

CHILD CLIENT INTAKE/ELIGIBILITY DETERMINATION FORM

Non-Residential Programs

7/2020

Client ID _____
First Contact Date _____

Household ID Number: _____
Case Close Date: _____

All questions should be completed within _____ of intake.

A. CLIENT DEMOGRAPHICS

1. Name: _____ Date of Birth: _____ 1. Phone intake 2. In-person intake
Parent/Guardian's Name: _____
2. Gender Identity: ☐ Female ☐ Male ☐ Other: _____ ☐ Not Reported (Client declined)
- ☐ Transgender female (male to female): *Someone whose sex is or was male but identifies as female*
- ☐ Transgender male (female to male): *Someone whose sex is or was female but identifies as male*
- ☐ Genderqueer/Gender non-conforming: *Someone who does not identify exclusively as male or female, somewhere in between or neither gender identity*
3. Age at First Contact: _____

4. Race/Ethnicity: <i>Client should self-identify.</i> <i>Check as many as apply</i>	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> South Asian (NEW in FY21 – Subgroup of Asian)	<input type="checkbox"/> Black/African American
	<input type="checkbox"/> Hispanic/Latinx	<input type="checkbox"/> Native Hawaiian/ Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> MENA (Middle Eastern North African) – Note federal agencies consider this a subgroup of White.
	<input type="checkbox"/> Other _____			

5. Custody: ☐ Client has Custody ☐ Client/Offender Joint Custody ☐ Offender has Custody ☐ Other Relative has Custody
☐ DCFS Custody ☐ Other: _____ ☐ Unknown
6. Lives With: ☐ Client ☐ Client and Offender ☐ Offender
☐ Other Relative ☐ Other: _____ ☐ Unknown
7. School: Not of School Age Pre-school Kindergarten 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th Graduated Dropout Unknown
8. DCFS: ☐ DCFS Open ☐ DCFS Investigation

B. NON-CASH BENEFITS / HEALTH INSURANCE:

1. Non-Cash Benefits:

- ☐ Food Stamps/food benefit card (Link Card) ☐ TANF Transportation ☐ Other Source
- ☐ Special Supplemental nutrition (WIC) ☐ Other TANF funded services ☐ Receives NO Non-Cash Benefits
- ☐ TANF Child Care services ☐ Section 8, public housing, rent assistance ☐ Unknown

2. Health Insurance

- ☐ Medicaid health insurance (18 and older only) ☐ State children's health insurance (Illinois Children's Medicaid) ☐ Private health insurance
- ☐ Medicare health insurance ☐ Veteran's administration med services ☐ No health insurance
- ☐ Unknown

C. SPECIAL NEEDS (Check as many as apply):

- ☐ No special needs indicated ☐ Unknown ☐ Not Reported
- ☐ Has hearing impairment ☐ Limited English – Primary Language: _____ ☐ Requires special diet
- ☐ Requires assistance in feeding, dressing, or toileting ☐ Requires wheelchair accessibility ☐ Other special need: _____
- ☐ Must have medication administered ☐ Has immobility
- ☐ Has visual impairment-requires assistance ☐ Has developmental disability

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D. SERVICES NEEDED: Check all services needed by child.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Emotional/Counseling | <input type="checkbox"/> Child care | <input type="checkbox"/> Medical Advocacy |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Individual Support | <input type="checkbox"/> Legal Services | <input type="checkbox"/> Crisis Intervention |
| <input type="checkbox"/> Financial | <input type="checkbox"/> School Advocacy (child) | <input type="checkbox"/> Employment | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Group Activity (child) | <input type="checkbox"/> Legal Advocacy | <input type="checkbox"/> Parent Child Support |
| <input type="checkbox"/> Lock up/Board up | <input type="checkbox"/> Education | <input type="checkbox"/> Medical Services | <input type="checkbox"/> Community Advocacy |
| | | | <input type="checkbox"/> Therapy |

E. CHILD'S BEHAVIORAL ISSUES

☐ No behavioral issues observed from any of the categories

- | Emotional | Physical | Social | Educational (if in school) |
|---|--|---|---|
| <input type="checkbox"/> Is often afraid | <input type="checkbox"/> Bed-wets (if over age 4) | <input type="checkbox"/> Plays with fire | <input type="checkbox"/> Misses school often not due to medical reasons |
| <input type="checkbox"/> Can't leaving parent | <input type="checkbox"/> Illnesses often | <input type="checkbox"/> Tries to act like a parent (role reversal) | <input type="checkbox"/> Has dropped out of school |
| <input type="checkbox"/> Accepts without question | <input type="checkbox"/> Weight problems | <input type="checkbox"/> Is very protective of family members | <input type="checkbox"/> Has problems obeying rules at school |
| <input type="checkbox"/> Cries often | <input type="checkbox"/> More active than other children | <input type="checkbox"/> Resists guidance and discipline | <input type="checkbox"/> Special Class behavioral problems |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> If yes, in special class | <input type="checkbox"/> Is possessive of toys (if age 3 or older) | <input type="checkbox"/> Has learning problems |
| <input type="checkbox"/> Little interaction | <input type="checkbox"/> Abuses drugs | <input type="checkbox"/> Hits, kicks, bites, shoves frequently | <input type="checkbox"/> Special Class learning problems |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Abuses alcohol | <input type="checkbox"/> Behaves like a younger child | |
| <input type="checkbox"/> Hurts self on purpose | | <input type="checkbox"/> Harms animals | |
| <input type="checkbox"/> Suicidal | | | |

F. RESIDENCE

Address: _____

City/town

Township

County

State Zip Code

(Enter UK for Unknown and NR for Not reported)

Type of Residence (At point of intake) (Required for Chicago DFSS grantees)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Emergency shelter (other DV or homeless) | <input type="checkbox"/> Substance abuse treatment facility | <input type="checkbox"/> Staying/living w/ family member | <input type="checkbox"/> Place not meant for habitation |
| <input type="checkbox"/> Transitional housing-homeless | <input type="checkbox"/> Jail/prison/juvenile detention ctr | <input type="checkbox"/> Staying/living w/ friend | <input type="checkbox"/> Other |
| <input type="checkbox"/> Perm. housing for formerly homeless | <input type="checkbox"/> Room/apt/house rented | <input type="checkbox"/> Hotel/motel paid for w/o emergency shelter voucher | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Psychiatric hospital/facility | <input type="checkbox"/> Apt/house owned | <input type="checkbox"/> Foster care home/group home | <input type="checkbox"/> Not Reported |

Length of stay in previous place (place indicated above) (Required for Chicago DFSS grantees.)

- ☐ 1 week or less ☐ 1 week to 1 month ☐ 1-3 months ☐ 3 months to 1 year ☐ 1 year or longer ☐ Unknown

Parent/Guardian Signature _____ Date _____

Counselor Signature _____ Date _____