Alaska Department of Health and Social Services
Division of Public Assistance

WORK SERVICES PROGRAM

FAMILY SUPPORT TEAM MEETING AGENDA

Date of Meeting: _____ Location: _____
Family Name: _____ Meeting Facilitator: _____

Case Status**:** (check one)

☐ Initial Meeting ☐ Emergency Family Support Meeting ☐ On Going / Follow Up

Family Obligation	Decision	Partners	Supports	Goal Date
1.				
2.				
3.				
4.				
5.				

Additional discussion and decisions**:**

_____

_____

_____

_____

Next Scheduled Family Support Team Meeting: _____

Location: _____ Next meeting facilitator: _____

FF 130 (06-4017) rev 7/12

Participants name:	Participants email address:	Participants phone number: