



P.O. Box 3913  
Winchester, VA 22604  
540.324.8965  
info@teensincva.org  
www.teensincva.org

NAME:	DOB:	GENDER: Male Female
SOC. SEC. #:	RACE:	TODAY'S DATE:
PARENTS/GUARDIANS:		
ADDRESS:		
PHONE: (H)	(W)	(CELL)
SCHOOL:	GRADE:	MEDICAID NUMBER:
REFERRING PERSON (worker, parent, etc., Please give us your name):		
PHONE NUMBER (of referring person):		
SERVICES START:	SERVICES END (projected):	

**PROGRAMS/SERVICES**

**Voc/ Mentoring** is a set of services designed to develop the skills and ability to practice a **vocation** in a productive way. Hours/week: \_\_\_\_\_ @ \$67.00/hour

**TEEN's 12-week** course consists of 2 classes per week with each class lasting 2 hours.

\_\_\_\_\_ @ 1600.00

**Life Skills/Teaching** abilities for adaptive and positive behavior that enable youth to deal effectively with the demands and challenges of everyday life \_\_\_\_\_ @ 67.00/ hour

**FUNDING INFORMATION**

FUNDING SOURCE: (Check applicable)

VJCCA \_\_\_\_\_

CSA/FAPT \_\_\_\_\_

ADOPTION SUBSIDY \_\_\_\_\_

DSS FUNDS \_\_\_\_\_



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**BRIEF LIST OF CLIENT/FAMILY NEEDS**

- 1.
- 2.
- 3.
- 4.

**BRIEF LIST OF DESIRED OUTCOME GOALS**

- 1.
- 2.
- 3.
- 4.

Is there a date by which services **MUST** begin? (IE. Court ordered. Please list)

Yes No If yes:

Are there any initial meetings you need intake coordinator or TEENS staff to attend prior to beginning services?

Yes No If yes (Please list):

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TEENS Inc. USE ONLY

DATE REFERRAL RECEIVED:

INTAKE ASSIGNED TO:

CONTACTED PARENT/GUARDIAN:

WORKER TO TAKE CASE:

START DATE OF CASE: