|  |  |
| --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989G (02/2017) | **STATE OF WISCONSIN** |
| **TELL US ABOUT YOUR FAMILY** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| Child / Family Assessment Procedure Used |
| Enter date |
| This page is a summary of the information you have shared with us about your family. The purpose of this information is to help develop a plan and intervention strategies that are meaningful to your family. |
| Natural Supports / Resources (people or supports that are helpful to your family) |
| Date: |
| Click here to enter text. |
| Routines / Activities (describe the child/family’s day) |
| Date: |
| Click here to enter text. |
| Priorities of the Family (activities your family would like to do) |
| Date: Click here to enter text. |