The Family Assessment of Support Tool (FAST) | 2014

Parent(s) Name:	**Child/Youth Name:**
Address:	**Age:**
Phone Number:	**Family Partner:**
Date Completed:	**Organization Name:**

In Wraparound, we work together as a team to support your family. We will share the information on this form with your care coordinator. If you give us permission, the information on this form will also be combined with information from other families to be used in research to study how our services work and how we could make our services work better for families. **Initial**_____

Types of Support

I. When we face challenges, we often look to people in our lives for support. This is especially true when raising a child with emotional or behavioral needs. Who are those individuals that you have or could turn to for support?

☐ Spouse/ Significant Other ☐ Friend ☐ Family Member ☐ Neighbor ☐ Faith Community ☐ Other

Presence of Support System

II. Please select the statement below that best fits you and your family.

When I am experiencing difficult times, the important people in my life who provide me with support (such as family members, spouse, partner, friends or others) are…

0. Available to provide support to me *most of the time* and *aware* of my family's situation
1. Available to provide support to me *some of the time* and *aware* of my family's situation
2. Available to provide support to me *some of the time*, but *not aware* of my family's situation
3. *Never* available to provide support to me/or I do not have any support people

Acceptance of Support System

III. When I think about how important people in my life react to …

	Accepted Most of the Time	**Accepted Some of the Time**	**Judged Some of the time**	**Judged Most of the Time**
a) My life choices and decisions, I feel	0	1	2	3
b) My child's mental health needs, I feel	0	1	2	3
c) My parenting style, I feel	0	1	2	3
d) My child's behavior, I feel	0	1	2	3

System Receptivity

IV. When I'm working with the professionals in my child and family's life…

		Most of the time	Some of the time	Rarely	Never
a)	I feel able to voice my ideas to the professionals	0	1	2	3
b)	I am understood by professionals	0	1	2	3
c)	My ideas are included in decision-making	0	1	2	3

Coping with Stress

V. When I think about the challenges I face…

		Strongly Disagree	Disagree	Agree	Strongly Agree
a)	I have the ability to deal with the things that happen to me	3	2	1	0
b)	I can handle things when things get tough, because I know what I can do to make things better	3	2	1	0
c)	I know that I can deal well with the unexpected	3	2	1	0
d)	I often feel helpless when dealing with the problems of life	0	1	2	3
e)	There is really no way I can solve some of the problems I have	0	1	2	3

VI. For most of us, major life changes can create stress for our families. In this next section we are interested in hearing about the areas of your life and your family's life that are likely to experience major change in the next 60 days.

☐ Emotional ☐ Family ☐ Cultural/Spiritual ☐ Health ☐ School/Work
☐ Safety ☐ A Place to Live ☐ Legal ☐ Social/Fun ☐ Other

SCORING SHEET	
Item	**Total Number**
Presence of Support	
Acceptance of Support	
Coping with Stress	
Expected Changes	

PLANNED CONTACT

☐ Supportive Contact: Weekly Phone or Support Group
☐ Moderate Contact: One face to face visit per month plus Supportive Contact
☐ Intensive Contact: Weekly face to face contact with Supportive and Moderate Contact

Thank you very much for taking the time to answer these questions!