Nurturing Parenting Program Family Enrollment Form  
Fairfax County Department of Family Services, Prevention Services  
12011 Government Center Parkway, Fairfax, VA 22035

Today’s Date:__________     Age group, start date and location of class (if known):______________________________________

Person completing this form:________________________________________ Date form received: (For Program use only)________________

How would you describe your family?   __Single  __Married    __Divorced    __Separated   __Living with friend   __Widow(er)

<table>
<thead>
<tr>
<th>Name</th>
<th>ID</th>
<th>Date Of Birth</th>
<th>Age</th>
<th>Sex</th>
<th>Race</th>
<th>Country of Origin</th>
<th>Live With You?</th>
<th>Child Status</th>
<th>Will Attend Program?</th>
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<td>Yes or No</td>
<td>B=Birth</td>
<td>Yes or No</td>
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<td>A=Adopted</td>
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<td>F=Foster</td>
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<td>S=Stepchild</td>
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Mother:  
Father:  
(If relevant) Co-parent/Other :  
Children:  

Address:  
Street number and name:  
City:  
State:  
Zip Code:  

Phone Numbers:  
Home:  
Is it okay to leave a message? __Yes  __No  
Work:  mother/father/coparent:  
Is it okay to leave a message? __Yes  __No  
Cell Phone:  mother/father/coparent:  
Is it okay to leave a message? __Yes  __No  
E-Mail Address:  
Is it okay to leave a message? __Yes  __No
Nurturing Parenting Program Family Enrollment Form

Do you have transportation to the group?  ____Yes  ____No

Are you court ordered to attend?  (Please circle appropriate response)  Mother:  yes / no  Father:  yes / no  Co-parent:  yes/no

How do you hope the Nurturing Program will help your family?

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Are you or your children working with other programs/agencies?  If so, please indicate:

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Program/Agency</th>
<th>Contact Person</th>
<th>Phone</th>
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Please describe any concerns/problems you are experiencing with your children:  Does your child have an IEP in effect or pending?  (List child’s name, circle Yes or No)

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

How did you hear about the Nurturing Parenting Program?

____Fairfax County Website (Self-Referral)  ____Phone inquiry (Self-Referral)  ____I am a Former Program Participant

____Flyer/Brochure/Poster  ____From a Former Program Participant

School Personnel name: phone:___________________________
Child Protective Services (CPS) worker name: phone:___________________________
Family Preservation worker name: phone:___________________________
Foster Care and Adoption (FC&A) worker name: phone:___________________________
Healthy Families worker name: phone:___________________________
Family Resource Center name: phone:___________________________
Community-based organization/non-profit agency: organization/contact name phone:___________________________
Therapist name: organization: phone:___________________________
Other Community Source: organization: contact person: phone:___________________________

FOR OFFICE USE ONLY:
NP staff person completing phone screening: ___________________________ Phone interview done with: ___________________________
Phone screening date: ___________________________ Relationship: ___________________________
NURTURING PROGRAM PROFESSIONAL USE FORM

CLIENT'S NAME: Last: ___________________ First: ___________________ Mi: ______

REFERRING PROFESSIONAL INFORMATION: Name: _____________________________
Phone #: ___________________________ FAX#: _____________________________
Agency/Program Affiliation: ______________________________________________

What is your relationship to this family? _____________________________________

When did you begin working with this family? ____ / ____ / ____ (date)

Will you continue working with this family? YES NO

If no, when is anticipated date of discharge/case closure? _____ I _____

REASON FOR REFERRAL:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(CPS ONLY) CPS risk assessment level at time of referral: High Medium Low

Do you want to be notified if this family misses a session? YES NO

If yes, please put on release of information form and ask for the family* signed consent.

Did this referral emanate from a Child Specific Team (CST) process? YES NO

What other agencies and/or programs are involved with this family?

If children are in foster care, will they be transported to the Nurturing Program? YES NO

If yes, please provide name and number of driver, or taxi company and contact: ___________________________

Phone number: ___________________________

ASSESSMENT INFORMATION

Are the parents learning English as a second language? YES NO

If yes, what is their primary language? ___________________________

Can the parents read to a 5th grade reading level? YES NO

Have the prospective adult participants who were sexually abused in childhood dealt with the sexual abuse? N/A Don't Know YES NO

If yes, they should be encouraged to deal with the sexual abuse first or in conjunction with the Nurturing Program.

Is any prospective participant addicted to drugs or alcohol? Don't Know YES NO

If yes, abuser must be in treatment and/or recovery to be considered for the Nurturing Program.

Have you known any of the participants to be acutely psychotic? YES NO

Are you aware of active suicidal behaviors of any prospective participant? YES NO

If yes, please explain:
How do the children perform in a group setting?

Are there any special concerns/issues with the children?

Other comments:

CHECKLIST FOR REFERRING PROFESSIONALS:

Have you advised the family:

* They must attend all sessions?  YES  NO
* Groups meet once a week?  YES  NO
* Each group session is 2.5 hours or 3 hours in length?  YES  NO
* You have asked to be notified if they miss a session?  YES  NO

Have you:

* Attached a signed release of information?  YES  NO
  (including all service providers approved by the family for consult)
* Completed the entire referral form?  YES  NO
  (incomplete forms will delay the referral process)
* Made yourself a copy of the referral?  YES  NO
* Returned the completed form?  YES  NO
  (to: Nurturing Program, 12011 Govt. Center Pkwy, Fairfax, VA 22035)

FOR OFFICE USE ONLY

Family ID #:________
Will participate in Nurturing Program for: _________________________________
Location: ___________________ Initial Session Date: _____/____/____
Day: ______________________ Time: ____________ am/pm

Will not participate Referral made to:

Reason/Recommendations: ________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Fairfax-Falls Church Comprehensive Services Act (CSA) Program

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

I understand that my family will be participating in an interagency service planning process under the provisions of the Comprehensive Services Act (CSA) for At-Risk Youth and Families VA §2.2-5200. The purpose of the Act is to provide high quality, child centered, family focused, cost effective, community-based services to youth with specialized needs and their families. Each of the public child-serving agencies offers different services and benefits. Each agency must have specific information in order to be of assistance. By signing this form, I am allowing agencies to exchange certain information about my child and family so it will be easier for them to work together effectively to provide or coordinate these services or benefits in accordance with VA §2.2-5207. All information about children and families obtained by team members to perform their responsibilities shall be confidential in accordance with VA §2.2-5210.

I, ________________________________, am signing this form for

(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

(FULL PRINTED NAME OF YOUTH)

(YOUTH’S LEGAL ADDRESS) (YOUTH’S BIRTHDATE) (YOUTH’S SSN-OPTIONAL)

My relationship to the client is: □ Self □ Parent □ Power of Attorney □ Guardian/Custodian □ Other Legally Authorized Representative

I want the following confidential information about the youth (except drug or alcohol abuse diagnoses or treatment information) to be exchanged with the agencies and parties listed below. Mark “No” next to information only if you do not wish it to be exchanged.

Mark “No” next to information only if you do not wish it to be exchanged.

<table>
<thead>
<tr>
<th>NO</th>
<th>NO</th>
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<tbody>
<tr>
<td>Assessment Information</td>
<td>Medical Diagnosis</td>
<td>Educational Records</td>
</tr>
<tr>
<td>Family Financial Information</td>
<td>Medical Records</td>
<td>Psychiatric Record</td>
</tr>
<tr>
<td>Benefits/Services Needed, Planned, and/or Received</td>
<td>Mental Health Diagnosis</td>
<td>Juvenile Justice Records</td>
</tr>
<tr>
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<td>Behavioral Health Care Records</td>
<td>Employment Records</td>
</tr>
</tbody>
</table>

Other information (write in): __________

I want: ____________________________

(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

and the following other agencies and their representatives in Fairfax-Falls Church to be able to exchange information for service planning and coordination and eligibility determination:

Family Assessment and Planning Team (FAPT), Community Policy and Management Team (CPMT) members and member agencies to include the Health Department; Department of Family Services; Juvenile and Domestic Relations District Court; Public Schools; Community Services Board; FAPT/CPMT parent representatives; FAPT/CPMT private agency representatives; and any other prospective/actual vendor/agency providing services outlined on the services plan developed by these teams and myself.

Other service providers or agencies: ______

I want to share additional information received after this consent is signed. **This consent is good until (not to exceed 2 years): ______**

I understand that:

- Information will be exchanged by written, verbal and computerized methods.
- I can withdraw this consent any time by notifying the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.
- I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.
- I want all the agencies to accept a copy of this form as a valid consent to share information.
- If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): ____________________________ Date: ____________________________

(CONSENTING PERSON OR PERSONS)

Person Explaining Form: ____________________________

(Name) (Title) (Phone Number)

Witness (If Required): _____________________________

(Signature) (Address) (Phone Number)

Effective: 12/16/11