**NYS Office of Alcoholism and Substance Abuse Services**
**Alcohol Awareness Program**
**EVALUATION FORM**

Provider name: _____ Report Year (July 1 to June 30): _____

County: _____

Alcohol Awareness Program Contact Person: _____

Telephone Number: _____ Fax: _____ E-mail: _____

Mailing address: _____

| Length of Alcohol Awareness Program | Number of Programs Delivered this Period: | Number of Youth Served this Period: |
|---|---|---|
| (Total # of hours): _____ | _____ | _____ |

Number of Total Youth Served in Each Age Range:

10-12 yrs. _____ 13-15 yrs. _____ 16-18 yrs. _____ 19-20 yrs. _____

FTE Allocation _____

Number of Family/Significant Others of Youth Served this Period: _____

| Source of Referral | (Specify Numbers) | Other Related Interventions with Youth: (Specify Numbers) | |
|---|---|---|---|
| Court | _____ | Family Relationships | _____ |
| School | _____ | Domestic Violence | _____ |
| Family | _____ | School Personnel | _____ |
| Other (specify) _____ | _____ | Other (specify) _____ | _____ |

Total Number of Youth Referred for Evaluation for Treatment this Period: _____

Pre and Post Test Evaluation Summary (if applicable):

Date: _____ Signed: _____

**Please return via fax, e-mail or mail to:**

**Attention Walt Davies**
**NYS Office of Alcoholism and Substance Abuse Services**
**1450 Western Ave.**
**Albany, NY 12203**
**Phone: 518-457-4384**
**Fax: 518-485-9480**
**E-mail: walt.davies@oasas.ny.gov**