

Date and time of request: \_\_\_\_\_ Phone Screening Interviewer: \_\_\_\_\_

Phone  Face to Face  Walk In

## Southwest Youth and Family Services

### Youth/Family Screening Form

4555 Delridge Way SW • Seattle, WA 98106  
206-937-7680

Caller's Name: \_\_\_\_\_ Relationship to Youth \_\_\_\_\_

Youth's **Legal** Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Who has legal custody \_\_\_\_\_

Is there a custody dispute:  Yes  No

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Address: \_\_\_\_\_

Referred By: \_\_\_\_\_ School Youth attends: \_\_\_\_\_

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

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**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

Comments: \_\_\_\_\_

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

Yes  No

**List the names and ages of all people in the household:** \_\_\_\_\_

**Have you ever been to SWYFS before?**  Yes  No

If yes, what services did you receive? \_\_\_\_\_

**Have you ever received counseling services?**  Yes  No

If yes, where and when: \_\_\_\_\_

**Are you or your family involved with any of the following?**

Family Court  Juvenile Court  CPS/DCFS

**Do you have any special requests? For example, service location, provider preference (gender, ethnicity, etc.), language (i.e. Spanish).**

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

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**Services Requested:**  Individual     Family     Both  
**Best times available for counseling:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Financial Information/Program Selection**

**Family Size:** \_\_\_\_\_ *(Number of people dependant upon income below)*  
**Family Income:** \$ \_\_\_\_\_  
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**Medicaid**  
**Do you have a Provider One Card/Medical Coupon?**  
 Yes             No

**Name on Provider One Card/Medical Coupon:** \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 or  
 Provider One Card #: \_\_\_\_\_  
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**City Counseling (age 11 – 19, lives in City limits)**  
 Yes             No  
 Sliding Scale Fee        \$ \_\_\_\_\_  
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**Private Pay**  
 Yes             No  
 Private Pay Fee        \$100 \_\_\_\_\_  
 Hardship?             Yes             No  
 Reason for hardship? \_\_\_\_\_  
 \_\_\_\_\_  
 Hardship Fee            \$ \_\_\_\_\_  
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\*\*\*\*\* ***\*\*Please route form to Diane Payne when completed.*** \*\*\*\*\*

**Fax 206-935-9967**

*For Provider One/Medical Coupons*  
Date eligibility determined: \_\_\_\_\_  
Client ID: \_\_\_\_\_  
Attach proof of eligibility

**Request given to:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Contact History (date and times)**

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**Date intake offered** \_\_\_\_\_

**Date intake occurred (if different from above, state reason why)**

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**Please remind the client to bring their Provider One Card/Medical Coupon and/or Insurance ID card and/or Fee to the intake appointment. *And arrive 20 minutes early to complete paperwork.***

