

## Family Place Intake Form (CHILD)

*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		
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
<p><b>Is your physical address your primary residence</b>    <input type="checkbox"/> No    <input type="checkbox"/> Yes, if yes how many months/years: _____</p> <p><b>Age:</b></p> <p style="padding-left: 40px;"><input type="checkbox"/> 0-5                      <input type="checkbox"/> 6-10                      <input type="checkbox"/> 11-17</p> <p><b>Marital Status</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> Single                      <input type="checkbox"/> Married                      <input type="checkbox"/> Divorced                      <input type="checkbox"/> Widowed                      <input type="checkbox"/> Not Applicable</p> <p><b>Gender:</b>    <input type="checkbox"/> Male                      <input type="checkbox"/> Female</p> <p><b>Race: Which group do you most identify with? (Check <u>ONE</u> selection)</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> White/Caucasian    <input type="checkbox"/> Black/African American    <input type="checkbox"/> Asian/Pacific Islander    <input type="checkbox"/> American Indian</p> <p>Other _____</p> <p><b>Ethnicity: Which group do you most identify with? (Check <u>ONE</u> selection)</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> Not Hispanic/Latino    <input type="checkbox"/> Mexican                      <input type="checkbox"/> Puerto Rican                      <input type="checkbox"/> Cuban                      <input type="checkbox"/> South American</p> <p>Other _____</p> <p><b>Education: Please check the highest level completed: (Check <u>ONE</u> selection)</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> Elementary/Middle School                      <input type="checkbox"/> High school diploma or GED                      <input type="checkbox"/> Technical/Community College</p> <p style="padding-left: 20px;"><input type="checkbox"/> 4 year College/Bachelor's degree                      <input type="checkbox"/> Graduate/Advanced Degree                      <input type="checkbox"/> Some College</p> <p><b>Employment Status: (Check <u>ONE</u> selection):</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> Employed Full-time    <input type="checkbox"/> Employed Part-time    <input type="checkbox"/> Unemployed    <input type="checkbox"/> Self-employed    <input type="checkbox"/> Not Seeking work</p> <p><b>Household Income: (Check <u>ONE</u> selection)</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> Less than \$10,000                      <input type="checkbox"/> \$10,000 to \$19,999                      <input type="checkbox"/> \$20,000 to \$29,999                      <input type="checkbox"/> \$30,000 to \$49,999</p> <p style="padding-left: 20px;"><input type="checkbox"/> \$50,000 to \$74,999                      <input type="checkbox"/> \$75,000 to \$99,999                      <input type="checkbox"/> \$100,000 or more</p> <p><b>What is your family size?</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> 1                      <input type="checkbox"/> 2                      <input type="checkbox"/> 3                      <input type="checkbox"/> 4                      <input type="checkbox"/> 5                      <input type="checkbox"/> 6                      <input type="checkbox"/> more than 7</p> <p><b>How many children do you have under the age of 18?</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> none                      <input type="checkbox"/> 1                      <input type="checkbox"/> 2                      <input type="checkbox"/> 3                      <input type="checkbox"/> 4                      <input type="checkbox"/> 5                      <input type="checkbox"/> more than 5</p> <p><b>How many children do you have under the age of 3?*</b></p> <p style="padding-left: 20px;"><input type="checkbox"/> none                      <input type="checkbox"/> 1                      <input type="checkbox"/> 2                      <input type="checkbox"/> 3                      <input type="checkbox"/> 4                      <input type="checkbox"/> more than 5</p> <p><b>Are you pregnant?*</b>    <input type="checkbox"/> No    <input type="checkbox"/> Yes, if yes how many months are you or due date: _____</p>		



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

<input type="checkbox"/> Driver's license, state issued ID card or passport	<input type="checkbox"/> CPC or DCF involvement
<input type="checkbox"/> DCF ACCESS online account	<input type="checkbox"/> Healthy Start or Healthy Families*
<input type="checkbox"/> Food or Cash Assistance	<input type="checkbox"/> Women, Children and Infants (WIC) assistance

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

<input type="checkbox"/> I don't have health insurance	<input type="checkbox"/> Medicaid for self	<input type="checkbox"/> Medicaid for children
<input type="checkbox"/> Military coverage/VA	<input type="checkbox"/> Medicare	<input type="checkbox"/> Pay cash
<input type="checkbox"/> West Volusia Hospital Authority Card	<input type="checkbox"/> Health insurance that you pay on your own	
<input type="checkbox"/> Health insurance from your job or a family member's job	<input type="checkbox"/> Other _____	

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

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

<b>Print First and Last Name:</b>		
<table style="width: 100%;"> <tr> <td style="width: 50%;"><b>Signature:</b></td> <td style="width: 50%;"><b>Date:</b></td> </tr> </table>	<b>Signature:</b>	<b>Date:</b>
<b>Signature:</b>	<b>Date:</b>	

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