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| Family Treatment Court  516 Third Ave., Room C-202  Seattle, WA 98104  206-477-2565 | |  | | | Original Date: | |  |
| Dates Revised: | |  |
|  | | |
| participant Screening | | | | | | | |
| **The Family Treatment Court Program is designed to support parents as they move through Dependency Court. We would like to help you address all issues you need help with but can only do this if we are aware of them. Your answers will be kept confidential and will not be released without your permission. Your answers will be used to determine eligibility for Family Treatment Court and for future planning should you be accepted into the program. You may refuse to answer any question but it may affect your eligibility screening.** | | | | | | | |
| Name: |  | | **🞎 M 🞎 F** | DOB: | |  | |

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| **HISTORICAL INFORMATION** |

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| **Family** | **Is this the first time you have been involved in a dependency? 🞎 Yes**  **🞎 No, I was involved as a child or with other children of my own**  **If no, what was the outcome of the prior dependencies?** | |  | | | | | | | |
| **Do you have any children not involved in this dependency?** | **🞎 Yes** | |  | **🞎** | **No** |
| **NAME** | **DOB** | | | | | |  | **Current**  **placement** | |
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| **DV**  **History** | **Have you ever felt controlled or isolated by a current or past partner?** | **🞎** | **Yes** | **🞎** | **No** |
| **Have you been hit, punched or otherwise hurt or injured by another person in the past year? If so, can you tell me more about it?** | **🞎** | **Yes** | **🞎** | **No** |
| **Do you feel safe in your current relationship?  (If no, does the person have resources to be in a safe place?)** | **🞎** | **Yes** | **🞎** | **No 🞏 N/A** |
| **Do you feel safe in your current living arrangement?** | **🞎** | **Yes** | **🞎** | **No** |
| **Is there a partner from any previous relationship who is making you feel unsafe now?** | **🞎** | **Yes** | **🞎** | **No** |
|  | **Have you ever attended counseling for issues of personal safety? If so, where were you seen?** | **🞎** | **Yes** | **🞎** | **No** |
|  | **Would you like to talk to someone about your personal safety?** | **🞎** | **Yes** | **🞎** | **No** |

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| **Legal History** | **Have you ever been convicted of domestic violence?** | **🞎** | **Yes** | **🞎** | **No** |
| **Have you ever been convicted of a felony?** | **🞎** | **Yes** | **🞎** | **No** |
| **Are you currently on probation or parole?**  **If yes, ROI signed for PO 🞏** | **🞏** | **Yes** | **🞏** | **No** |
| **Have you ever been convicted of a felony assault against a child or other dependent person?** | **🞏** | **Yes** | **🞏** | **No** |
| **Have you ever been convicted of a sexual offense?** | **🞏** | **Yes** | **🞏** | **No** |
| **Do you have any outstanding charges or warrants?** | **🞎** | **Yes** | **🞎** | **No** |
| **Do you have a driver’s license?** | **🞎** | **Yes** | **🞎** | **No** |
| **If so, is your driver’s license currently suspended or revoked?** | **🞎** | **Yes** | **🞎** | **No** |
| **Have you ever lived in any other states as an adult?** | **🞎** | **Yes** | **🞎** | **No** |
| **Have you used any other names?** | **🞎** | **Yes** | **🞎** | **No** |
| **Would you like to talk to someone about your current legal problems?** | **🞎** | **Yes** | **🞎** | **No** |

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| **EDUCATIONAL AND VOCATIONAL HISTORY** |

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| **Have you ever been diagnosed with a learning disability?** | **🞎 Yes** | **🞎 No** |
| **Have you ever been enrolled in a special education class?** | **🞎 Yes** | **🞎 No** |
| **Do you have any difficulties understanding what you read?** | **🞎 Yes** | **🞎 No** |
| **Do you have any difficulties with writing?** | **🞎 Yes** | **🞎 No** |
| **When were you last employed?** |  |  |
| **What types of job experiences do you have?** |  |  |

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| **DRUG AND SCREENING INVENTORY** |
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| Please describe the person’s use of alcohol or drugs (other than tobacco or prescribed pain medications) in their lifetime. (Note drug used, age of first use, frequency and quantity used at height of use, and date of last use.) \***Person’s drug of choice(s).** |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | SUBSTANCE | AGE OF FIRST USE | FREQUENCY OF USE | QUANTITY | HOW LONG | DATE OF LAST USE | NOTES | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |

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| **Do you feel that alcohol or drugs are a problem in your life?** | **🞎 Yes 🞎 Probably 🞎 Maybe 🞎 No** | |
| **Are drugs or alcohol a problem for anyone in your family?** | | **🞎 Yes 🞎 Probably 🞎 Maybe 🞎 No** |
| **Are you willing to attend treatment and follow through with your treatment recommendations?** | | **🞎 Yes 🞎 Probably 🞎 Maybe 🞎 No** |

