



Beyond Empowerment Enrollment Form
To be completed by the Beyond Empowerment provider

Participant's Name: _____ **Date:** _____

1. The applicant is between the ages of 18-21 years old
 Yes No
2. The applicant qualifies for mental health services or co-occurring services
 Yes No
3. The applicant presents for services in Miami- Dade County
 Yes No
4. The applicant consents to receiving support and services
 Yes No

A person's appearance, style, dress, or mannerisms (like the way they walk or talk) may affect the way people think of them. On average, how do you think people you know would describe your appearance, style, dress or mannerisms?

- | | |
|---|---|
| <input type="checkbox"/> Very feminine | <input type="checkbox"/> Somewhat masculine |
| <input type="checkbox"/> Mostly feminine | <input type="checkbox"/> Mostly masculine |
| <input type="checkbox"/> Somewhat feminine | <input type="checkbox"/> Very masculine |
| <input type="checkbox"/> Equally feminine and masculine | |
| <input type="checkbox"/> I am unsure | |
| <input type="checkbox"/> I do not want to respond | |

What sex were you assigned at birth, on your original birth certificate?

- Male Female

How do you describe yourself (check one)?

- Male
 Female
 Transgender
 Do not identify as female, male or transgender
 I am unsure
 I do not want to respond

Do you think of yourself as (please check all that apply):

- Straight



- Gay or lesbian
- Bisexual
- Transgender, transsexual, or gender non-conforming
- I am unsure
- I do not want to respond

If the participant answered “transgender” to the question above, ask:

- Transgender or transsexual, male to female
- Transgender or transsexual, female to male
- Gender non-Conforming
- I am unsure
- I do not want to respond

Clinical Information:

Mental Health Diagnosis _____	

Identify assessment(s) used to acquire diagnosis (Check all that apply):	
<input type="checkbox"/> Bio-psychosocial	Date completed: _____
<input type="checkbox"/> Functional Assessment Rating Scale (FARS)	Date completed: _____
<input type="checkbox"/> Mental Health Outcome	Date completed: _____
<input type="checkbox"/> Ansell Casey:	Date completed: _____
<input type="checkbox"/> Other:	Date Completed: _____

Approval

Request for enrollment number. To be completed by SFBHN representative:		
The individual is enrolled in Beyond Empowerment Yes <input type="checkbox"/> No <input type="checkbox"/>		
Enrollment number: _____ Date of Enrollment: _____		
Request Completed By (Print)	Signature	Date

E-mail the form to SFBHN. Electronically submitted documents must be password protected.