Deschutes County System of Care is an integrated network to support children/youth and their families in order to help them function better at home, school, and in life. We want families and youth voice included in all phases and would love to hear your ideas on how to strengthen our community.

**Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_

**Phone Number or Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I participate in services as a:**  Family Member  Youth/Young Adult  Client/Service User  Natural Support  Community Partner

**Area of concern, need, barrier, opportunity for growth:** Access to Care  Funding/Coverage of Services  Service Support Ideas  Coordination of Care  Type of Providers  Other:

**Please describe concern, need, barrier, opportunity for growth:** (need that you would like the System of Care to address)**:**

**Please describe anything that is currently working well:**

**Goal/Outcome:** (what it would look like for you if we resolved your concern, need, barrier or opportunity for growth):

**Solution Plan Description:** (please describe ideas or suggestions you have to solve the barrier or support your innovation recommendation):

**For Internal Use Only:**

**Assigned to:** Executive Committee  Advisory Committee  Practice Level Workgroup  Review Committee

**Advisory Council Member Assigned to this:**

**Identified system strengths based on barrier or innovation presented:**

**Identified system needs or gaps based on barrier or innovation presented:**

**Existing Services and Support that could help** (brainstorm)**:**

|  |  |  |
| --- | --- | --- |
| Objective/Task | Assigned to: | Due Date: |
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|  |  |  |
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|  |  |  |

**Outcome and follow up with up with person submitting form:**