PCAP Alberta
Parent Child Assistance Program

PCAP Initial Intake Form

Referral Source:

Agency: _____ Has the client ever been Involved in a PCAP Program? (B-0E)

Referral Code: (ASI-D) _____ Yes___ No___ Explain:_____

Contact Name: _____ Site #: _____PCAP ID #:_____

Phone: _____ Is the client currently active in a PCAP Program? (B-0D)

Email: _____ Yes ___ No ___Original Date: (mm/dd/yyyy):___/___/_____

Agency Intake Information:

Intake Worker: _____ Mentor: _____

Enrollment Date: (mm/dd/yyyy):_____/_____/_____

Client Info:

Name: _____ D.O.B.: (mm/dd/yyyy):___/___/_____

Alias Names: _____ Phone: _____

Address: _____

Email:_____ Alberta Health Care Number: _____

Do you identify with a specific Race/ Culture? (Circle) (ASI-G17):

White South Asian (East Indian, Pakistan, Sri Lankan) Chinese Filipino West Asian (Iranian, Afghan)
Southeast Asian (Vietnamese, Cambodian, Laotian, Thai) Korean Japanese Black Latin American First Nations
Metis Inuit (Inuk) Other, specify _____

Country of Birth if other than Canada: _____

Are you a member of a First Nation/Indian Band? (ASI-G17) No___ If Yes, Specify:

Band _____ Reserve _____

Do you have (Indian) Status? Registered or Treaty Indian as defined by the Indian Act of Canada.

No_____ If yes, Treaty or Status #_____

Are you currently pregnant? (B3:25) Yes ____ No _____

If yes, how many months/weeks? _____ Due Date: _____

How far along were you when you found out you were pregnant?_____

What prenatal care have you had since you confirmed the pregnancy?_____

_____

Doctor: _____ Hospital: _____

If Pregnant in the last six months but not now, what was the outcome of the pregnancy? (B3:25a)

Date of birth of baby? _____ # of Weeks Pregnant at Delivery_____

Baby's name: _____ Weight _____

Which hospital? _____ Doctor: _____

Were there any complications? _____

Did you receive any prenatal care during your pregnancy? _____

_____

Doctor: _____ Hospital: _____

Miscarried_____ Terminated_____ Still Birth _____ # of weeks _____

Was this pregnancy planned? (B3:TC17) Yes___ No___

If not planned, did you consider an abortion? (B3:TC18) _____

Are you using birth control regularly?(B3:22)

Yes___, specify what type: (B3:23)_____

No___, reason: (B3:24)_____

During the past 6 months, did you use Family Planning Services?(B3:37)

☐ Yes, working well ☐ Yes, but problems ☐ No, but needed ☐ No, not needed (B3:25a)

_____

_____

_____

_____

_____

_____

CUSTODY OF TARGET CHILD (B4C:48-51) ☐ **N/A Currently Pregnant**	Don't know -7	Never asked -9
48. Who has legal custody of target child prior to enrollment? ☐ Client ☐ Bio dad ☐ Child deceased ☐ Other family* ☐ CFS ☐ Other* ☐ Adoptive family *Other, who:_____		
49. Who does target child live with prior to enrollment? ☐ Client ☐ Bio dad ☐ Child deceased ☐ Other family* ☐ CFS ☐ Other* ☐ Adoptive family *Other, who:_____		
50. For how many months of the past 6 prior to enrollment did the target child live with client? __ months (code 0 if none; if less than 1 month, code 1)		
51. For how many months of the past 6 did the target child live in state-paid foster or family care? __ months (code 0 if none; if less than 1 month, code 1)		

Comments on CUSTODY OF TARGET CHILD:

CLIENT'S CHILDREN (INCLUDING TARGET CHILD) (B5B:86 & B4E:65)

Prior to enrollment in PCAP:	Don't know -7	Never asked -9
86. Location of client's biological children (including Target Child):		
a. How many of client's biological children live with client? (code # of children; 00=none) __ __		
b. How many of client's biological children do NOT live with client? __ __		
65. a. How many non-biological children were living with the client in the past 6 months? _ _		

Comments on BIOLOGICAL CHILDREN:

Alberta PCAP Council
Parent Child Assistance Program

Client #			
Mentor #			
Date:	(mm)	(dd)	(yy)

Biological Children at Enrollment

Legend Codes:	
FASD:	Fetal Alcohol Spectrum Disorder
C:	Confirmed Diagnosis
DOB:	Date of Birth
S:	Suspected
D:	Death
SB:	Still Birth

Form is to be completed as soon after enrollment as possible.

INCLUDE: Target child first and then list from youngest to oldest. If Target child is not yet born, leave the top line blank, submit copy and fill in information after birth. If known include any children who have died in their proper birth order. Code age at death under AGE and skip custody questions.

Name		**Sex**		**DOB**				**Legal Custody With**							**Lives With**								**Permanently Lost Custody?**		**FASD**	
Last	First	Male	Female	mm	dd	yr	Age, SB, D	Client	Family	Friends	Govt	Adopted	Emancipated	Other	Ran Away	Client	Family	Friends	Government	Adopted	Emancipated	Other	No	Yes	C	S

Brief Relationship History:

Have you had a partner in the past six months prior to enrollment, and if so for how long (Supportive or not)? Are you currently living with your partner? (B4F:71)

Is your current relationship with the father of the baby? If no, is the father of baby involved?

Are you feeling unsafe in any way in your relationship with your partner?

Are you currently in what you would consider to be an abusive relationship with your partner?(ASI:F29a)

Have you been in abusive relationships in the past, or ever been beaten while pregnant?(ASI:F29b-c)

Who are you closest to? Who is a support to you?

Brief Addiction History:

Do any of your friends have a problem with alcohol or other drug use?

Does the father of the baby have a problem with alcohol or drug use? (ASI: H13)

Does your current partner have a problem with alcohol or drug use?

Tell me a bit about your dad.

Tell me a bit about your mom.

Did either of your parents, or other family members have a problem with alcohol or drug use? (ASI: H1-13)

Do you know if your mother drank when you were young or during her pregnancy with you? (ASI:C12)

Before you knew you were pregnant, how often did you drink beer, wine, coolers or liquor? Describe a typical day of drinking:

In the past month, how often did you drink beer, wine, coolers or liquor?

Before you knew you were pregnant, what drugs did you use? Describe a typical day of drug use:

In the past month, what types of drugs have you used? What is your primary drug of choice?

How many Cigarettes/day did you smoke in the month prior to pregnancy?_____

Are you currently smoking? If yes, how many Cigarettes/day?_____

Alcohol/Drug Treatment (B1: 1-14)

Have you ever attended a residential treatment program or accessed other forms of Addiction support?

No_____ If yes, complete the following chart:

Document client involvement with any and all alcohol/drug treatment prior to enrollment in PCAP.

	Yes, completed 1	Yes, in progress 2	Yes, but dropped 3	No 0	Don't know -7	Never Asked -9	Name of Treatment Facility/Agency
1. Inpatient (30 days, or less than 30 days)							
2. Inpatient (more than 30 days)							
If No, skip to Question 3: a. Length of program _ _ days							
b. Time spent IN program _ _ days							
3. Outpatient							
4. Methadone dosing							
5. Alcohol/drug support group							
If No, skip to Question 6: a. Type of group: ☐ AA ☐ NA/CA ☐ both ☐ other:							
6. Individual counselling							
7. Detox							
8. Treatment program while incarcerated							
9. Other treatment: (specify what kind)							

*Not applicable= not in treatment this 6-month period				*Not applicable -8	Don't know -7	Never asked -9
10. Treatment was for:	☐ Alcohol	☐ Drugs	☐ Both			
11. Treatment was:	☐ Mandated	☐ Voluntary				
12. Was/were her child(ren) with her in treatment? (inpatient only)	☐ Yes	☐ No				
13. Any alcohol/drug assessment for treatment done?	☐ Yes	☐ No				
14. Did she have drug or alcohol monitoring? (outside of treatment)	☐ Yes	☐ No				

Comments on ALCOHOL/DRUG TREATMENT:

Abstinence from Alcohol & Drugs (B2:15-21)

As of the date of enrollment in PCAP:		Yes 1	No 0	Don't know -7	Never asked -9
15. Is client currently clean from drugs? (for at least one month) If Yes, skip to Question 17.					
16. If using at time of enrollment, what drugs does client use now? (check a response for each)					
a. Cocaine					
b. Heroin					
c. Marijuana					
d. Crack					
e. Methamphetamine					
f. Other Specify other:_____					
17. How many months currently clean? (Code 00 if used in last month prior to enrollment)	_ _ months				
18. Is the client currently abstinent from alcohol? (for at least one month)					
19. How many months currently abstinent? (Code 00 if used in last month prior to enrollment)	_ _ months				
20. Does client have a problem with alcohol? (i.e., alcoholic; answer even if client not currently drinking)					
21. Prior to PCAP, what was the longest number of months in a row client has been clean and sober with no relapses, even if currently using. (Do not count cigarettes & methadone use.) Check only ONE	☐ Never ☐ 1-2 ☐ 3-5 ☐ 6-11 ☐ 12-17 ☐18-23 ☐ 24-29 ☐ 30-35 ☐ all 36				

Comments on ABSTINENCE FROM ALCOHOL & DRUGS:

Family Stability (B5C:87-92)

	Yes 1	No 0	Don't know -7	Never asked -9
87. What sources of income has client had in the past 6 months? (check yes or no for each)				
a. Employment (hers) (01)				
b. Odd jobs she does (02)				
c. Parent/grandparent (03)				
d. Other relative (04)				
e. Husband/wife/boyfriend/girlfriend (05)				
f. Friends/acquaintances (06)				
g. Income Support (SFI) (07)				
h. PDD/AISH (08)				
i. If yes, for psychiatric condition? ☐ Or medical condition? ☐				
j. Other government cheque (09), specify:				
k. Band payouts (10)				
l. Other (11), specify:				
m. Drug sales/prostitution (12)				
n. Fraud/cheque-kiting (13)				
o. Other illicit (14), specify:				
88. What is her main source of income prior to enrollment? (Enter 2 digit number from above) _ _				
89. Has client been employed during this 6-month period prior to enrollment, even if currently not?				
a. How long employed this 6 month period prior to enrollment: __ months __ weeks __ days				
b. Type of employment ☐ None ☐ Full-time (F/T) ☐ Part-time (P/T) ☐Irregular work ☐ Was employed, but don't know what type of employment				
c. Describe:				
90. Client is currently employed? ☐ No ☐ Yes, F/T ☐ Yes, P/T ☐Yes, Irregular work (Currently=At end of 6-month period) ☐ Yes employed, but don't know what type of employment				
a. Current job:				
91. Does client currently receive income support (SFI) for herself or her children?				
a. Number of months client/family received income support (SFI) during last 6 months: _ _ mos.				
b. Are health benefits included? Describe:				
92. During the past 6 months, did client: (if no income support/SFI in past 6 months, code No):				
a. STOP receiving income support (SFI) ☐ Yes, because of work ☐ Yes, other reason ☐ No Reason:				
b. START receiving income support (SFI) ☐ Yes, because of work ☐ Yes, other reason ☐ No Reason:				

Comments on SOURCES OF INCOME:

5A. IN WHAT LIVING AND HOUSING SITUATIONS HAVE YOU BEEN IN THE PAST 6 MONTHS?

(B5A:81-85)

	Yes 1	No 0	Don't know -7	Never asked -9
72. In what housing situations has client lived during past 6 months? (check yes or no for each)				
a. Homeless (01) (incl. couch surfing, emergency shelters)				
b. Living in Shelters/Motels (02)				
c. Living with Friends/Relatives (03)				
d. Permanent Housing (04) (renting or owning)				
e. Transitional Housing (05)				
f. Transitional Clean & Sober Housing (06)				
g. Inpatient treatment (07) (incl. mental health and alcohol/drug treatment)				
h. Incarcerated (jail, prison, etc.) (08)				
i. Other situation (09):				
73. What is her CURRENT housing situation? (Enter 2 digit number from above) _ _				
74. Who lives with client in her current housing situation prior to enrollment in PCAP?				
75. During this 6-month period, was any housing PCAP contracted housing?				
76. Has client moved in past 6 months? Code # of moves. _ _ moves (00=no moves; 66=too many moves to count)				

