Eligibility Screening

Participant First Name: _____

Participant Last Name: _____

Participant Preferred Name:

Contact Information

Contact Person Name:

Relationship to Participant:

Gender (on Government ID): ☐ Female ☐ Male

Address: _____

City: _____ Zip Code: _____

County: ☐ Nisqually Tribal Land ☐ Mason County

☐ Lewis County ☐ Grays Harbor

Phone Number: Text: ☐ Yes ☐ No

Email: _____

I check my email regularly: ☐ Yes ☐ No

Preferred contact method: _____

Best times to contact: ☐ 9am-12pm ☐ 12pm-5pm ☐ 5pm-6pm

Referral Agency (if applicable): _____

Referral Agency Contact Name: _____

Referral Agency Contact Phone: _____

Referral Agency Contact Email:

Eligibility

Household Size: Household Income (All Members):

Hardship Request (for those who do not meet income requirement):

☐ Would like information ☐ No

Disability: _____

Documentation: ☐ 504 ☐ IEP ☐ DDA Care Plan ☐ Medical Provider ☐ DVR ☐ Other _____

Do you have medical documentation of your functional abilities/assistive technology needs?

☐ No ☐ Yes (please provide the report or provider name and contact)

Provider: _____ Phone: _____

Additional Information

Race/Ethnicity Group:

☐ American Indian ☐ Alaska Native ☐ Asian
☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern
☐ White, Not Hispanic ☐ Native Hawaiian or Pacific Islander

Age Group:

☐ 0-5 ☐ 6-11 ☐ 12-14 ☐ 15-17
☐ 18-21 ☐ 22-30 ☐ 30-64 ☐ 65+

Current School (if applicable): _____

Current Grade (if applicable):

☐ Pre K ☐ K-1 ☐ 3-4 ☐ 5-6
☐ 7-8 ☐ 9th ☐ 10th ☐ 11th
☐ 12th

Name of person completing form: _____

Date: _____

How did you hear about us?

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