CHILDREN'S COURT SERVICES NETWORK

SERVICE PLAN AUTHORIZATION FORM

CHECK ALL THAT APPLY: ☐ FTJOP ☐ PSN ☐ JCAP ☐ FISS ☐ DPA ☐ CD ☐ Probation Juv ID #:_____

Youth's Name: Last_____ First_____ M.I_____ D.O.B._____

Tracker: _____ Agency:_____ Phone:_____

Worker:_____ Phone:_____ Order: *from*_____ *to*_____

AODA Assessment: ☐ **Required** ☐ **Not Required**

NOTICE TO CLIENT/PARENT/GUARDIAN: A drug/alcohol Assessment is required if the AODA Screen (administered to the Youth under provisions set forth in Chapters 48.547 and 938.547, Children's Code, Wisconsin State Statute) indicates or based on the charge. If an Assessment is indicated, a Referral will be made and you are expected to cooperate with it.

AODA Assessment	**ZXA**				**¼ hour**		
All Other Authorized Services [1]	**Service Code**	**Provider Name**	**Provider I.D.#**	**# Units Approved**	**Type of Unit**	**Unit Cost**	**Service Cost**
Tracking	YTK			420	1/10 hr.	3.20	1344.00

[1] **All staff please indicate the rationale and the goal for the services you are requesting. For FTJOP: Tracker will include Service Plan in area provided or on an attachment. Request for Services are subject to CCSN Administration approval.**

Service Rationale/Plan:

SIGNATURES: The undersigned acknowledges the above services reflect the status of the initial CCSN Service Plan. The undersigned also understands and agrees to abide and cooperate with these services, plus any changes that may need to be made subject to the needs of the youth, or as a result of the AODA assessment, during the time the undersigned youth is subject to the jurisdiction of Milwaukee County Children's Court. The undersigned grants consent for an AODA assessment to be completed on the named youth. The undersigned further agrees to allow the above-named Provider(s) to share the results of the assessment and/or treatment with Milwaukee County Children's Court Center Administrative staff, and any other identified professional agency listed in the CCSN Provider Network, as needed.

_____ YOUTH _____ DATE _____ TRACKER/PO/IS/OTHER _____ DATE

_____ PARENT/CAREGIVER _____ DATE _____ CCSN ADMINISTRATION _____ DATE

***Program Start & End Dates:**_____ to _____

CCSN CLERICAL: Scripts Entry Date: _____ by _____ DB Entry Date:_____ by _____ Faxed/E-mailed Scan Date:_____ by:_____