

SPOKANE'S HOMELESS
ADULT AND PARENTING
ASSESSMENT FORM

SPOKANE CONSUMER UPDATE INTAKE FORM

STAFF ONLY: Organization/Program: _____ **Agency Consumer ID#** _____
Services Provided to Consumer: (Circle all that apply) Outreach/Contact, Case Management, Treatment, Support Group, Shelter, Transitional Housing, Permanent Housing, Mentoring, Follow-up, Parenting, Job Skills, Life Skills, Mental Health, Chemical Dependency, Domestic Violence, Education, Childcare.
 Services were delivered in (circle one): City or County.
Grant and Year: (Circle all that apply) SHP 2000, SHP 2001, HS Grant, THOR, S+C, Other: _____

Last Name 1st and 2nd Initial: _____, First Name Initial: _____, Middle Name Initial: _____ Maiden Name Initial: _____ VET: _____

CURRENT DATE: _____ BIRTHDATE: _____ - _____ - _____, SEX: M____, F____, T____, Other _____

ETHNICITY: Circle One: Of Hispanic Origin Not of Hispanic Origin

RACE:(Circle One) White, Native American, African American, Asian/Pacific Islander, Biracial: (please list) _____ & _____,

Other: _____ Tribal Affiliation (Name of Tribe): _____

Update on Consumer – Complete following information if it is an update on consumer or child(ren)

Do you use community voicemail? YES NO ---

Do you have a: (circle all that apply) Valid State Identification card, Drivers license, Social Security card, Birth Certificate

Referred From (Circle one): Self, Other Outreach, Shelter, School Hospital, Mental Health, Doctor, Drug Treatment, Police/Legal, CPS, Friends/Family, Other: _____

Present Income (Circle All Types That Apply): No Income, TANF, GAU, GAX, SSI, SSD, Child Support, ADATSA, Food Stamps, Part-Time Work, Full-Time Work, Veterans Benefits, Private Retirement, SSA, Unemployment, State Industrial, Medicare, Medicaid, Student Loans, Other _____

Total Present Monthly Income \$ _____

Total Amount of Food Stamps: \$ _____

Do have health insurance at this time? Yes, No

Are your children enrolled in SCHIP? Yes No NA

Do you receive WIC? Yes No NA

Since homeless has health care: Improved, Worse, Same.

Since homeless has childcare: Improved, Worse, Same, NA

Highest grade completed (Circle one):

College Graduate, AA, Technical Degree, Some College, High School Graduate, GED, 7th, 8th, 9th, 10th, 11th Grade, Less than 7th Grade

Describe Location Last Residence (Where you became homeless):

-City of Spokane: (Write Name of Neighborhood)

Neighborhood: _____

-Area in Spokane County: (circle area in county or write Town Name): North, South, City of Spokane Valley, W. Plains or Incorporated Town: _____

-ZIP Code: _____ -Other WA County: _____ -Other State: and City _____

Classification for Services – Are you: (Check One)

Have You Been Homeless Before: YES NO

Household with Children (Family)

How long have you been Homeless? _____

Household without Children (Single or with another adult)

Are you on a Permanent Affordable Housing waiting list? YES NO

Independent Youth (under age 18 – without parents/guardians) Please complete Independent Youth Intake

In the past 30 days have you been discharged from? (Circle All That Apply):

Jail/Prison, Drug TX, Alcohol TX, Psychiatric TX, Hospital, Drug & Alcohol TX, CD/MH TX, Respite, NA.

Where did you stay last night? (Circle one) Streets/Camper/Car, With Family/Friends, Shelter, Jail, Hospital, Transitional Housing, Drug TX, Alcohol TX, Psychiatric TX, Rental House/Apt, Your Own Home, Motel/Hotel

How long have you stayed at this location? _____

Were your children with you at this location? Yes No NA

Did you leave your home due to Domestic/Intimate Partner Violence?

Yes No

Reason Became Homeless (Circle all that apply):

Lack of Income, Lost Job, Lack of Affordable Housing, Illness, Alcohol Abuse, Drug Abuse, Partner Substance Abuse, Evicted, Domestic Violence, Moved, Mental Health Problems, Jail/Prison, Substandard Housing, Family Conflict, CPS Issues, Physical Disability, Fire, Other _____

Are you pregnant? Yes No NA

What is your due date? _____

Do you have any Disabilities, Please list, if any: _____

COMPLETE FOR ALL FAMILY MEMBERS.

<i>If more than 2 adults, please list their information on back.</i>	<i>Relationship to You</i>	<i>Initial of Last Name</i>	<i>Initial of First Name</i>	<i>SEX</i>	<i>Birth Date</i>	<i>Ethnicity</i>	<i>Type of Disability</i>	<i>Income Source</i>
Adult 2: Other Adult Living with you								
Adult 3: Other Adult living with you								

<i>Children</i>	<i>Relationship to You</i>	<i>Living with: You Other Parent Other Residence</i>	<i>How long</i>
Child 1 --			
Child 2--			
Child 3--			
Child 4			
Child 5			

For all Children (those living with you and not with you) complete the Child Intake form

COMPLETED BY STAFF: (UPDATE EACH TIME FORM IS COMPLETED!)

1. Was there space available today for the requested service(s)? Yes __, No __. 2. Was this person put on a pending/waiting list? Yes __, No __.
 If Consumer is ineligible, give reason: _____
 If Consumer is Housed: Address of Housing Unit: _____ Unit Number: _____

COMPLETE ONLY IF THIS IS AN UPDATE ON CONSUMER

Parent Identifier: (last initial, first initial, gender, DOB): _____

	Child 1			Child 2			Child 3			Child 4			Child 5							
Last initial																				
First Initial																				
Gender	M	F	O	M	F	O	M	F	O	M	F	O	M	F	O					
DOB																				
Ethnicity	Hispanic Origin Not Hispanic Origin			Hispanic Origin Not Hispanic Origin			Hispanic Origin Not Hispanic Origin			Hispanic Origin Not Hispanic Origin			Hispanic Origin Not Hispanic Origin							
Race																				
Disabilities	Alcohol/Drug Abuse Mental Illness Mental Ill/AL/Drug Learning Dis Chronic Heath Physical Dis Other:			Alcohol/Drug Abuse Mental Illness Mental Ill/AL/Drug Learning Dis Chronic Heath Physical Dis Other:			Alcohol/Drug Abuse Mental Illness Mental Ill/AL/Drug Learning Dis Chronic Heath Physical Dis Other:			Alcohol/Drug Abuse Mental Illness Mental Ill/AL/Drug Learning Dis Chronic Health Physical Dis Other:			Alcohol/Drug Abuse Mental Illness Mental Ill/AL/Drug Learning Dis Chronic Health Physical Dis Other:							
Are they homeless	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Live w/	Mom Dad Other Relative Foster Care Other: _____			Mom Dad Other Relative Foster Care Other: _____			Mom Dad Other Relative Foster Care Other: _____			Mom Dad Other Relative Foster Care Other: _____			Mom Dad Other Relative Foster Care Other: _____							
School																				
Grade																				
Daycare provided by																				
Reasons for not attending school	Transportation prob. Unable to register (no documents) Not in one place long enough Lack of clothing, shoes, cleanliness Doesn't like school Must baby sit younger siblings Been Sick Too Tired Other:			Transportation prob. Unable to register (no documents) Not in one place long enough Lack of clothing, shoes, cleanliness Doesn't like school Must baby sit younger siblings Been Sick Too Tired Other:			Transportation prob. Unable to register (no documents) Not in one place long enough Lack of clothing, shoes, cleanliness Doesn't like school Must baby sit younger siblings Been Sick Too Tired Other:			Transportation prob. Unable to register (no documents) Not in one place long enough Lack of clothing, shoes, cleanliness Doesn't like school Must baby sit younger siblings Been Sick Too Tired Other:			Transportation prob. Unable to register (no documents) Not in one place long enough Lack of clothing, shoes, cleanliness Doesn't like school Must baby sit younger siblings Been Sick Too Tired Other:							
Date of last regular School attendance																				
Enrolled in special classes due to disability	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Reduced/ Free Lunches at school	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
# of times child eats a day	<1x	1	2	3	3+	<1x	1	2	3	3+	<1x	1	2	3	3+	<1x	1	2	3	3+
# of times in the past 30 days child (1 & 2)																				
1. Skipped a meal due to not enough food	0	1	2	3	4+	0	1	2	3	4+	0	1	2	3	4+	0	1	2	3	4+
2. Went a whole day without eating	0	1	2	3	4+	0	1	2	3	4+	0	1	2	3	4+	0	1	2	3	4+
Have Health/Medical Insurance (type)	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Have Dental Insurance (type)	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Date of last routine check up																				
Up-to-date on immunizations	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Need medical or dental treatment	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Able to take medication that has been prescribed	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Children receiving SSI	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Child witnessed DV	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					
Teenage Child with Child	Yes		No	Yes		No	Yes		No	Yes		No	Yes		No					

SHORT FORM: ADULT CONSUMER ASSESSMENT

TRANSPORTATION:

1. Description of Transportation: Circle One	Take the Bus: 0 Transfers 1 Transfer >1 Transfer Own a Car: Reliable Unreliable Walk/Bike <1 hr/day >1 hr/day Rides from Others Reliable Unreliable No Dependable Transportation
2. Am able to buy bus tokens/pass when needed.	Never Sometimes Always NA
3. Am able to buy gas when needed.	Never Sometimes Always NA

EMPLOYMENT:

1. At least one adult in the family is employed:	Not Employed Seasonal Part-Time Full-Time
2. How many hours worked last week?	# of Hours: _____
3. Employment income meets basic financial needs.	YES NO NA
4. Employment benefits include health insurance.	YES NO NA
5. Barriers to employment are: (Circle all that apply)	Childcare Felony Transportation Health Issues Job Experience
6. At least one adult in the family possesses specific job skills.	1-NONE 2-SOME 3-GOOD
7. Are you currently looking for work?	YES NO NA

INCOME/MONEY MANAGEMENT:

1. Income meets all basic needs of family.	1-All the time, 2-Most of the time, 3-Some of the Time, 4-None of the time.
2. Do you have a monthly budget?	YES NO
3. Do you have a checking account?	YES NO
4. Do you have a Payee?	YES NO NA

EDUCATION OR EDUCATIONAL DEVELOPMENT PLAN:

Adult 2 refers to a second adult (spouse, partner, etc) living in your household. Leave blank if not 2nd adult.

1. Highest grade completed by You: (Circle 1): College Graduate, AA, Technical Degree, Some College, High School Graduate, GED, 10 th , 11 th , or 12 th Grade, 7 th , 8 th , or 9 th Grade, Less than 7 th Grade	1a. Highest grade completed by Adult 2: (Circle 1): College Graduate, AA, Technical Degree, Some College, High School Graduate, GED, 10 th , 11 th , or 12 th Grade, 7 th , 8 th , or 9 th Grade, Less than 7 th Grade, Unknown
2. In the next year do you plan to attend the following? GED Program, Comm./Tech College, 4 Yr School, None of above	2a. In the next year do you plan to attend the following? GED Program, Comm./Tech College, 4 Yr School, None of above
3. Barriers to education are: (Circle all that apply) Childcare Transportation Health Issues Financial Felony	3a. Barriers to education are: (Circle all that apply) Childcare Transportation Health Issues Financial Felony

NUTRITION:

1. The family is accessing food stamps. Circle "NA" if you don't need food stamps.	YES NO NA
2. With your current income (including food stamps if appropriate), you can purchase enough food to feed family members for breakfast, lunch and dinner.	1-All the time, 2-Most of the time, 3-Some of the Time 4-None of the time.
3. When eligible, the family uses emergency food bank services:	Monthly, Several Times a Year, Not At All, NA
4. All family members are able to maintain any special diet required by a medical condition.	1-All the time, 2-Most of the time, 3-Some of the Time 4-None of the time. 5. NA

PHYSICAL AND MENTAL HEALTH:

1. Compared to other people your age, would you say your health is:	Excellent Very Good Good Fair Poor
2. All adults have a regular doctor or clinic.	YES NO
2a. Can you afford medical co-pay?	YES NO NA
3. All adults have a regular dentist.	YES NO
3a. Can afford dental co-pay?	YES NO NA
4. The family has resources to buy supplies (excluding first aid and other Over-the-Counter items), medications or treatments not covered by insurance.	1-All the time, 2-Most of the time, 3-Some of the Time, 4-None of the time.

5. The family relies on emergency services for regular health care:	1-All the time, 2-Most of the time, 3-Some of the Time, 4-None of the time.
6. Adults have up-to-date immunizations (Diphtheria/tetanus every 10 years).	YES NO
7. Adults have been tested for TB in the last 2 years.	YES NO
8. Adults have had a complete physical in the last 2 years.	YES NO

10. You have a serious or chronic health problem that affects your daily life? YES NO	10a. Adult 2 has a serious or chronic health problem that affects his/her daily life? YES NO Unknown
You are (Circle One): Participating in treatment___, Participating in Support Group ____, No longer needs treatment ____, On waiting list___ Refuses treatment___, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never Went___ Other issues/activity) _____ If on waiting list, Date applied _____. Date treatment will start _____.	Adult 2 is: (Circle One): Participating in treatment___, Participating in Support Group ____, No longer needs treatment ____, On waiting list___ Refuses treatment___, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never Went___ Unknown___ Other issues/activity) _____ If on waiting list, Date applied _____. Date treatment will start _____.

11. You have a serious mental health problem that affects your daily life? YES NO	11a. Adult 2 has a serious mental health problem that affects his/her daily life? YES NO Unknown
You are (Circle One): Participating in treatment___, Participating in Support Group ____, No longer needs treatment ____, On waiting list___ Refuses treatment___, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never Went___ Other issues/activity) _____ If on waiting list, Date applied _____. Date treatment will start _____.	Adult 2 is: (Circle One): Participating in treatment___, Participating in Support Group ____, No longer needs treatment ____, On waiting list___ Refuses treatment___, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never Went___ Unknown___ Other issues/activity) _____ If on waiting list, Date applied _____. Date treatment will start _____.

12. You have drug/alcohol dependency that affects your life? YES NO	12a. Adult 2 has drug/alcohol dependency that affects his/her daily life? YES NO Unknown
You are (Circle One): Participating in treatment___, Participating in Support Group ____, No longer needs treatment ____, On waiting list___ Refuses treatment___, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never Went___ Other issues/activity) _____ If on waiting list, Date applied _____. Date treatment will start _____.	Adult 2 is: (Circle One): Participating in treatment___, Participating in Support Group ____, No longer needs treatment ____, On waiting list___ Refuses treatment___, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never Went___ Unknown___ Other issues/activity) _____ If on waiting list, Date applied _____. Date treatment will start _____.

13. You have experienced Domestic/Intimate Partner Violence? YES NO Are you seeking advocacy? YES NO	17a. Adult 2 has experienced Domestic/Intimate Partner Violence? YES NO Unknown Are they seeking advocacy? YES NO
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FAMILY RELATIONS:

1. Have you experienced domestic/Intimate Partner violence: YES _____ NO_____	2a. How long ago? ___ less than 3 months, ___ 3 to 6 months ago, ___ 6 to 12 months ago, or ___ over one year ago.
2. Is the family receiving any kind of counseling? Yes No If yes, what kind? _____	

LEGAL ISSUES

1. Have you been charged with a crime during the last 2 years. YES NO Please indicate type (Circle all that apply) Felony Misdemeanor Traffic Infraction (speeding, parking) DUI Other: _____	1a. Has Adult 2 been charged with a crime during the last 2 years. YES NO Please indicate type (Circle all that apply) Felony Misdemeanor Traffic Infraction (speeding, parking) DUI Other: _____
2. Do you have any outstanding legal fines? YES NO NA	2a. Does Adult 2 have any outstanding legal fines? YES NO NA Unknown
3. Do you have a valid drivers license? YES NO If Yes, issuing state: _____	3a. Does Adult 2 have a valid drivers license? YES NO NA Unknown If Yes, issuing state: _____

4. Do you currently pay child support? YES NO NA	4a. Does Adult 2 currently pay child support? YES NO NA Unknown
5. Do you owe any back child support? YES NO NOT SURE NA	5a. Does Adult 2 owe any back child support? YES NO NOT SURE NA

VETERANS-

This sections applies to all clients who answered "YES" to Vet question	Is Adult 2 a VET? YES NO DON'T KNOW REFUSED
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1. Which military service eras did you serve? (Check all that apply) <input type="checkbox"/> World War I (April 1917—Nov 1918) <input type="checkbox"/> Between WWI and WWII (Dec 1918—August 1940) <input type="checkbox"/> World War II (Sept 1940—July 1947) <input type="checkbox"/> Between WWII and Korean War (Aug 1947—May 1950) <input type="checkbox"/> Korean War (June 1950—Jan 1955) <input type="checkbox"/> Between Korean and Vietnam War (Feb 1955—July 1964) <input type="checkbox"/> Vietnam Era (Aug 1964—April 1975) <input type="checkbox"/> Post Vietnam (May 1975—July 1991) <input type="checkbox"/> Persian Gulf Era (Aug 1991— Present) <input type="checkbox"/> Don't know <input type="checkbox"/> Refused	1a. Which military service eras did Adult 2 serve? (Check all that apply) <input type="checkbox"/> World War I (April 1917—Nov 1918) <input type="checkbox"/> Between WWI and WWII (Dec 1918—August 1940) <input type="checkbox"/> World War II (Sept 1940—July 1947) <input type="checkbox"/> Between WWII and Korean War (Aug 1947—May 1950) <input type="checkbox"/> Korean War (June 1950—Jan 1955) <input type="checkbox"/> Between Korean and Vietnam War (Feb 1955—July 1964) <input type="checkbox"/> Vietnam Era (Aug 1964—April 1975) <input type="checkbox"/> Post Vietnam (May 1975—July 1991) <input type="checkbox"/> Persian Gulf Era (Aug 1991— Present) <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
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2. How long did you serve on active duty in the military? _____ Months _____ Years	2a. How long did you serve on active duty in the military? _____ Months _____ Years
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5. What branch of military did you serve in? <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refused	5a. What branch of military did Adult 2 serve in? <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
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3. Did you serve in a war zone? YES NO DON'T KNOW REFUSED If yes, What war zone? (Check all that apply) <input type="checkbox"/> Europe <input type="checkbox"/> North Africa <input type="checkbox"/> Vietnam <input type="checkbox"/> Laos and Cambodia <input type="checkbox"/> South China Sea <input type="checkbox"/> China, Burma, India <input type="checkbox"/> Korea <input type="checkbox"/> South Pacific <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Other Length of time served in a war zone? _____ months	3. Did Adult 2 serve in a war zone? YES NO DON'T KNOW REFUSED If yes, What war zone? (Check all that apply) <input type="checkbox"/> Europe <input type="checkbox"/> North Africa <input type="checkbox"/> Vietnam <input type="checkbox"/> Laos and Cambodia <input type="checkbox"/> South China Sea <input type="checkbox"/> China, Burma, India <input type="checkbox"/> Korea <input type="checkbox"/> South Pacific <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Other Length of time served in a war zone? _____ months
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4. Did you ever receive hostile or friendly fire in a war zone? YES NO DON'T KNOW REFUSED	4a. Did Adult 2 ever receive hostile or friendly fire in a war zone? YES NO DON'T KNOW REFUSED
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6. What type of discharge did you receive? <input type="checkbox"/> Honorable <input type="checkbox"/> General <input type="checkbox"/> Medical <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> Other <input type="checkbox"/> Don't know <input type="checkbox"/> Refused	6a. What type of discharge did Adult 2 receive? <input type="checkbox"/> Honorable <input type="checkbox"/> General <input type="checkbox"/> Medical <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> Other <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
--	---

List Resources You Are Using	Circle Frequency of Use	Comments/Concerns
	Never, Weekly, Monthly, Several times a year.	
	Never, Weekly, Monthly, Several times a year.	
	Never, Weekly, Monthly, Several times a year.	
	Never, Weekly, Monthly, Several times a year.	
	Never, Weekly, Monthly, Several times a year.	

