Date and time of request: ______________________ Phone Screening Interviewer: ________________________

☐ Phone ☐ Face to Face ☐ Walk In ☐ Mailed/Faxed

Southwest Youth and Family Services
Youth/Family Screening Form

4555 Delridge Way SW • Seattle, WA 98106

206-937-7680

Fax to: 206-935-9967

****At this time, we are only accepting referrals for Medicaid-eligible clients. Please inquire about grants for non-Medicaid clients****

PLEASE FILL REFERRAL FORM COMPLETELY

Caller's Name: ______________________________ Referred by: ________________________________

Phone: ____________________ Relationship to Youth: ____

Youth's **Legal** Name: __________________________________ Age: _____ Date of Birth: _________

Youth's preferred name (if applicable): _____________________

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Name Race/Ethnicity: _________

Is youth aware of referral? ☐ Yes ☐ No

Name of Parent/Guardian: _____________________ Who has legal custody: _________________

Is there a custody dispute? ☐ Yes ☐ No

For 13 and over, is the parent/guardian aware of referral? ☐ Yes ☐ No

Youth's Phone: ______________________ Parent/Guardian's Phone: _______________________

Is it alright to leave messages on above phone number/s? ☐ Yes ☐ No

Address: ____

Reason for contacting the agency (*brief* statement of concern):

____

____

____

____

Have any of the following issues impacted your family? (Check all that apply)

☐ Domestic Violence	☐ Family Conflict	☐ Sexual Abuse	☐ Physical Abuse
☐ Drug Abuse	☐ Alcohol Abuse	☐ Divorce/Separation	☐ Legal Involvement
☐ School Problems	☐ Depression/Anxiety	☐ Medical Concerns	☐ Recent Deaths/Losses
School: ______________		☐ Eating Concerns	☐ Identity Issues
☐ Self-Harm			

Do you have any concerns about you/your child's safety at this time? (Suicide attempts/ideation)

☐ Yes ☐ No ____

List the names and ages of all people in the household: ____

____

Has the client or family been to SWYFS before? ☐ Yes ☐ No

If yes, what services were received? ____

Has the client or family ever received counseling services? ☐ Yes ☐ No
If yes, where and when: ____

Is the client or family involved with any of the following?
☐ Family Court ☐ Juvenile Court ☐ CPS/DCFS
Contact_______________ **Contact**________________

Southwest Youth and Family Services Counseling team does its best to accommodate for special requests of clients. Please be aware that, although we try, we are not always able to do so.

Preferred language for services?_______________________________

Preferred location of services?_________________________________

Any other special requests?

____

Do you need any special accommodations? *For example, special needs, hearing, reading, assistance completing forms, etc.?*

____

Services Requested: ☐ Individual ☐ Family ☐ Both
Best times available for counseling:

____

Financial Information/Program Selection

Medicaid
Do you have a Provider One Card/Medical Coupon?
☐ Yes ☐ No

Name on Provider One Card/Medical Coupon: ____
Provider One Card #: ___________________

City Counseling (age 9 – 19, lives in City limits)
☐ Yes ☐ No

Family Size: ______*(Number of people dependent upon income below)*
Family Income: ______
Sliding Scale Fee: ______

08/2019