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 (Total # of hours): ______	Number of Programs Delivered this Period: ______	Number of Youth Served this Period: ______

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

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