

**Family-Centered Services (FCS)**

**Family Interaction Termination Summary**

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| Billing Child Name      | HHS Worker Name      |
| Referral Date      | HHS Worker Email      |
| Financial County      | HHS Worker Contact Number (Phone/Cell)      |
| Service Area      | State ID      |
| Termination Date      |  |
| Family Support Specialist Name/Author      | Parent/Caretaker Name and Address      |
| Current Placement of Child(ren)      | Parent/Caretaker Email      |

**Family Interactions and attempted Family Interactions during the Service Month** (If a family is not engaged in services, document **all** attempts to contact the family during the service month. Include the date, method of contact, and names of individuals.)

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| **Date of contact** | **Type of contact** | **Start/end time of contact** | **Location of contact** | **Who was present or response to attempted contact** |
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**Family Interactions**

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| *Describe parents’ ability to care for the children during family interactions, including an overview of family activities and conversations, during the service month. Note any progress or barriers to child safety and well-being during family interactions, observed behavioral changes for the parents, and observations of parents using change to address the identified safety concerns.***Describe parents’ overall progress/barriers since the last monthly report:**      |

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| Family Support Specialist Signature: | Date:      |
| Supervisor Signature: | Date:      |

A copy of the (Month/Year) Case Progress Report was received and reviewed.

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| Parent Signature: | Date:      |
| Parent Signature: | Date:      |
| Family Support Specialist Signature: | Date:      |