: one time only

Total # of one time or requested for service period: _____

Total $_____ requested for service period

Provider #4: _____ Service Provided: Counseling

Start Date: _____ End Date: _____

Rate Charged by Vendor: $ _____ Per: one time only

Total # of one time or requested for service period: _____

Total $_____ requested for service period

Provider #5: _____ Service Provided: Counseling

Start Date: _____ End Date: _____

Rate Charged by Vendor: $ _____ Per: one time only

Total # of one time or requested for service period: _____

Total $_____ requested for service period

Provider #6: _____ Service Provided: Counseling

Start Date: _____ End Date: _____

Rate Charged by Vendor: $ _____ Per: one time only

Total # of one time or requested for service period: _____

Total $_____ requested for service period

Special Education Category (only required if SPED is mandate type):

☐Autism ☐Hearing Impairment/Deaf ☐Orthopedic Impairment
☐Deaf-Blindness ☐Learning Disability ☐Other Health Impairment
☐Developmental Delay ☐Intellectual Disability ☐Severe Disabilities
☐Emotional Disturbance ☐Multiple Disabilities ☐Traumatic Brain Injury
☐Vision Impairment

Audit Documentation:

Consent to Exchange Information Form ☐ Attached ☐ Previously Submitted
Most Recent Reassessment CANS completed: _____ ☐ Attached ☐ Previously Submitted
Most Recent Comprehensive CANS completed: _____ ☐ Attached ☐ Previously Submitted
Current IEP end date: _____ ☐ IEP Attached ☐ IEP Previously Submitted
Current ESY IEP end date: _____ ☐ ESY IEP Attached ☐ ESY IEP Previously Submitted ☐ N/A
Vendor Progress Reports/Report Cards: ☐ Attached
Vendors Considered for current service requests: _____
_____
_____

Reason for choosing current vendor(s): _____

Vendor Rate Sheets: ☐ Attached ☐ Previously submitted

Recommendations for funded services are subject to approval and authorization by the King George County Community Policy and Management Team.

☐ I agree to this plan
☐ I disagree with this plan, because

_____

_____
Case Manager Signature Date

FAPT Members Signatures

_____ ☐ agree ☐ disagree

_____ ☐ agree ☐ disagree

_____ ☐ agree ☐ disagree

_____ ☐ agree ☐ disagree

_____ ☐ agree ☐ disagree

_____ ☐ agree ☐ disagree

Other Participant's Signatures

_____ _____

_____ _____

_____ _____