Situations with no children

- ☐ Lives alone
- ☐ Lives with husband, no children
- ☐ Lives with boyfriend/girlfriend (domestic partner, no children)
- ☐ Lives with parents, grandparents, other family, no children
- ☐ Lives with in-laws &/or their family, no children
- ☐ Lives with non-related women/men (roommates), no children

Situations with children

- ☐ Lives with child(ren), no other adults
- ☐ Lives with husband & child(ren)
- ☐ Lives with boyfriend/girlfriend & child(ren)
- ☐ Lives with relatives & child(ren)
- ☐ Lives with in-laws &/or their family & child(ren)
- ☐ Lives with non-related roommates & child(ren)

☐ Some other situation: _____

Comments on LIVING SITUATION/HOUSING:

5E. IN THE LAST 6 MONTHS, HAVE YOU HAD ANY ARRESTS OR BEEN IN JAIL?

(B5E:100-105)

	Yes 1	No 0	Don't know -7	Never asked -9
94. Was client arrested in past 6 months? If No, skip to Question 101.				
a. Charges: ☐ L03.Shoplifting/Vandalism ☐ L04.Parole/Probation Violations ☐ L05.Drug Charges ☐ L06.Forgery ☐ L06a.Criminal Impersonation (Identity Theft) ☐ L07.Weapons Offense ☐ L08.Burglary/Larceny/Breaking & Entering ☐ L09.Robbery ☐ L09a.Other Theft Charge: ☐ L10.Assault ☐ L11.Arson ☐ L12.Sexual Assault ☐ L13.First or second degree murder/manslaughter ☐ L14.Solicitation/Communication for the Purposes of Prostitution ☐ L15.Obstruction of Justice ☐ L15a.Possession of Stolen Property ☐ L18.Disorderly conduct, vagrancy, public intoxication ☐ L19.Driving while intoxicated ☐ L20.Major driving violations ☐ L16.Other:				
b. Number of times arrested __ __ times				
c. Charges are: ☐ New charge ☐ Old warrant ☐ Both				
95. Was client jailed in past 6 months? If No, skip to Question 102.				
a. Number of times jailed __ __ times				
b. For what?				
c. Facility:				
96. Was client in Home Detention at any time during past 6 months? (ie. Conditional Sentence Order, incl. house arrest, court-imposed curfew)				
97. Was client in Prison at any time during past 6 months? If No, skip to Question 104.				
a. Facility:				
b. # of months (of 6): __ __ mos				
98. Was client on Probation or Parole at any time during past 6 months?				
99. Did advocate play a role in type of sentence imposed in past 6 months?				
a. If yes, how so?				

Comments on ARRESTS/JAIL:

Medical Status

Do you have any chronic medical problems which continue to interfere with your life? (Include FASD diagnosis) *(ASI M3.)* Yes_____ No _____

If yes, specify: _____

Are you taking any prescribed medication on a regular basis for a physical problem? *(ASI M4.)*

_____

_____

_____

Psychiatric Status/Mental Health

Have you ever had a psychiatric evaluation? Yes _____ No _____ *(ASI P2a.)*

If so, Evaluation results/Diagnosis: (ASI P2b/P2c.) _____

_____

Have you been prescribed medication for any psychological/emotional problem? *(ASI P11.)*

_____

_____

_____

Goals

What goals or issues do you feel are important to address, with support from your Mentor and the Program?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Parent Child Assistance Program

Services Coordination - Page 1

Client Name _____

ID# _____

Mentor Name _____

Review and update every 6 months. Supervisor to initial appropriate month when done.

____ 6 ____ 12

____ 18 ____ 24

____ 30 ____36

Agency Name: _____ Start Date:

Service: _____

Contact Person & Position: _____

Address: _____ End Date:

_____

CITY POSTAL CODE

Phone: _____

Agency Name: _____ Start Date:

Service: _____

Contact Person & Position: _____

Address: _____ End Date:

_____

CITY POSTAL CODE

Phone: _____

Agency Name: _____ Start Date:

Service: _____

Contact Person & Position: _____

Address: _____ End Date:

_____

CITY POSTAL CODE

Phone: _____

Validity

Advocate/Mentor is confident of accuracy of information presented in this report: ☐ Yes ☐ Mostly ☐ Not at all

Comments on validity: (if you code Mostly or Not at all, note why)

Final Comments

Comments on client's situation prior to enrollment in PCAP: