

Dear Parent/Guardian,

Your student has the opportunity to register for Truancy Groups provided at Samuel Clemens high school FREE OF CHARGE. These groups are intended to recovery hours for your student to avoid truancy court.

The FREE groups are held once a week from 4:15-5:15 in the Clemens Library. No transportation home will be provided.

The following are required forms that need to be completed in order for your student to participate.

Pages 1-3 are your copies

Pages 4-8: Please complete the highlighted sections.

Please send forms (pages 4-8) back with your student by October 23, 2015. They can turn the forms in to Ms. Zuniga or Ms. Henry in the Blue Office.

Once the forms have been processed, your student will be placed in a Truancy Group for 4 weeks. Any questions about absences, amount of time earned, or truancy court should be directed to your student's Assistant Principal.

The first group meeting will be on the first Monday or Tuesday of the month. Parents/Guardians are required to attend from 4:15p-4:45p. If you cannot make this time please contact me to schedule a time that you are available. This may impact your student's ability to participate in group at this time.

This packet is for Truancy Groups only. If you would like to participate in Family or Individual sessions, please contact me so we can schedule a time for sessions.

Thank you,

Dawn Hensley

S.T.A.R. Program Counselor

Connections: Individual and Family Services

Phone: 210-659-9067

Fax: 210-659-9293

Crisis Hotline: 1-800-532-8192

KEEP THIS FORM

Connections Individual and Family Services, Inc. Notice of Privacy Practices Form

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions please contact your counselor or our administrative office.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an **Acknowledgement Of Receipt Of Privacy Practices**. Once you have received your Notice of Practices, disclosure of your protected health information will be used for treatment, payment and health operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care/treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay our health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other health care providers to provide, coordinate, or manage your health care upon your written consent. For example, your protected health information may be provided to another counseling agency to whom you have been referred to ensure that the necessary information is available to diagnose or to treat you.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include activities that your insurance plan may undertake before it approves or pay for the services we recommend or information provided to our funding sources in order to report services provided.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to quality assessment activities, employee review activities, licensing and/or credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your counselor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to follow-up on services provided.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or contract services) for the agency. Whenever an arrangement between our office and a business involves the use or disclosure of your protected health information, we will have written contract terms that will protect your health information.

We may use or disclose your health information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your protected health information for the other marketing activities. For example, your name and address may be used to send a newsletter about our agency and the services we offer. You may contact your counselor or our administrative office to request that these materials not be sent to you.

Uses and Disclosure of Protected Health Information Based upon Your Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may use professional judgment to determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help you with your healthcare or with payment of your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up personal belongings, request for appointments or other similar forms of health information.

Other Permitted and Required Uses Disclosures That May Be Made Without Your Consent

Required By Law: We may use or disclose your protected health information when we are required to do so by law.

Emergencies: We may use or disclose your protected health information in an emergency situation. If this happens, we will try to obtain your Acknowledgement Of Receipt Of Privacy Practice as soon reasonably practicable after the delivery of services. In the event of your incapacity or in an emergency, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.

KEEP THIS FORM

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for law intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcements having lawful custody, the protected health information of the inmates or patients under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

Your Rights:

You have the right to inspect and copy your protected health information. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopy. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice or by contacting our administrative office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

You have the right to request restriction of your protected health information. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by agreement, except in an emergency.

You have the right to request alternative communication from us: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or the location, and provide satisfactorily how communication will be handled under the alternative means or locations you request.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. The right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exception, restrictions and limitation. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to the additional request.

You have the right to make a complaint about our privacy policies: If you are concerned that we have violated your privacy rights, you may file a complaint with your counselor or our administrative office using the information listed at the bottom of this page. You may file a written complaint with the Department of Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date _____

Counselor/ Staff Sheila Dawn Walke LPC-Intern Telephone 830 303 0309

Fax 210 659 9293 Email dhensley@connectionsnonprofit.org

Address: 700 W FM 78 suite 203 Cphlo, TX 78108

Supervised by: Michelle Dawn Satter LPC-s

CLIENT RIGHTS AND GRIEVANCE PROCEDURE

Connections Individual and Family Services, Inc. (dba. Connections)

- Every client shall receive services or appropriate referral without regard to race, color, age, gender, marital status, sexual orientation, religion, national origin or disabling condition (including mental illness.) Clients also have the right to be treated as individuals with varying needs based on cultural, social and religious backgrounds.
 - Every client has the right to be treated with dignity and respect, and the right to courteous and professional services.
 - Every client has the right to refuse services, treatment, or medication unless law or court order has limited such rights.
 - Every client, including youth, shall have the right to seek services on his/her own, and will be treated in the same manner as clients referred by parents or other referring entity.
 - Specific information about care or treatment alternatives shall be provided to the client or family upon request.
 - Every client shall participate in treatment or service planning to the extent of his/her ability to do so.
 - Every client shall be given written information about any fees for service if such fees exist. No client shall be denied services based on the inability to pay. Any client denied services shall receive an explanation for the denial.
 - Every client shall be free of physical, sexual, verbal or other abuse and from neglect or exploitation from other clients and from agency staff.
 - Every client has the right to privacy and confidentiality. No records or other information regarding the client shall be either released or obtained without specific written permission from the client and/or their parent or guardian. The client shall also be protected even in the event of agency approved tours of facilities.
 - Clients will not perform labor or services for the facility unless for therapeutic purposes or to satisfy program requirements stated in the program policy and procedure and approved by the Board of Directors.
 - Each client receiving services shall be informed of these rights in writing before receiving services.
- Clients may voice grievances and recommend changes in policy, free from restraint and discrimination. Clients have the right to register complaints about any program to the agency or directly to the funding/regulatory agency at any time, and also have the right to any available protection and advocacy services in order to receive assistance in understanding/exercising the rights described here. All personnel have access to these services and phone numbers.
- It is your right as a client, or the right of your family members or representative, to seek remedy for any grievance based on the care or services you receive from Connections, including any complaints based on any violation of your rights, any instances of abuse, neglect, or exploitation, or any violation of regulatory agency rules.

The procedure for any grievance is as follows:

- You should meet with your counselor, Dawn Hensley, telephone number 830 303 0329, or the staff member(s) involved and express the problem. In the absence of the counselor or staff member directly involved, you may go to any other counselor or staff member.
- If no resolution occurs, the counselor or staff member and the client should take the complaint to the Program Director/Administrator in charge, Elaine Brandon, at 830-629-6571; then to the Executive Director, Kellie Stallings, until a satisfactory solution occurs.
- If no resolution occurs, the complaint will be forwarded to the funding source and/or regulatory agency for the program in question in order to have the case considered and a final decision rendered.
- You have the right to go directly to the funding or regulatory source for any complaint at any time.

The name and address of the funding agency for the STAR Program is:

Texas Department of Family and Protective Services
Attn: Lisa Canales, Contract Manager
Mail Code Y-987
P.O. Box 149030
Austin, TX 78714-9030
Tel: (512) 438-4497

- Your Complaint will be documented and acknowledged within 24 hours (72 hours on weekends). A reasonable time frame for final disposition is seven working days.
- Pens, paper, envelopes, postage, access to a telephone and assistance with writing the complaint will be made available to you upon request.

Client Signature

Date

Parent/guardian signature if minor client

Date

Staff Signature

Date

Consent for GROUP Services

Connections Individual and Family Services, Inc. (dba Connections)

By signing below you agree that:

*You have received a copy of the Notice of Privacy Practices Form and the Client Rights and Grievance Procedure

*You agree to consent to provide services to include any of the following: Youth Counseling, Family Counseling, Youth Coping Skills Training, Parent Skills Training, Crisis Intervention. You have been given a copy of the consent that discusses Counseling Techniques, Confidentiality, Exceptions to confidentiality, Financial Agreement, and Hours of Operation.

*You understand that the Counselor must report the following information to the appropriate authority:

- Verbal or written threat of suicide or homicide
- Emotional, physical, or sexual abuse or neglect of a child, elderly, or handicapped person
- A court order requesting Counselor files

*You agree to allow Connections Counselor(s) to obtain and release only information relevant to this client to the following entity: Samuel Clemens High School. This is effective for up to 180 days, which expires on: _____ (180 days from today).

*You understand that at any time you can ask for more information or clarification on the above mentioned items.

Adult/Parent/Guardian

Date

Minor Client

Date

Counselor

Date

Client Registration Form for the Services To At-Risk Youth (STAR) Program

(*indicates required field)

Intake Initials	Staff Initials	Intake Date / or *Open Date	Data Entry Staff Name	Data Entry Date
Target Youth Information			Client ID:	
*Last Name:		*First Name:	Middle Name:	
*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Suffix: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> JR <input type="checkbox"/> SR	*Date of Birth:	SSN:	
*Ethnic Group (select only one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Unable To Determine <input type="checkbox"/> Non-Hispanic				
*Race (select all that apply): <input type="checkbox"/> Am Indian/Ak Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacif Isl <input type="checkbox"/> White <input type="checkbox"/> Unable To Determine				
*County Number:	*County Name:		Colonia (if applicable):	
*Client Address	H=Home & W=Work Address: <input type="checkbox"/> H <input type="checkbox"/> W		P=Primary & S=Secondary Address: <input type="checkbox"/> P <input type="checkbox"/> S	
*Address Line 1:		*City:	*State:	*ZIP Code:
Telephone Number (with Area Code)	P=Land Line & C=Cell Phone	H=Home & W=Work Phone/Email	P=Primary & S=Secondary Phone/Email	
1.	<input type="checkbox"/> P <input type="checkbox"/> C	<input type="checkbox"/> H <input type="checkbox"/> W	<input type="checkbox"/> P <input type="checkbox"/> S	
2.	<input type="checkbox"/> P <input type="checkbox"/> C	<input type="checkbox"/> H <input type="checkbox"/> W	<input type="checkbox"/> P <input type="checkbox"/> S	
Email Address:	<input type="checkbox"/> H <input type="checkbox"/> W		<input type="checkbox"/> P	
Target Youth Registration			Registration ID:	
*Client's Presenting Problem (Select One) a. At Risk Youth or b. Delinquent Behavior:				
<input type="checkbox"/> Runaway <input type="checkbox"/> Truant <input type="checkbox"/> Family Conflict <input type="checkbox"/> Misdemeanor Offense <input type="checkbox"/> State Jail Felony Offense <input type="checkbox"/> Youth Under 10 Delinquent Offense				
c. Offence Code:				
*School Status when Entering Program: <input type="checkbox"/> Attending Regularly <input type="checkbox"/> Attending-Some Truancy <input type="checkbox"/> Suspended				
<input type="checkbox"/> Expelled <input type="checkbox"/> Dropped Out <input type="checkbox"/> Parents Withdrawn <input type="checkbox"/> Alt. Sch./GED Homebound				
<input type="checkbox"/> Graduated High School <input type="checkbox"/> School Not In Session <input type="checkbox"/> Completed GED <input type="checkbox"/> Under School Age				
Has target youth been homeless in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is there an open CPS case? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Youth adjudicated or on probation?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Referral Source (select one): <input type="checkbox"/> Self (Youth) <input type="checkbox"/> Parental Figure <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Provider Agency Staff				
<input type="checkbox"/> School <input type="checkbox"/> Protective Services <input type="checkbox"/> Texas Youth/Runaway Hotline <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Juvenile Probation				
<input type="checkbox"/> Clergy/Church <input type="checkbox"/> MHMR <input type="checkbox"/> Other Private Agency <input type="checkbox"/> Other Youth Service Agency				
<input type="checkbox"/> Other Hotline <input type="checkbox"/> Court Ordered				
*Where is the youth living at initiation of service? <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Living Independently <input type="checkbox"/> No Stable Liv. Environ.				
<input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Relative's Home <input type="checkbox"/> Secured Facility Detention Ctr. <input type="checkbox"/> Street <input type="checkbox"/> Structured Substitute Care				
<input type="checkbox"/> Trans. From Other Shelter <input type="checkbox"/> Unstructured Substitute Care (Friends, etc.) <input type="checkbox"/> with Biological or Adoptive Parents				
<input type="checkbox"/> with Legal Guardian				
*1. The family earns under \$63,000.00 per year. <input type="checkbox"/> Yes <input type="checkbox"/> No				
*2. The child lives with or has lived with a parent or relative sometime in the past six months. <input type="checkbox"/> Yes <input type="checkbox"/> No				
*3. The crisis did not occur because a family member refused employment or training for employment. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Family Housing: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Temporary with Relatives/Friends <input type="checkbox"/> Shared Housing with Relatives/Friends				
Primary Language Spoken in the Home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Others				
Contributing Factors: <input type="checkbox"/> 1. Severe Family Conflict <input type="checkbox"/> 2. Violence in Family <input type="checkbox"/> 3. Youth's Assaultive Behavior				
<input type="checkbox"/> 4. Youth's Problems w/Juvenile Justice <input type="checkbox"/> 5. Youth's Drug/Alcohol Abuse <input type="checkbox"/> 6. Youth has Suicidal Thoughts <input type="checkbox"/> 7. Youth Attempted Suicide in Past				
<input type="checkbox"/> 8. Past Victim of Child Abuse <input type="checkbox"/> 9. School Problems <input type="checkbox"/> 10. None Apply				

Info about PARENT / GUARDIAN

Texas Department of Family and Protective Services
Prevention and Early Intervention (PEI) Division

Form 2075A
September 2014

Primary Caregiver (PCG) Information						Client ID:	
*Last Name:			*First Name:			Middle Name:	
*Date of Birth:		SSN:	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Suffix: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> JR <input type="checkbox"/> SR		
Education Level:		<input type="checkbox"/> Pre-K/Kinder	<input type="checkbox"/> 1 st Grade	<input type="checkbox"/> 2 nd Grade	<input type="checkbox"/> 3 rd Grade	<input type="checkbox"/> 4 th Grade	<input type="checkbox"/> 5 th Grade
<input type="checkbox"/> 6 th Grade		<input type="checkbox"/> 7 th Grade	<input type="checkbox"/> 8 th Grade	<input type="checkbox"/> 9 th Grade	<input type="checkbox"/> 10 th Grade	<input type="checkbox"/> 11 th Grade	<input type="checkbox"/> 12 th Grade
<input type="checkbox"/> Did Not Graduate		<input type="checkbox"/> Graduated H.S./GED	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Post Graduate	<input type="checkbox"/> Unknown	
*Relationship to Target Youth:		<input type="checkbox"/> Aunt	<input type="checkbox"/> Brother	<input type="checkbox"/> Father	<input type="checkbox"/> Female Cousin	<input type="checkbox"/> Foster Father	
<input type="checkbox"/> Foster Mother		<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Male Cousin	<input type="checkbox"/> Mother	<input type="checkbox"/> Other, Non-Related	
<input type="checkbox"/> Other, Related		<input type="checkbox"/> Sister	<input type="checkbox"/> Step Father	<input type="checkbox"/> Step Mother	<input type="checkbox"/> Uncle		
*Marital Status Code:		<input type="checkbox"/> CH=Child, Not Applicable	<input type="checkbox"/> DI=Divorced	<input type="checkbox"/> SE=Separated	<input type="checkbox"/> MA=Married	<input type="checkbox"/> SI=Single, Never MA	
<input type="checkbox"/> UK=Unknown		<input type="checkbox"/> WI=Widowed					
*Ethnic Group (select only one):		<input type="checkbox"/> Hispanic	<input type="checkbox"/> Unable To Determine	<input type="checkbox"/> Non-Hispanic			
*Race (select all that apply):		<input type="checkbox"/> Am Indian/Ak Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Native Hawaiian/Pacif Isl	<input type="checkbox"/> White	<input type="checkbox"/> Unable To Determine
Client Address - Same as Target Youth? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, complete the County, Address, Phone Number and Email Address sections below.							
*County Number:		*County Name:			Colonia (if applicable):		
*Client Address		H=Home & W=Work Address: <input type="checkbox"/> H <input type="checkbox"/> W			P=Primary & S=Secondary Address: <input type="checkbox"/> P <input type="checkbox"/> S		
*Address line 1:		*City:		*State:		*ZIP Code:	
Telephone Number (with Area Code)		P=Land Line & C=Cell Phone		H=Home & W=Work Phone/Email		P=Primary & S=Secondary Phone/Email	
1.		<input type="checkbox"/> P <input type="checkbox"/> C		<input type="checkbox"/> H <input type="checkbox"/> W		<input type="checkbox"/> P <input type="checkbox"/> S	
2.		<input type="checkbox"/> P <input type="checkbox"/> C		<input type="checkbox"/> H <input type="checkbox"/> W		<input type="checkbox"/> P <input type="checkbox"/> S	
Email Address:		<input type="checkbox"/> H <input type="checkbox"/> W		<input type="checkbox"/> P			
Secondary Caregiver (SCG) Information						Client ID:	
*Last Name:			*First Name:			Middle Name:	
*Date of Birth:		SSN:	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Suffix: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> JR <input type="checkbox"/> SR		
Education Level:		<input type="checkbox"/> Pre-K/Kinder	<input type="checkbox"/> 1 st Grade	<input type="checkbox"/> 2 nd Grade	<input type="checkbox"/> 3 rd Grade	<input type="checkbox"/> 4 th Grade	<input type="checkbox"/> 5 th Grade
<input type="checkbox"/> 6 th Grade		<input type="checkbox"/> 7 th Grade	<input type="checkbox"/> 8 th Grade	<input type="checkbox"/> 9 th Grade	<input type="checkbox"/> 10 th Grade	<input type="checkbox"/> 11 th Grade	<input type="checkbox"/> 12 th Grade
<input type="checkbox"/> Did Not Graduate		<input type="checkbox"/> Graduated H.S./GED	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Post Graduate	<input type="checkbox"/> Unknown	
*Relationship to Target Youth:		<input type="checkbox"/> Aunt	<input type="checkbox"/> Brother	<input type="checkbox"/> Father	<input type="checkbox"/> Female Cousin	<input type="checkbox"/> Foster Father	
<input type="checkbox"/> Foster Mother		<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Male Cousin	<input type="checkbox"/> Mother	<input type="checkbox"/> Other, Non-Related	
<input type="checkbox"/> Other, Related		<input type="checkbox"/> Sister	<input type="checkbox"/> Step Father	<input type="checkbox"/> Step Mother	<input type="checkbox"/> Uncle		
*Marital Status Code:		<input type="checkbox"/> CH=Child, Not Applicable	<input type="checkbox"/> DI=Divorced	<input type="checkbox"/> SE=Separated	<input type="checkbox"/> MA=Married	<input type="checkbox"/> SI=Single, Never MA	
<input type="checkbox"/> UK=Unknown		<input type="checkbox"/> WI=Widowed					
*Ethnic Group (select only one):		<input type="checkbox"/> Hispanic	<input type="checkbox"/> Unable To Determine	<input type="checkbox"/> Non-Hispanic			
*Race (select all that apply):		<input type="checkbox"/> Am Indian/Ak Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Native Hawaiian/Pacif Isl	<input type="checkbox"/> White	<input type="checkbox"/> Unable To Determine
Other Family Members Information							
*Last Name	*First Name	*Date of Birth	Age	*Relationship to Youth	Participate in Family Sessions?		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		

Permissions (select all that apply): ☐ Messages may be left on my voice mail. ☐ Mail may be sent to my home.
☐ Email may be sent to me. ☐ Agency staff (besides counselors) may contact me.

Required Signature

I certify that, to the best of my knowledge, the above information is true and correct, and I authorize services.

Printed Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date

Prevention and Early Intervention Protective Factor Survey for Caregivers

PROGRAM STAFF USE ONLY

PRE TEST ☐POST TEST ☐

PEIS Client ID#

Caregiver First Name

Caregiver Last Name:

Caregiver DOB:

Today's Date:

Is this family member an expectant parent with no other children in the home? Yes ☐ No ☐Has this family member completed the program? Yes ☐ No ☐

Thank you for taking the time to fill out this survey! The information will be used to evaluate the program. For each of the questions, please answer in your own opinion or experience instead of trying to answer for other members of your family. Please answer honestly. There are no right or wrong answers.

If you have any questions about one of the statements or the answer scale, ask one of the program staff. Please do not skip a question.

Part I. Please circle the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. For example, the number 4 means that the statement is true about half the time.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems.	1	2	3	4	5	6	7

Part II. Please **circle** the number that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

Prevention and Early Intervention Protective Factor Survey for Caregivers

Part III. This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services.

Please write the child's age or date of birth and then answer questions with this child in mind.

Child's Age _____ or DOB ____/____/____

If you are expecting your first baby and there are no more children in your home, STOP here.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
12. There are many times when I don't know what to do as a parent.	1	2	3	4	5	6	7
13. I know how to help my child learn.	1	2	3	4	5	6	7
14. My child misbehaves just to upset me.	1	2	3	4	5	6	7

Part IV. Please tell us how often each of the following happens in your family.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
15. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
16. When I discipline my child, I lose control.	1	2	3	4	5	6	7
17. I am happy being with my child.	1	2	3	4	5	6	7
18. My child and I are very close to each other.	1	2	3	4	5	6	7
19. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
20. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7