BOYS & GIRLS CLUBS OF GARDEN GROVE

ARCHES
Access to Resources for Children s Health, Education & Support

10602 Chapman Ave, Suite 101 • Garden Grove, CA 92840 • Tel 714-532-7940 • Fax 714-532-7945

A) Information/Información

Parent(s') Name(s): (first & last)	Child Name: (first & last)	Child Name: (first & last)	Child Name: (first & last)
_____	_____	_____	_____
Date of Birth:			
_____	_____	_____	_____
Address: (include zip code)	Date of Birth:	Date of Birth:	Date of Birth:
_____	_____	_____	_____
_____	School: _____	School: _____	School: _____
Phone Number (s):			
_____	Grade: _____	Grade: _____	Grade: _____
How Many 0-5 in Household?:			
_____	Type of Insurance:	Type of Insurance:	Type of Insurance:
Type of Insurance:			

B) Authorization/Autorización

Parent/Guardian or Responsible Person's Authorization: I hereby consent to an exchange of confidential information between BOYS & GIRLS CLUBS OF GARDEN GROVE and appropriate agencies concerning my child/self in order to enhance the treatment and follow-up of the condition for which this referral is made.

La Autorización del Padre/Guardían o Persona Responsable: Consentimiento para intercambiar información confidencial de mi niño o sí mismo entre BOYS & GIRLS CLUBS OF GARDEN GROVE y agencias apropiadas para aumentar el tratamiento y la medida complementaría de la condición de que está referido.

Parent/Guardian or Responsible Person's Signature: _____ Date: _____
Firma del Padre/Guardián o Persona Responsible

Referred By Name:_____Agency _____ Phone # _____

Primary Language spoken in client's home _____

Reason for Referral:

_____

_____

C) Service Requested

Basic/Environmental	Social Services	Infant/Children	Infant/Children Contd.
__ Clothing/food/baby items	___Cash Aid	___Well baby check ups	___ Medical Home
___unsanitary conditions	__ Cash Aid/Teen Parent	___Annual physical	___ IFSP/IEP
___ transportation	__ Food Stamps	___ Immunizations	___ Child Development
___ homeless	__ Medi-Cal	___ Sick Child Care	___ Tutoring
___ Inadequate housing	__ Covered CA	___ Dental Care	___ School Supplies
___ Homeless	__ Social Security Number/Card	___ Vision	___ Youth Development Services
___ New to County/Country	___ Birth Certificate	___ Developmental Delay	___ Preschool
___ Hygiene Items	___ Kaiser Kids	___ Drug Exposed Infant	___ Other
___ Utility Assistance	___ CHIP	___ Child Care	
___ Other	___Other	___ Car Seat	

Educational/Vocational	Mental Health/Family	Other	Medical (Adult)
___ ESL/Literacy	___ Grief Counseling	___Child Support	__Post Partum
___ Job Assistance/Training	___ Rape Incest Counseling	___ Immigration	__ Annual Physical
___ School Enrollment	___ Anger Management	___ Restraining Order	__ Sick Care
___ GED	___ Suicide Prevention	___ DV Victim	___ Family Planning
___ Parenting Classes	___Domestic Violence Prevention/ Intervention	___ Custody	___ Dental Care
___ Employment	___ Poor Support System	___ Identification	___ Specialty Care
___ Child Care		___ Legal Assistance	___ Tobacco Use
___ Other		___Holiday Assistance	___Drug/Alcohol Abuse
		__Tax Assistance	___ Well Adult Care
		___Family Activities	___ Private Insurance
			___ Vision
			___ Other

Additional Children or Adults in the Household			
Name: (first & last) _____ _____ Date of Birth: _____ School: _____ Grade: _____ Type of Insurance:	Name: (first & last) _____ _____ Date of Birth: _____ School: _____ Grade: _____ Type of Insurance:	Name: (first & last) _____ _____ Date of Birth: _____ School: _____ Grade: _____ Type of Insurance:	Name: (first & last) _____ _____ Date of Birth: _____ School: _____ Grade: _____ Type of Insurance:

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

E) Case Closed Date _____ **Data-Entry Date** _____