|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SECTION I: Identifying Information – Completed by Intake Specialist**  **Date Family Contacted:** Click or tap to enter a date. | | | | |
| **Family Name:**  Click or tap here to enter text. | | | **Preferred Language:**  Click or tap here to enter text. | |
| **Address of Family:** Click or tap here to enter text.  **City, State, Zip:** Click or tap here to enter text.  **County where family resides:** Click or tap here to enter text. | | | **Phone number:** Click or tap here to enter text.  **Best way to contact family (phone, text, person, other):** Click or tap here to enter text. | |
| **Non-custodial Parent(s) Name:** Click or tap here to enter text.  **Address:** Click or tap here to enter text.  **City, State, Zip:**Click or tap here to enter text. | | | **Phone number:** Click or tap here to enter text.  **Best way to contact (phone, text, person, other):** Click or tap here to enter text. | |
| **Community Agency:** Click or tap here to enter text.  **Community Contact Name:** Click or tap here to enter text.  **Community Contact Number:** Click or tap here to enter text.  **Date of Referral:** Click or tap to enter a date. | | | **Has the family had previous involvement with DCF?**  **Yes No If yes, choose from the following:**  Choose an item.  **Is the family court-involved?**  **Yes**  **No**  **If yes, enter name of court:** Click or tap here to enter text.  **Reason for court-involvement:** Click or tap here to enter text. | |
| **Family members:**  **Name DOB SSN**   |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | | | |
| **Reason for referral:**      Click or tap here to enter text. | | | | |
| |  | | --- | | **Recommended Tier:**  **Tier 1 Tier 2**  **Services Needed:**  **Housing Stability**  **Financial Stability**  **Connection to Community Mental Health**  **Assistance with signing up for DCF or other community assistance programs**  **Parenting skills**  **Child Behavior**  **Medically needy child/family member** | |  | | | | | |
|  |  |  | |  |
| Assigned Case Team: Click or tap here to enter text. | | | | |
| Assigned Tier: Click or tap here to enter text. | | | | |