SOAR Initial Meeting Worksheet – Child Applicant

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| --- | --- | --- | --- | --- | --- |
| **Name**: |  | **DOB**: |  | **SSN**: |  |

**CONTACT INFORMATION**

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| --- | --- | --- | --- | --- | --- |
| **Mailing** **Address**: |  | | | | |
|  |  | | | | |
| **Residence Address** *(if different from mailing)***:** |  | | | | |
|  |  | | | | |
| **Who does the child**  **live with?** |  | | **Is this the child’s legal guardian?** | |  |
| **Phone** **Number/Email** *(child or legal guardian):* |  | | | | |
| **Mother’s Name:** |  | **Father’s Name:** | |  | |
| **Mother’s Maiden Name**  *(if applicable):* |  | **City/State of Child’s Birth:** | |  | |

**SCHOOL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **School Name:** |  | **Current Grade:** |  |
| **Teacher Name:** |  | **Is an IEP in place?** |  |

**What is going on that led you to seek SOAR assistance?**

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HEALTH INFORMATION

Current medical conditions/illnesses/diagnoses

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| --- | --- | --- | --- | --- |
| **Mental/Developmental Health** | |  | **Physical Health** | |
| **Condition** | **Onset Date** |  | **Condition** | **Onset Date** |
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**TREATMENT PROVIDERS**

Hospitals, Clinics, Psychiatrists, Treatment in Juvenile Justice Facilities

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| --- | --- | --- | --- |
| **Facility** | **Treatment Provider** | **Dates Accessed** | **Conditions Treated** |
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**COLLATERAL SOURCES**

Family, child welfare, case managers, or anyone else that can provide information about the child’s conditions.

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| **Name** | **Relationship** | **Contact Information** | **What information do they have?** |
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