

Ancillary Screening Tool

Women with children, pregnant women, and women who are seeking custody of their children:

1. Are you in need of primary medical care? Yes No

If yes where and date of appointment: _____

2. Are you in need of prenatal care? Yes No

If yes where and date of appointment: _____

3. Are you in need of child care in order to attend the above appointments?

Yes No

If yes where was referral made to: _____

4. Do you have children in your custody or are your trying to regain custody?

Yes No

If yes, are your children in need of primary pediatric care and immunizations?

Yes No

If yes, are you willing to have a referral made to meet the needs for primary pediatric care and immunization of your children? Yes No

If yes, where and date of appointment: _____

5. Are you in need of women specific services that address?

- Yes No Relationships
- Yes No Sexual and physical abuse
- Yes No Family therapy
- Yes No Nutrition education
- Yes No Education to GED level;

If yes to any of the above issue, where and date of appointment: _____

6. Are your children in need of any therapeutic intervention that address the following issues?

- Yes No Developmental needs
- Yes No Sexual and/or physical abuse
- Yes No Neglect

If yes to any of the above issue, where and date of appointment:

7. Are you in need of access to transportation services to support treatment and the other services identified in this interview?

_____ **Yes** _____ **No**

If yes, where was the individual referred? _____

8. Does the individual meet the intensive case management referral policy?

_____ **Yes** _____ **No**

If yes, date referred to intensive case management _____

I have been advised of the above services and provided a brochure for future use if my needs change.

Individual's Name/Date

Counselor