# Alaska Department of Health & Social Services, Division of Public Assistance

**WORK SERVICES PROGRAM**

# **FAMILY SUPPORT TEAM MEETING AGENDA**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Meeting: | | Click here to enter a date. | Location: | Click here to enter text. | |
| Family Name: | Click here to enter text. | | Meeting Facilitator: | | Click here to enter text. |

Case Status**:** (check one)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Initial Meeting |  | Emergency Family Support Meeting |  | On Going / Follow Up |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family Obligation** | **Decision** | **Partners** | **Supports** | **Goal Date** |
| 1.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter a date. |
| 2.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter a date. |
| 3.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter a date. |
| 4.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter a date. |
| 5.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter a date. |

Additional discussion and decisions**:**

Click here to enter text.

|  |  |
| --- | --- |
| Next Scheduled Family Support Team Meeting: | Click here to enter a date. |

|  |  |  |  |
| --- | --- | --- | --- |
| Location: | Click here to enter text. | Next meeting facilitator: | Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| **Participants name:** | **Participants email address:** | **Participants phone number:** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
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