

Strengthening Families Program

Intake Application

Name of Parent / Guardian: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

The Child's Name: _____ Date of Birth: _____

Parent with Disability YES NO

Child with Disability YES NO

Do you have any food allergies? _____

Optional Information: (This information will be kept confidential)

CPS Case

Criminal Justice Case

Substance Abuse Case

Temporary Assistance for
Needy Families (TANF)

1. How did you hear about the Strengthening Families Program?

2. What would you like to get from this program?

3. Are you and your child ready to commit to a program of 14 weeks to a better relationship with your family? Do you speak Spanish? Does your child speak Spanish?

4. Do you have young children you will bring to the program that will need Childcare? If so what are their names and ages?

1. _____

3. _____

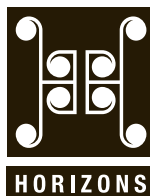
2. _____

4. _____

Please send your application by fax to (415) 487-6724

or e-mail: hramos@horizons-sf.org

or call (415) 487-6707 to fill it out by phone.



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