

**CHILD/FAMILY SERVICES
RESULTS OF CHILD SUCCESS TEAM**

Service Options: ___ Center Based ___ Home Based ___ FCCH

Location: _____ Teacher: _____

Child: _____ Date of Birth: _____

Staff Present: _____

Parent or Representative Present: _____

AREAS OF CONCERN _____

INTERVENTIONS/ACTIONS:	<i><u>Person Responsible</u></i>	<i><u>Follow-Up Date</u></i>
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A. _____

B. _____

C. _____

D. _____

ADDITIONAL COMMENTS _____

SUBMITTED BY: _____ **DATE:** _____

Distribution: White - Grantee Disabilities Supervisor (RHS) Yellow - Child/Family File Pink - Parent
White - Delegate Disabilities Coordinator (MHS)