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.

HORIZONS