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| **DRUG AND ALCOHOL TREATMENT HISTORY** |

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| **PREVIOUS TREATMENT** | **DATES OF TREATMENT** | **COMPLETED? (Y OR N)**  **(IF NOT, WHY?)** | **LENGTH OF ABSTINENCE** | **ROI COMPLETED** |
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| **TRAUMATIC BRAIN INJURY** | |
| **Have ever been diagnosed or treated for a head injury?**  **If so, where were you seen? (ROI)** | 🞎 Yes 🞎 No |
| **Have you ever been hit in the head and been knocked unconscious?** | 🞎 Yes 🞎 No |
| **Have you ever had a seizure?** | 🞎 Yes 🞎 No |
| **Have symptoms of a head injury ever impacted your ability to participate in services?** | 🞎 Yes 🞎 No |

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| **MENTAL HEALTH-compare to MMS** | | | | | |
| **Please list tell us if you have ever spoken to a mental health professional, psychologist, or psychiatrist for any psychiatric reasons. (Record agency name, contact person, contact information, type of treatment and a description of the outcome.)** | | | | | |
| **Facility/Contact** | **Dates of Treatment** | **Type of treatment** | **Diagnosis /Outcome** | **ROI completed** | **Notes-Medications, referral source, reason for referral, tx.** |
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| **Have you ever been hospitalized for mental health issues?**  **Have you ever tried to hurt yourself? If so, when? Please describe the treatment you received:**  **Have you ever tried to commit suicide? If so, when? Please describe the treatment you received:** | | | | | |

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| **Family Treatment Court prefers to refer our participants to individualized and culturally appropriate services. Do you have a preference to specific kinds of treatment agencies? (i.e. gender specific, LBGQ, Native, etc? ) If so, please explain** |

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| **PHYSICAL HEALTH** | | | | | | |
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| **Please rate your current physical health** | **🞎 Poor 🞎 Fair 🞎 Good 🞎 Excellent** | | | | | |
| Do you currently have medical insurance or a medical coupon? If so, what type? | | | **🞎** | **Yes** | **🞎** | **No** |
| Are you currently pregnant? | | | **🞎** | **Yes** | **🞎** | **No** |
| Do you currently have any chronic medical problems (HIV, TB, Hep C, Diabetes, etc.)? | | | **🞎** | **Yes** | **🞎** | **No** |
| ***Please explain*:**  **Would you like to be tested for Hep C?**  **🞏 No, not interested or tested negative (circle one)**  **🞏 Yes, sign ROI for Sea Mar and make referral**  **🞏 Yes, ask for treatment plan** | | | | | | |
| **When was your last physical?** | | | | | | |
| **Would you like help getting medical (including family planning) or dental care?** | | **🞎 Medical 🞎 Dental 🞎 Both 🞎 Neither** | | | | |
| If no, do you currently have a medical provider? Please list contact information and complete ROI. | | | **🞎** | **Yes** | **🞎** | **No** |

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| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers: | | |
| ***Name of the Drug*** | ***Dosage*** | ***Frequency Taken*** |
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**Are you taking your medications as prescribed? 🞏 Yes 🞏 No**

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| initial Family needs assessment |
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| **Please identify and rate goals in Family Treatment Court:** |

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| **🞎** | **Having money to pay bills** | **🞎** | **Getting furniture, clothing, toys** | **🞎** | **Getting medical coupons for my family** |
| **🞎** | **Getting a safe/stable place to live** | **🞎** | **Having emergency child care** | **🞎** | **Having a satisfying job** |
| **🞎** | **Getting a job** | **🞎** | **Getting where I need to go** | **🞎** | **Getting respite care for my child** |
| **🞎** | **Having enough food for my family** | **🞎** | **Finding someone to talk to about my child** | **🞎** | **Planning for future health needs** |
| **🞎** | **Feeding my child** | **🞎** | **Budgeting money** | **🞎** | **Expanding my education, skills and interests** |
| **🞎** | **Finding care for my child in the future** | **🞎** | **Having time to take care of myself** | **🞎** | **Participating in parent groups or clubs** |
| **🞎** | **Visiting with my child** | **🞎** | **Adapting my house for my child** | **🞎** | **Managing the daily needs of my child at home** |
| **🞎** | **Getting in touch with people I need to talk to** | **🞎** | **Meeting safe/sober people** | **🞎** | **Saving money for the future** |

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| **SOBER SUPPORT NETWORK** | | | | | | | |
| **Who in your family and circle of friends can you count on to provide support to you? Who have you turned to for support in the past? Who would you identify as long term support? (for example, cultural community, social relationships, churches/spiritual connections, neighbors)** | | | | | | | |
| **How can your family/friends support you? (e.g. attend appointments, complete background for visit supervision, transportation, etc.)** | | | | | | | |
| **Is your partner involved and supportive of you? 🞏 NA** | | | | | | | |
| **Describe your involvement with sober support groups in the past: (sponsor, home group)** | | | | | | | |
| **Family Treatment Court will require you to attend at least two sober supports per week. Are you willing to attend sober supports, identify a sponsor and find a home group?** | | | | | | | |
| **Please list all people you identify as part of the team supporting your family in this dependency case:**  **(social workers, treatment providers, attorneys, family members, case managers, friends, etc.)** | | | | | | | |
| **Name** | | **Relationship** | | | **Phone Number** | | |
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| **Please list everywhere you are currently receiving services *(chemical dependency, mental health, physical health, public benefits, housing, case management, employment, etc.)*:**  **Please describe your resources for transportation to get to services:**  **FTC requires that participants not only attend services but demonstrate progress in services. How motivated are you to do this on a scale of 1-10?**  **What motivates you?** | | | | | | | |
| **APPLICANT’S REQUEST FOR ENROLLMENT IN FAMILY TREATMENT COURT** | | | | | | | |
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| **Statement of Affirmation** | | | | | | **Initial** | |
| The information in this application is true to the best of my knowledge. | | | | | |  | |
| I am at least 18 years of age. | | | | | |  | |
| I have spoken with the treatment specialist about her previous conversations with my attorney and other people involved in my case. | | | | | |  | |
| My dependency case began less than 9 months ago. | | | | | |  | |
| I will maintain residency in King County while in the Family Treatment Court program. | | | | | |  | |
| I do not have a history of being a perpetrator of sexual abuse or felony child abuse. | | | | | |  | |
| I am voluntarily agreeing to participate in Family Treatment Court and this decision is of my own free will. | | | | | |  | |
| I am willing to admit that my child(ren) is (are) dependent. | | | | | |  | |
| I want my child(ren) returned to my custody. | | | | | |  | |
| I am willing to admit that my use is a problem. | | | | | |  | |
| I am willing to participate in a chemical dependency assessment and engage in treatment according to the assessment recommendations. | | | | | |  | |
| I am willing to sign releases for the Family Treatment Court team to share information with all of my treatment providers and other individuals relevant to my dependency case. | | | | | |  | |
| I understand that I may be given a sanction by the team if I am not completing UA’s and attending sober supports as required in the court order. I understand that if I turn in falsified sober supports, I could be discharged from the FTC. | | | | | |  | |
| I have been given a copy of the prescription medication form and understand how to utilize it. I understand that if I use any drug not prescribed by my doctor with the purpose of altering my mind or consciousness, my team will consider it a relapse and my clean date will be reset. | | | | | |  | |
| **Next Steps *(i.e. type of funding, where to go for assessment, next meeting with recruitment specialist, next court date, etc.)*:** | | | | | | | |
|  | | | | | | | |
| **Signatures** | | | | | | | |
| Parent Signature: |  | | Liaison Signature: |  | | | |
| Parent Name: |  | | Liaison Name: |  | | | |
| Date: |  | | Date: |  | | | |

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| **INTERVIEWER CHECKLIST-FOR STAFF USE ONLY** | | | |
| Family: | **Placement info on kids**  **Relationship with other parent:**  **Family support willing to attend hearings, meetings?** | | |
| Personal Safety: | Requested assistance in this area  Has attended DV in past  Any current NCO’s  Referral made to: | | |
| Legal History: | Requested assistance in this area  Has outstanding warrants or charges  Has other dependencies  Contact info for other attys/SW: | | |
| Personal Health: | Has medical insurance/coupon  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has medical provider and signed ROI  Referred for medical coupon  Requested assistance in this area | | |
| Drug Use: | **🞎 Has service provider**  **🞎 ROI completed**  **🞎 Records requested \_\_\_\_\_** | | |
| Mental Health: | Previous MH Diagnosis:  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Requested assistance in this area  ROI signed  History of Self harm  History of hospitalizations? | | |
| Overall:  Referrals made: | Eligible  Currently in treatment  Reason not eligible: | Yes  Yes |  |

**FOLLOW UP CHECK LIST FOR PARTICIPANT**

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| **Task** | **Info** | **Follow up** |
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**Notes:**

**Collateral Questions-Guide**

**Applicant:**

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| ***Is the parent in compliance with services currently?*** | ***Yes No*** |
| **UA’s-where, frequency, results?** |  |
| **Please describe any history of the following and how they have impacted the parent’s ability to do services:** | |
| **MH diagnosis** | |
| **Trauma** | |
| **Domestic violence** | |
| **Head injury** | |
| **Cognitive impairment** | |

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| ***Describe existing support network-*** |
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| ***Concerns/barriers:*** |
| **Concerns:** |
| ***Strengths:*** |
|  |
| **Other parent:** |
| **Involved and supportive-** |
| **Represented by-** |
| **Domestic violence-** |
| **Mental health history-** |

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| ***Children*** |
| **Current placement:** |
| **Visits (frequency, duration, supervised):** |
| **Special needs/Current interventions:** |
| **History of trauma/DV:** |