

EFSS 90 Day Review

DATE OF REPORT

FAMLINK CASE ID	CASE NAME (LAST, FIRST)	EFSS REFERRAL DATE
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Provider Information

AGENCY'S NAME	PROVIDER'S NAME	PHONE NUMBER (AREA CODE)
ADDRESS		

OMAHA PROBLEMS		ENTRY	EXIT		ENTRY	EXIT		ENTRY	EXIT
	KNOWLEDGE			BEHAVIOR			STATUS		
	KNOWLEDGE			BEHAVIOR			STATUS		
	KNOWLEDGE			BEHAVIOR			STATUS		

Case Summary

Provide the Service Plan Goals and include family concerns and strengths.

Describe the progress the family has made on the Service Plan goals during this reporting period.

Describe the family's involvement in case planning during this reporting period.

Identify any new concerns or barriers that have been identified with the family during this reporting period.

Identify any resources or referrals that were made available to the family during this reporting period.

Justification for continuation of EFSS services.

This form should be submitted to the CA Regional Liaison for the EFSS Program by the 15th of the month.

EFSS Review and Approval

PROVIDER'S SIGNATURE	DATE	PROVIDER'S NAME
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	CA REGIONAL LIAISON'S SIGNATURE	DATE

Dates of Client Contact

FACE TO FACE VISITS	LETTERS	NO SHOWS	TELEPHONE CONTACT

This form should be submitted to the CA Regional Liaison for the EFSS Program by the 15th of the month.