GRIEF COUNSELING QUESTIONNAIRE

Name of Agency : ____

Person of Contact: ____

Contact information : ____

1. Was the child/youth referred for services?

2. What were the circumstances that occurred for the individual(s) to receive a referral?

3. Does the child/youth have insurance? If so, how is LCCSF a payor of last resort?

4. Is the individual established as a client with the provider? Do they have client files and/or was the service completed on site for a one time only visit?

5. Can we anticipate additional services to be completed/invoiced for the individual(s) through the grief counseling policy/grief funds?

Additional information:

Is there any additional information you want to share in regard to the services completed?