FCS PROGRAM

PRE-SCREENING

Todays Date_______

FCS service requested   Housing   Employment

(Please Circle One)

Immediate crisis need

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____

Full Name____

Date of Birth__________   Phone # _______________

Email_____________________________________

Mailing Address______________________________________

____

Disability Income SSI   SSDI

Have you ever received treatment for addiction or mental health?

Yes   No

Treatment Organaztion___________________________________

Would you like information on receiving a MH/SUD assessment?

Yes No

Do you currently have WA State Medicaid? Yes No

Provider One Number________________________________

Please sign giving us verbal consent to submit

Applicant____________________   Agency Staff______________