

CHILD CLIENT INTAKE/ELIGIBILITY DETERMINATION FORM

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

- ☐ Is often afraid
- ☐ Can't leaving parent
- ☐ Accepts without question
- ☐ Cries often
- ☐ Mood swings
- ☐ Little interaction
- ☐ Nightmares
- ☐ Hurts self on purpose
- ☐ Suicidal

Physical

- ☐ Bed-wets (if over age 4)
- ☐ Illnesses often
- ☐ Weight problems
- ☐ More active than other children
- ☐ If yes, in special class
- ☐ Abuses drugs
- ☐ Abuses alcohol

Social

- ☐ Plays with fire
- ☐ Tries to act like a parent (role reversal)
- ☐ Is very protective of family members
- ☐ Resists guidance and discipline
- ☐ Is possessive of toys (if age 3 or older)
- ☐ Hits, kicks, bites, shoves frequently
- ☐ Behaves like a younger child
- ☐ Harms animals

Educational (if in school)

- ☐ Misses school often not due to medical reasons
- ☐ Has dropped out of school
- ☐ Has problems obeying rules at school
- ☐ Special Class behavioral problems
- ☐ Has learning problems
- ☐ Special Class learning problems

F. RESIDENCE

Address: _____

City/town

Township

County

State

Zip Code

(Enter UK for Unknown and NR for Not reported)

Type of Residence (IMMEDIATELY prior to coming to dv shelter/transitional housing program) Required for shelter clients; optional for others but some funders, e.g. Chicago DFSS, require this info for all clients.)

- | | | | |
|---|---|---|---|
| <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 shelter clients; optional for others but some funders, e.g. Chicago DFSS, require this info for all clients.)

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

PREVIOUS SERVICE USE (shelter/transitional housing clients only): In the Last Year....

- 1—Has the child used another domestic violence shelter in this part of IL? YES NO If yes, about how long ago (approx date): _____
- 2—Has the child used another homeless shelter in this part of IL? YES NO If yes, about how long ago (approx date): _____

Parent/Guardian Signature _____ Date _____

Counselor Signature _____ Date _____