OFFICE USE ONLY

Date of Inquiry _____ ☐In Person ☐Zoom ☐Phone Call
Spoke w/ ☐ Mother ☐Father ☐Guardian ☐School Counselor

☐Email Forms date_____ ☐Email Award ☐ Email counselor
☐ Counselor List ☐ **School District** ☐CH ☐GIL ☐QC ☐Higley
☐PHX ☐Mesa ☐Tempe ☐Other_____

School Name _____ ☐**E** ☐**Jr** ☐**HS**
Grade____ City_____
☐ **Grant NMK** $_____ ☐**Zip Code**_____ ☐**LBF Funds** $____
☐Youth Counseling ☐Parent/Child Support ☐NMK

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 ☐Other _____

☐**School District** _____☐**School Zip Code** _____ ☐**School Counselor Name**_____

Name of the Child needing services: _____ **Grade:**_____ **Name of School**_____
Name of the Child needing services: _____ **Grade:**_____ **Name of School**_____

FINANCIAL RESOURCES
☐Food Stamps ☐ACCHS Ins. ☐WIC ☐ HUD Housing ☐Free/Reduced Lunch

Health Insurance Information
Insurance Company:_____ Name of the Insured:_____ DOB_____

Counseling service coverage? ☐Yes ☐No Co-pay $_____

DEMOGRAPHIC INFORMATION
☐White ☐Black ☐American Indian/Alaska Native ☐ Asian ☐Native Hawaiian/Other Pacific Islander ☐Hispanic/Latino

What are some concerns about mental wellness for your child(ren)?
☐ Depression ☐Anxiety ☐Chronic Illness ☐Autism_____☐Blind ☐Hearing Impaired ☐ Child Isolation☐ Drug Addiction
☐ Suicide Attempt Date:_____ ☐ Sexual Abuse ☐ Safety issue ☐ Suspension from school ☐ Cyberbully issues ☐Yes ☐No☐
Other Medical Diagnosis_____(don't need medical records) 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 ❒ Church ❒ Friend ❒ Counselor ❒ notMykid ❒ Google ❒ School Counselor:_____

Other resources for families: Financial Assistance Youth Support Groups Parenting/Youth Workshops
Internet Safety Education Other resources needed for your family Provide Parenting and Youth Workshops

Checklist: Document(s) Needed For Approval

NO ORIGINAL DOCUMENTS. RECENT COPIES ONLY.

INCOME/FINANCIAL BENEFITS

□Free/Reduced Lunch Letter Child's Name _____ □Food Stamps □WIC
□Pay Stubs (3 months of Stubs) Per person □Work Invoices □Unemployed since _____
□ HUD Housing Award Letter

MEDICAL INSURANCE BENEFITS

□ Copy of **Medical Insurance** Card **□No Insurance Benefits**
□ Counseling Benefits □ Co-pay $_____
□How many sessions through your insurance benefits?_____
□ACCHS Ins. ID _____
□Name of your child(ren) who have counseling benefits? _____

Please send your documents to laloboyfoundation@gmail.com. We look forward to assisting your family.

Thank you,

Paolla Jordan

Paolla Jordan, Founder/President

Laloboy Foundation Agreement Terms

This agreement describes the responsibilities of each parent/client recipient that has received a counseling stipend award. The Laloboy Foundation "LBF" is a third party that is paying the provider of care for the services rendered by you. LBF is depending on the parent/client to follow the guidelines listed below since there is limited staff. Please review carefully.

1. At the time of service (counseling session), you will be responsible to pay the balance of the copay. Failure to make your copay payment can result in a hold on services or forfeiture of the stipend award.
2. Your counseling stipend is good for **90 days**. If you need an extension, it would be up to the parent/client to request an extension in writing.
3. If you are granted an additional award for counseling stipends, you agree to submit another application after your child has completed their 2nd session (previous award) to avoid interruption of services.
4. If your child needs additional services past the initial 3 sessions, you agree to call the office or email a request for an additional stipend.
5. Each family is aware that the funds available through LBF are on a first-come, first-serve basis.
6. Each parent/client will be solely responsible for adhering to the "**no show policy**" and pay the penalty to the provider of care as stated in the agreement of services from your counseling provider.
7. LBF will not pay for any late fees, no-show fees, or copays outside of the counseling session commitment award.
8. Each parent/client will be responsible for submitting a **complete** application along with documentation from the checklist. Note: If the question doesn't apply, put N/A *not applicable*
9. If a client has an outstanding bill with their counselor, it will be your responsibility to get LBF your invoice so that we can pay on your behalf up to $100 per session.
10. The client and family understand that counseling services are in high demand and will do everything in their power to follow the cancelation policy, pay a no-show policy fee, and pay their copay at the time of service. Failure to do so will jeopardize your stipends award with LBF.
11. If a client needs someone to translate in Spanish, the client will give consent in writing to their counselor or LBF.

I HAVE READ AND UNDERSTOOD THIS AGREEMENT AND WILL SHARE IN MY RESPONSIBILITY TO ENSURE THERE ARE NO INTERRUPTIONS ON COUNSELING SERVICES.

_____ _____

Parents Name (PRINT) (Signature) Date

_____ _____

Client/Patient/Child Name Cell phone