Community Response Referral and Intake Form

(highlighted areas will be reported to UNMC)

First Name	MI	Last Name
Maiden Name (if applicable)	Alias or any other names used	

Are you currently working with an agency in your community?	☐Yes , Name of Agency:_____Staff Person Name:_____ ☐No ☐Client doesn't Know ☐Client Refused ☐Data not collected
U.S. Military Veteran	☐Yes ☐No ☐Client doesn't Know ☐Client Refused ☐Data not collected

Household Relationship Information (select one)	☐Couple with No Children ☐Couple (Parent & Friend) with Child(ren) ☐Foster Parent ☐Grandparent(s) &Child(ren) ☐Non-Custodial Caregivers ☐Single Female Parent ☐Single Male Parent ☐Single Person ☐Two Parent Family ☐Other	Name of Children under age 18 living in the household: Name: Relation: Sex DOB/Age: Name: Relation: Sex DOB/Age:
Is this family expecting a child?:	☐ Yes ☐ No ☐ If yes, what is the due date:	If yes, what is the due date:
Date of Birth (DOB)		☐Full DOB ☐Approx. or partial DOB ☐Client doesn't know ☐Client refused
Gender (select one)	☐Woman ☐Man ☐Prefer not to say ☐Other: _____	
Race/Ethnicity	☐American Indian or Alaska Native ☐Hispanic or Latino ☐White ☐Black or African American ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Data not collected ☐Prefer not to say	
Does your child have a disability?	☐ Yes ☐ No ☐Client doesn't know ☐Client refused ☐Data not collected	
Do you (the caregiver) have a disability of long duration?	☐ Yes ☐ No ☐Client doesn't know ☐Client refused ☐Data not collected	
Are you a farmworker/agricultural worker?	☐ Yes ☐ No ☐Client doesn't know ☐Client refused ☐Data not collected	
Which of the following systems have you been involved with? (Check all that apply)	☐ Child Welfare: Abuse/Neglect (3a) ☐ Child Welfare: Office of Juvenile Services (3b) ☐ Child Welfare: Mental Health (3c) ☐ Other ☐ Probation ☐ Corrections ☐ Don't Know	

Which of the following systems are you currently involved with?	☐ Child Welfare: Abuse/Neglect (3a) ☐ Probation ☐ Child Welfare: Office of Juvenile Services (3b) ☐ Corrections ☐ Child Welfare: Mental Health (3c) ☐ None ☐ N/A
Domestic violence victim/survivor?	☐ Yes ☐ No ☐Client doesn't know ☐Client refused ☐ Data not collected
Medicaid Eligibility?	☐Yes ☐No ☐Client doesn't know ☐Client refused ☐Data not collected
Highest grade completed	☐ 6th grade or less ☐ 7th grade ☐ 8th grade ☐ 9th grade ☐ 10th grade ☐ 11th grade ☐ 12th grade (High School Diploma) ☐ GED/Modified Diploma ☐ 1+ years of college Vocational/Trade School Degree ☐ Associate's Degree ☐ Bachelor's Degree ☐ Graduate Degree (Master's or Doctoral) ☐ Other: _____

Today's Date:	**Time: am/pm**	**Name of Referring Party:**
Email:		**Referring Party Phone (primary):**

Concerns and Needs

Basic Needs/Housing Support

☐ Homeless or nearly homeless ☐ Unsafe/unhealthy/unstable housing ☐ Daily food for children/adults
☐ Basic household items needed for health/safety ☐ Transportation for school/appointments

Financial Support

☐ Unemployed ☐ Job Skills needed ☐ Employed/low income

Parenting Support

☐ Parenting skills ☐ Parenting resources

Children

☐ Difficult childhood behaviors at home ☐ Difficult behaviors in school/community ☐ Truancy
☐ Physical or developmental disabilities

Safety

☐ Family Member(s) concerned for personal safety in the home, school and community

Mental, Social Emotional, Physical Well-Being

☐ Recent death in the family ☐ Trauma/PTSD ☐ Adult has mental health concerns
☐ Basic household items needed ☐ Family member(s) has an alcohol, chemical or pharmaceutical drug concern
☐ Child/youth has mental health/behavioral health concerns and family requires additional support

Family Supports/Informal

☐ Family New to the Area ☐ Non-English Speaking ☐ Family isolated
☐ Lacks Support from friends, family and/or community ☐ Member of Church

What is the most urgent need right now? (Please describe)

_____

_____

_____

By signing below, as the parent/Caregiver, I am aware that this referral and the information contained within, will be shared with the Community Response Team for consideration of possible care management services and/or supports. I hereby provide consent to disclose this information to that team only for the purposes of determining eligibility and offering said services/supports.

Parent/Caregiver Consent and Signature

Phone

Date

Referring Party Signature

Phone

Age