



Children & Family Services | Behavioral Health | Education | Advocacy

PREVENTION SERVICES SCREENING FORM

Program: Youth Mentoring Parent Coaching Therapeutic (Family) Visits Outdoor Camp/Mentoring

Funding Source: FAPT Private Pay(Self-Pay) Other funding source: _____

Please complete information for the **FAPT funded Child***(or the youngest child's name if "Other" or "Self-Pay" funding for the program selected)

***Fapt Funding (Approval) Dates/hours:** _____/_____ **Self-Pay Rate/Hour:** _____

***Services Approved (Transportation, Group, Case Management in addition to Individual Sessions):** _____

***Child First Name** _____ ***Last Name** _____

***Date of Birth:** _____

***Child Gender:** Male Female

***Gender Identity:** Male Female AGender GenderFluid Non-Binary Transgender Non-Conforming Two-Spirit

***Pronouns:** He/Him She/Her They/Them Other: _____

***Ethnicity:** Hispanic Non -Hispanic

***Race:** Indigenous American Asian Bi-Racial Black or African American Hawaiian/Pacific Islander
Hispanic Multi -Racial White Other: _____

***Preferred Language:** _____

***Religion:** Buddhist Christian Hindu Jehovah's Witness Jewish Muslim Not Identified Other _____

***Enrolled School** _____ ***Grade** _____

***Child Address:** _____ **Zip Code:** _____

With Whom Does Child live (Names/Relationship): _____

***Email (contact email for Client):** _____ ***Phone:** _____

Legal Guardian Name _____ **LG/SW Phone Number** _____

Legal Guardian/SW email address: _____

Locality of Payer/Referring Agency: _____

Emergency contact Information

Name: _____ **Phone:** _____

Address: _____

Adult Name(s) (For Visit or ParentCoaching): _____

Address: _____

Email: _____ **Phone:** _____

Additional children names(if applicable)Name and Birthdate for each:

RECOMMENDED GOALS/YOUTH INTERESTS/ADDITIONAL NOTES: