



1516 East Colonial Drive, Suite 305, Orlando FL 32803-4706 / Phone (305) 647-8973 / Fax _____

W&A Application for Services

Date Received: _____ Date Started: _____ Retaining List Services None Applicable

Client Name: _____ DOB: _____ Age: _____ Race: _____ Sex: _____
 Client Record ID #: _____ SS#: _____ Medicaid #: _____
 Legal Guardian: _____ Relationship: _____
 Primary Caregiver Name: _____ Relationship: _____
 Address: _____ Telephone: _____
 Referral Source: _____ Contact Person: _____
 Telephone: _____ Mailing Address: _____

PRIMARY CAREGIVER: check all that apply

Two Parents Single Father Other Relative(s) Out of Home Placement
 Single Mother Grandparent(s) Foster Parent(s) Other (specify) _____

SCHOOL STATUS: check only one

Enrolled Suspended Home-Bound Enrolled in GED Program Dropped out of school
 Expelled Alternative Education Graduated Not Applicable

REFERRAL SOURCE ASSESSMENT OF PRESENTING PROBLEMS: check all that apply

Abuse / Neglect Aggressive / Delinquent Behavior Anger Management Communication
 Sexual Abuse Lack of Academic Performance Parent/Child Relationship(s) Parenting Skills
 Sex Offender School Discipline Problems Substance Abuse Truancy
 Other (Specify) _____

DIAGNOSTIC INFORMATION - ICD9 / DSM-IV:

Date of Diagnosis: _____ Current Medications: _____
 Please add number and description:
 Axis I: _____ Axis IV: _____
 Axis II: _____ Axis V: _____
 Axis III: _____

CURRENT PLACEMENT:

Is the client at risk of an out-of-home placement? Yes No If Yes, where?
 Foster Care Relative Youth Academy/Training Center Psychiatric Hospitalization
 Secure Detention Group Home Residential Treatment Facility Respite/ Emergency Shelter
 Other (specify) _____
 How great is the risk of the placement? Low Moderate High Placement Pending

PLACEMENT HISTORY: Not Applicable

Placement	How Many Times	Duration	Date
<input type="checkbox"/> Foster Care	_____	_____	_____
<input type="checkbox"/> Relative	_____	_____	_____
<input type="checkbox"/> Psychiatric Hospitalization	_____	_____	_____
<input type="checkbox"/> Group Home	_____	_____	_____
<input type="checkbox"/> Residential Treatment Facility	_____	_____	_____
<input type="checkbox"/> Respite/ Emergency Shelter	_____	_____	_____
<input type="checkbox"/> Other (specify) _____	_____	_____	_____

Does this client have any previous or current DJJ involvement? Yes No

Probation _____
 Youth Academy/Training Center _____
 Secure Detention _____
 Other (specify) _____

CAREGIVER INFORMATION:

Primary Caregiver:

- Biological Mother Biological Father Foster Mother Foster Father Other _____
 Adoptive Mother Adoptive Father Grandmother Grandfather
 Step-Mother Step-Father Other Female Relative Other Male Relative

Primary Caregiver Highest Education Completed:

- Some High School High School Diploma/ GED Some College Vocational / Technical/ Associates Degree
 Bachelors Degree Masters Degree Other (specify) _____

Primary Caregiver Employment:

- Unemployed Employed Retired Occupation: _____

Secondary Caregiver:

- Not Applicable
 Biological Mother Biological Father Foster Mother Foster Father Other _____
 Adoptive Mother Adoptive Father Grandmother Grandfather
 Step-Mother Step-Father Other Female Relative Other Male Relative

Secondary Caregiver Highest Education Completed:

- Some High School High School Diploma/ GED Some College Vocational / Technical/ Associates Degree
 Bachelors Degree Masters Degree Other (specify) _____

Secondary Caregiver Employment:

- Unemployed Employed Retired Occupation: _____

Annual Income Range for Family:

- 15,000 or under 50,001-65,000
 15,001-25,000 65,001-80,000
 25,001-35,000 80,001-100,000
 35,001-50,000 Over 100,000

Sources of Income for Family:

- Employment Income Supplemental Security Income
 Social Security Child Support
 TANF Other (specify) _____
 AFDC

INFORMATION ON SIBLINGS / OTHER CHILDREN LIVING IN THE HOME:

Name	Age	Race	Sex	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are any of the children listed above previous or current clients of W&A: Yes No If Yes, when? _____

SUMMARY REGARDING CLIENT AND FAMILY CURRENT STATE:

Signature of referral source _____ Date _____