



Strengthening Families Information Request Application

If you are interested in participating or finding out more about this free program, please fill out the information below and email to TheClubhouse@ashleytreatment.org. A Clubhouse staff member will contact you upon receipt.

Important: Completing and submitting this application does not secure your space in the program. If selected, you will be contacted by a staff member of The Clubhouse. Space is limited due to funding. Thank you!

Once we can resume in-person services, all Clubhouse services, including the meals, will be available at our physical space – location to be announced.

Date: _____

Referred By: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Email: _____

Work Phone: _____ Mobile Phone: _____

Gender: _____

Race:

Black/African American

Asian or Pacific Islander

Multiracial

White

Hispanic/Latino

Other

Please name your spouse or significant other who will be attending: _____

Gender: _____ Phone: _____

Please list the names and ages of all your adolescents that are between the ages of 12 and 17 years old (18 and above if still in high school) who will be attending.

Adolescent #1

Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Race:

Black/African American

Asian or Pacific Islander

Multiracial

White

Hispanic/Latino

Other

Name of School Your Adolescent Is Attending: _____

Continued on next page...

Adolescent #2

Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Race:

Black/African American

Asian or Pacific Islander

Multiracial

White

Hispanic/Latino

Other

Name of School Your Adolescent Is Attending: _____

Adolescent #3

Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Race:

Black/African American

Asian or Pacific Islander

Multiracial

White

Hispanic/Latino

Other

Name of School Your Adolescent Is Attending: _____

Adolescent #4

Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Race:

Black/African American

Asian or Pacific Islander

Multiracial

White

Hispanic/Latino

Other

Name of School Your Adolescent Is Attending: _____

Adolescent #5

Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Race:

Black/African American

Asian or Pacific Islander

Multiracial

White

Hispanic/Latino

Other

Name of School Your Adolescent Is Attending: _____

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Adolescent #6

Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Race:

Black/African American

Asian or Pacific Islander

Multiracial

White

Hispanic/Latino

Other

Name of School Your Adolescent Is Attending: _____

CONSENT TO CONTACT

I am interested in talking to someone about the Strengthening Families Program. I give permission for them to contact me regarding this program.

Name: _____ Date: _____

Signature: _____