

CHILD SCREENING INFORMATION FORM

(Use this form to gather additional information based on the Family Intake and Additional Family Information Forms for each family member needing services and/or supports)

Date:		Staff Completed: _____	
Family Member ID:	Last Name:	First Name:	Middle Initial:
Nickname	Birthdate		Age
Gender		Other Gender	
Section 1. Education / Employment			
Educational Status: <i>(Please check one)</i> <input type="checkbox"/> Child Currently Enrolled in School <input type="checkbox"/> Dropped Out <input type="checkbox"/> Alternative Program <input type="checkbox"/> Suspended <input type="checkbox"/> Graduated High School <input type="checkbox"/> Received HiSET/GED <input type="checkbox"/> Working towards a GED <input type="checkbox"/> SPED Certificate of Completed <input type="checkbox"/> Preschool or Kindergarten Completed <input type="checkbox"/> Other: _____ How many days suspended this school year? _____		School Name/Last School Attended: _____ After-School Program: (if enrolled) _____ If referred by School, name of personnel: _____ _____	
1. What is the highest grade in school this child/youth has completed? _____ 2. How is this child/youth doing in school? _____ _____ _____ 3. Is this child/youth on an Individualized Education Plan or a Special Education Plan? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Did not answer 4. Is this child/youth on a 504 Plan? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Did not answer 5. Has this child/youth missed more than 8 days in the last 10 school weeks? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Did not answer If yes, about how many days? _____ 6. Does this child/youth have a job? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Did not answer			
Section 2. Physical and Mental Health			
Does this child/youth have a disability? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Did not answer <i>(Please check all that apply)</i> <input type="checkbox"/> Medical/Physical <input type="checkbox"/> Visual <input type="checkbox"/> Hearing <input type="checkbox"/> Developmental <input type="checkbox"/> Mental/Behavioral Health <input type="checkbox"/> Autism Spectrum Disorder		What is the overall physical and mental health of this child/youth? <i>(Please circle one)</i> <div style="text-align: center; margin: 5px 0;"> Poor Fair Good Excellent </div> <hr/> Does this child/youth have any condition(s) that requires regular care or follow-up? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Did not answer What is/are the condition(s)? _____ _____ _____	

Has this child/youth seen a doctor or nurse practitioner in the last 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Did not answer
Has this child/youth seen a dentist in the last 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Did not answer
Do you have any concerns about alcohol or drug use for this child/youth?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Did not answer
Has this child/youth ever used mobile crisis teams?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Did not answer
Has this child/youth ever been hospitalized for mental health reasons?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Did not answer
Does this child/youth have difficulty following rules?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Did not answer

Section 3. Safety

Safety Questions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
This child/youth feels safe in his/her home.					
This child/youth feels safe in his/her school.					
This child/youth feels safe on the streets in his/her neighborhood.					
1) Has this child/youth witnessed violence?	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Did not answer	
2) Has this child/youth been involved in a situation where he/she has been or is being exploited?	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Did not answer	
3) Is this child/youth involved in the court?	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Did not answer	
4) Is this child/youth involved with a gang?	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Did not answer	
5) Has this child ever been detained by the police or arrested?	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Did not answer	
For what reasons:					
<input type="checkbox"/> Care and Protection					
<input type="checkbox"/> Children Requiring Assistance (CRA)					
<input type="checkbox"/> Charged with an offense/crime					
<input type="checkbox"/> On probation					
<input type="checkbox"/> Family Court (Divorce, Custody)					
6) Has this child/youth ever run away?	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Did not answer	

Section 4. Basic Needs

Is this child/youth currently living with their family? ☐ Y ☐ N ☐ Did not answer

If no, who is the child/youth living with _____

Does this child/youth need assistance with:

Food ☐ Y ☐ N ☐ Did not answer Clothing ☐ Y ☐ N ☐ Did not answer

Section 5. Agency Involvement *(Please check all that apply)*
Is this child/youth or your family involved with any of the following agencies? *(Check all that apply)*

<input type="checkbox"/> MassHealth	<input type="checkbox"/> Court: _____	<input type="checkbox"/> City/Town Resources: _____
<input type="checkbox"/> DTA (Department of Transitional Assistance)	<i>(name of court)</i>	_____
<input type="checkbox"/> DCF (Department of Children and Families)	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> DYS (Department of Youth Services)	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> DMH (Department of Mental Health)	<input type="checkbox"/> Community Agency: _____	_____
<input type="checkbox"/> DDS (Department of Development Services)	_____	

Section 6. Civic Engagement

Is this child/youth involved with any of the following: *(Check all that apply)*

- | | | |
|--|--|--|
| <input type="checkbox"/> Sports | <input type="checkbox"/> Community Service Projects | <input type="checkbox"/> Scouting |
| <input type="checkbox"/> Fine Arts (e.g., painting, drawing) | <input type="checkbox"/> Volunteering | <input type="checkbox"/> Community Civic Organizations |
| <input type="checkbox"/> Performing Arts (e.g., music, dance, theater) | <input type="checkbox"/> School Clubs/Student Government | <input type="checkbox"/> Faith-based Organizations |
| <input type="checkbox"/> Other: _____ | | |

Section 7. Disposition

For office use only

Staff Updated: _____ **Updated by Date:** _____

Staff Updated2: _____ **Updated by Date:** _____

Notes: