The Institute For Family Enrichment *Prevention/Early Intervention Services*

REGISTRATION FORM

Referral Date:	Referred by:	Referral Agency:	Referral Agency Phone:
TIFFE Prevention/ Early Intervention (check all that apply): ❑MOP ❑Nurturing Program ❑Malama (TCOY) ❑Baby Time Attended 6+ of 12 sessions for above programs? ❑Yes ❑No ❑Nurturing Families ❑PL/Home Reach ❑Workshop: ____________ ❑Other: ____________		Island: Registration Date:	Site: TIFFE Staff:
For Home Reach services only: *Date Assigned to PE:*	*Date Contact Initiated:* *Within 1 day of assignment?* *❑ Yes ❑ No*	*Date of 1st Scheduled Home Visit:* *Within 5 working days of Phone Contact? ❑ Yes ❑ No*	

FAMILY INFORMATION

Mother's Last Name:	Mother's First Name:	Phone #:
Father's Last Name:	Father's First Name:	Phone #:
Other Adult's Last Name:	Other Adult's First Name:	Phone #:
Residential Street Address:	City, State:	Zip Code:

Emergency Contact:
Last Name: First Name: Home/Work/Cell#: Relationship:

Family Composition:
❑Intact 2 parents ❑Single Parent Male ❑Single Parent Female ❑Divorced/Separated
❑Foster Home ❑Extended Family ❑# of grandparents in home _____
❑# of other adults in home ❑# of sibs in home ❑#of sibs out of home ❑Other __________

Children's First & Last Names	Birth date	Age	Male	Female
____________________	________	____	❑	❑
____________________	________	____	❑	❑
____________________	________	____	❑	❑
____________________	________	____	❑	❑
____________________	________	____	❑	❑

Ethnicity (check **one** primary ethnicity):
❑African American ❑Filipino ❑Marshallese ❑Vietnamese ❑Declined to specify
❑Native American/Alaskan ❑ Hawaiian/Part-Hawaiian ❑Micronesian ❑Other Asian
❑Caucasian ❑Japanese ❑Puerto Rican/Mexican/Cuban ❑Other Pacific Islander
❑Chinese ❑Korean ❑Samoan ❑Other: ____________________

Annual Family Income (optional-used for demographic information):
Under $10,000 $10,000-20,000 $20,000-30,000 $30,000-40,000 Over $40,000

Health Insurance:
❑None ❑AlohaCare-Quest ❑HMAA ❑HMSA ❑HMSA-Quest ❑HMSA-HPH Plus ❑Kaiser ❑MDX ❑Med-Quest
❑Medicaid-Quest ❑Medicare (65+) ❑TriCare ❑TriWest ❑University Health Alliance ❑Other____________________
Policy # (optional):________________________ Preferred Hospital:________________
Primary Physician____________________ Address: ________________________ Phone: ____________

Please complete the back of this form as applicable to program.

Has an **Ages & Stages Questionnaire (ASQ)** been completed with your child(ren)? ❑Yes ❑No

If "Yes", who did the ASQ? ❑This program ❑Other ______________________________

Has an **Ages & Stages Social-Emotional Questionnaire (ASQ-SE)** been completed with your child(ren)? ❑Yes ❑No

If "Yes", who did the ASQ-SE? ❑This program ❑Other ______________________________

Linkage/Referral to: ____ Date:______________

Are you currently involved with CPS? ❑Yes ❑No

Are you currently involved in any other TIFFE services? ❑ Yes ❑No

If you have other TIFFE services, please describe: ____

Are you currently participating in any other community program services? ❑ Yes ❑No

If "Yes", please describe: ____

Have you attended anger management classes before? ❑Yes ❑No Agency: ____________________________

Are there any topics you would like more information about (i.e., community resources, child development, alternatives to spanking, etc.): ____