Family Place Intake Form (ADULT)

☐ Family Place Daytona
☐ Family Place Deltona
☐ Dr. Rawji's Office

All Family Place services are free and voluntary. Please complete this Family Place Intake Form so that we can better serve you.

First and Last Name:		Date of Birth:
Physical Address		☐ Homeless; if homeless please provide last known address
City:	State:	Zip Code:
Home Phone:	Mobile Phone:	Can you receive texts? Y or N
Email Address:		Do you need an email account: Y or N

Is your physical address your primary residence ☐ No ☐ Yes, if yes how many months/years: ________

Age:
☐ less than 18 ☐ 18-29 ☐ 30-54 ☐ 55-64 ☐ 65+

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female

Race: Which group do you most identify with? (Check ONE selection)
☐ White/Caucasian ☐ Black/African American ☐ Asian/Pacific Islander ☐ American Indian
Other______________________________

Ethnicity: Which group do you most identify with? (Check ONE selection)
☐ Not Hispanic/Latino ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ South American
Other______________________________

Education: Please check the highest level completed: (Check ONE selection)
☐ Elementary/Middle School ☐ High school diploma or GED ☐ Technical/Community College
☐ 4 year College/Bachelor's degree ☐ Graduate/Advanced Degree ☐ Some College

Employment Status: (Check ONE selection):
☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed ☐ Self-employed ☐ Not Seeking work

Household Income: (Check ONE selection)
☐ Less than $10,000 ☐ $10,000 to $19,999 ☐ $20,000 to $29,999 ☐ $30,000 to $49,999
☐ $50,000 to $74,999 ☐ $75,000 to $99,999 ☐ $100,000 or more

What is your family size?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ more than 7

How many children do you have under the age of 18?
☐ none ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5

How many children do you have under the age of 3?*
☐ none ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ more than 5

Are you pregnant?* ☐ No ☐ Yes, if yes how many months: ____________ **AND** due date: _____________

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Please tell us what you CURRENTLY have right now (Check ALL that apply):

☐ Driver's license, state issued ID card or passport	☐ CPC or DCF involvement
☐ DCF ACCESS online account	☐ Healthy Start or Healthy Families*
☐ Food or Cash Assistance	☐ Women, Children and Infants (WIC) assistance

How is your healthcare covered? (Check ALL that apply):

☐ **I don't have health insurance**	☐ Medicaid for self	☐ Medicaid for children
☐ Military coverage/VA	☐ Medicare	☐ Pay cash
☐ West Volusia Hospital Authority Card	☐ Health insurance that you pay on your own	
☐ Health insurance from your job or a family member's job	☐ Other ________________	

Please tell us what you NEED help with at this time (Check ALL that apply)

☐ Assistance with finding health insurance	☐ Computer/Fax/Phone assistance or use
☐ DCF ACCESS online account	☐ Healthy Start or Healthy Families
☐ Food or Cash Assistance	☐ Women, Children and Infants (WIC) assistance
☐ Driver's license, state issued ID card or passport	☐ Primary care (i.e. family doctor or walk-in clinic)
☐ Prenatal care	☐ Post-partum care
☐ Family planning/birth control	☐ Pediatric care
☐ Mental health/counseling	☐ Substance abuse services-drug & alcohol
☐ Housing	☐ Transportation
☐ Employment	☐ Education/Literacy
☐ Citizenship/Immigration	☐ Support services
☐ Legal assistance	☐ Parent Partner or Café Dialogue
☐ Don't feel safe where I live	☐ Referral to other services
☐ Other needs not listed (Please write below):	

Florida law requires that information contained in medical and/or client records be held in strict confidence and is not to be released without written authorization. By signing this form, you agree that we can share this participant information with community providers that can assist with services. The authorization you sign below on this page will remain in effect for six months from today's date or until you/or your family no longer require services from the Healthy Start Family Place. You have the right to withdraw your authorization at any time.

Print First and Last Name:	
Signature:	**Date:**

For Family Place use only	*Intake Staff Name:*		*Date:*
Partner Partner Referral: Y or N	*HS Referral signed: Y or N*	*Folder created: Y or N*	
Well Family System (WFS): Y or N	*WFS ID numbers:*	*# Services:*	*# Referrals:*
Comments:			