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**OFFICE USE ONLY**

Date of Inquiry Stipend Award \_\_\_\_\_

Date of Appointment  30min 1 hr

In Person Video Call Conference Call

QB Input Vcita  Ck List  H2S docs Other

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_

 **School District**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**\_\_\_\_\_\_\_

 **Grant Award NMK** \_\_\_\_\_\_ **LBF Funds** $\_\_\_\_\_\_

 **Nationality\_\_\_\_\_\_\_\_\_\_\_**

**Laloboy Foundation Intake Form** **Translator Needed\_\_\_\_\_\_\_\_**

# **Mother’s Name**: Address: City Zip

Cellular Phone #: E-mail Address:

**Father’s Name**:

Address: City Zip

Cellular Phone #: E-mail Address:

**How many children and ages?** B/G B/G B/G \_\_\_\_\_B/G \_\_\_\_ Live with you part-time or full-time?\_\_\_\_\_\_\_\_\_\_\_\_\_

 Single Divorce  Married  Other Relatives in the household\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apt Home Special Needs Child Chronic Illness **School District** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code** \_\_\_\_\_\_\_\_\_\_

**Name of the Child needing services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_**

**Name of the Child needing services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_**

## EMPLOYMENT & FINANCIAL RESOURCES

Employed hours per week Unemployed Last time you had a job Yrs/Mos. Disability Ck $ VA Check $

Furlough since Work Hours were cut back\_\_\_\_\_\_\_ how many hours per week? Unemployment $\_\_\_\_\_\_\_

Food Stamps ACCHS Ins. WIC  HUD Housing Free/Reduced Lunch

Child Support $ For how many kids?

## Health Insurance Information

Insurance Company: Billing Address: City Zip

Name of the Insured: DOB Primary  Secondary

Policy # Group# Counseling service coverage? Yes No Co-pay $

## What are some concerns about mental wellness for your child(ren)?

 Depression Anxiety Chronic Illness Autism Blind Hearing Impaired

 Other Medical Diagnosis (don’t need medical records)  Suicide Attempt Date: / /  Child Isolation

 Drug Addiction  Sexual Abuse  Safety issue  Suspension from school  Cyberbully issues Yes No

Has your child(ren) been in counseling before? Yes No

If so, what are the name of the practice and the name of the therapist?

Are both parents in favor of counseling? YesNo Do you have the authority to make medical decisions for your child? Yes No

Are you fully prepared to give your child(ren) the support that they need and follow the instructions of your therapist? Yes No

|  |
| --- |
| **How did you hear about the Laloboy Foundation?** |
| Website  School  Church  Friend  Counselor  notMYkid  Google Other: |

## Race and Ethnicity Data (this information does not influence the decision in qualifying for services with LBF)

 Hispanic or Latino  Not Hispanic Latino  White Black or African American American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander  American Indian or Alaska Native and White  Asian and white

 Black or African American and white  Amer. Indian/Ak Native and Black African Amer.  Other

**Here are some of the resources that we possibly can provide or know another agency that can help:**

 Counseling Stipends  Youth Support Group Services  Parenting and Youth Workshops Connecting families with other local community groups in Arizona that support families Public Speaking at the schools and other youth organizations upon request