ANY COMMENTS YOU WOULD LIKE TO MAKE:

INTERVIEWER COMMENTS:

Check here if actively parenting (*Continue to Parenting Assessment form*)

PARENTING ASSESSMENT

Date of assessment: _____

EDUCATION STATUS OF CHILDREN:	
<i>Complete only if school-age children (K-12). If no school-age children go to Physical and Mental Health.</i>	
1. All school-age children are attending school.	YES NO
2. How many schools have your children been enrolled in during the last year? _____	
3. One or more of your children frequently misses school. (unexcused absences)	More than 5 times in a month More than 10 times in a year
4. One or more of your children are having discipline problems at school.	YES NO
5. Parents can afford basic school supplies and fees.	1. All the time, 2. Most of the time, 3. Some of the Time, 4. None of the time. 5. NA
6. How often do Parents attend conferences with School Staff regarding their child's performance in the last school year?	1. All the time, 2. Most of the time, 3. Some of the Time, 4. None of the time. 5. NA.
7. How often do Parents attend school related activities (presentations, sporting events) in the last school year?	1. All the time, 2. Most of the time, 3. Some of the Time, 4. None of the time. 5. NA.
8. Do any of your children need additional help in school?	YES NO
9. Are your children getting the extra help that they need in school?	YES NO
10. Does one or more of your children have an IEP (Individual Education Plan)?	YES NO Needs One
11. Do your children feel safe in school?	YES NO
12. Do your children feel safe going back and forth to school?	YES NO

PHYSICAL AND MENTAL HEALTH:	
1. All children have a regular doctor or clinic.	YES NO
2. All children have a regular dentist.	YES NO
3. Compared to other children (your son or daughter's age), would you say your son or daughter's health is:	Excellent Very Good Good Fair Poor
4. Do any of your children have a serious or chronic health problem that affects their daily life? YES NO	
Child is (Circle One): Participating in treatment __, Participating in Support Group ____, No longer needs treatment ____, On waiting list ____, Refuses treatment ____, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never went ____, Other issues/activity) _____.	
If on waiting list, Date applied _____ Date treatment will start _____.	
5. Do any of your children have a serious mental health problem that affects their daily life? YES NO	
Child is (Circle One): Participating in treatment __, Participating in Support Group ____, No longer needs treatment ____, On waiting list ____, Refuses treatment ____, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never went ____, Other issues/activity) _____.	
If on waiting list, Date applied _____ Date treatment will start _____.	
6. Do any of your children have an alcohol/drug dependency that affects their daily life? YES NO	
Child is (Circle One): Participating in treatment __, Participating in Support Group ____, No longer needs treatment ____, On waiting list ____, Refuses treatment ____, Can't afford treatment ____, Been dropped from the program ____, Completed Treatment ____, Never went ____, Other issues/activity) _____.	
If on waiting list, Date applied _____ Date treatment will start _____.	

CHILD CARE / PRESCHOOL: (Go to 'Resource List ' if no young children)	
1. Preschool age children are enrolled in Early Head Start, Head Start, ECEAP? <i>NA if no pre-school children.</i>	NA YES NO
2. Do children have a safe place to play outside?	YES NO
3. Do you have a place you can take your children in case of an emergency?	YES NO
4. Have you ever utilized the crisis nursery in Spokane? If YES, how many times? _____	YES NO

RESOURCE LIST

List resources/activities you use or do with your children, and circle the frequency of activity.

Resource/Activity	Frequency of Activity	Resource/Activity	Frequency of Activity
Library	Never, Daily, Weekly, Monthly, Several Times a Year	Faith-based Organization	Never, Daily, Weekly, Monthly, Several Times a Year
Community Centers	Never, Daily, Weekly, Monthly, Several Times a Year	Social Service Org (e.g. YWCA, YMCA, TLC)	Never, Daily, Weekly, Monthly, Several Times a Year
After School Programs	Never, Daily, Weekly, Monthly, Several Times a Year	Working with Treating Professional (counseling)	Never, Daily, Weekly, Monthly, Several Times a Year
Time with extended family (Grandparents, aunts, etc.)	Never, Daily, Weekly, Monthly, Several Times a Year	Shopping	Never, Daily, Weekly, Monthly, Several Times a Year
Parks (pools, summer programs, playground, etc.)	Never, Daily, Weekly, Monthly, Several Times a Year	Reading	Never, Daily, Weekly, Monthly, Several Times a Year
Youth Sports (e.g. Soccer, Baseball)	Never, Daily, Weekly, Monthly, Several Times a Year	TV	Never, Daily, Weekly, Monthly, Several Times a Year
Movies	Never, Daily, Weekly, Monthly, Several Times a Year	Describe Other:	Never, Daily, Weekly, Monthly, Several Times a Year

ANY COMMENTS YOU WOULD LIKE TO MAKE:

INTERVIEWER COMMENTS: