

Strengthening Families Program 6-16

Full name of youth(s) referred for participation:

Parent/Guardian's Last Name:

Name of the adult(s) in the home that will participate:

Name of the children in the home that will participate and their ages:

Number of children in the home that will need child care and their ages:

Family's address:

Parent/Guardian's phone number:

Parent/Guardian's email:

Reason you feel this family is a good candidate for the SFP group:

Please check any special needs of family/children/parents:

- | | |
|---|--|
| <input type="checkbox"/> Criminal charges pending | <input type="checkbox"/> Currently on probation/parole |
| <input type="checkbox"/> Currently suspended from school | <input type="checkbox"/> Mental health diagnosis |
| <input type="checkbox"/> Known substance abuse issues | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Suspected substance abuse issues | <input type="checkbox"/> Other |

Please identify the family member(s) name(s) with the special need(s) identified in the question above. Also, please provide details needed to understand the impact the issues may have in a group setting.

Please provide any other information you feel would be important to share.

Please return this form by email, fax, or mail to:

Michelle Wilson * Cabarrus Health Alliance * 1307 S. Cannon Blvd * Kannapolis * NC * 28083.

Email: mlwilson@cabarrushealth.org * Fax number: 704-934-4208

Referral provided by: _____

Phone number: _____

Best time of day to contact: _____