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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-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. | | |