Family Support program

Initial Screening

Case # _____

Client Name: _____ Date _____

DOB: _____ Age: _____Gender _____

Race: _____ Religion: _____

School: _____ Grade: _____

Siblings: _____

Comments: _____

Child's Home Address: _____

City: _____ FL. Zip: _____

Home Ph # _____ Cell Ph# _____

Legal Guardian: _____ Relation to Child: _____

Child Resides with (include Adults and children) _____

_____

Contact Email Address: _____

Emergency Ph #: _____

Eligibility Criteria:

Person is living inside Palm beach County ☐ Yes.

Person Served Is age birth to age 12 ☐ Yes.

Person served has diagnosis of developmental disability o

Developmental delay ☐ Yes.

Persons Authorized to discharge the child:

_____

_____

Reason(s) for Referral _____

Diagnosis from physician: _____

_____

Program(s) Referred To:

☐ Respite ☐ Parent Training ☐ Parent Mentoring Network

Parent / Guardian/ Caregiver Must Fill out a survey before leaves