Intake Screening Form

Fax: 813-200-3996/Phone Number 888-920-8761
Email Address: KIntake@childrenshomenetwork.org

Today's Date: _______ **Placement Date**: _______ **Adjudication Date**: _______ **FSFN #**: ________

County: ☐ **Orange** ☐ **Osceola** ☐ **Seminole**

☐ **Self-Referral** ☐ **Partner Agency** ☐ **Other Specify**: ___________________

☐ **CHN** ☐ **CPI** ☐ **DCF** ☐ **CHS** ☐ **ESI** ☐**GAL** ☐**GCJFS** ☐**I&P** ☐**OHU**

Receives relative caregiver funds ☐**Yes** ☐**No** **Receives TANF** ☐**Yes** ☐**No**

Eligible for Level 1 Licensure ☐**Yes** ☐**No** **Pursuing Level 1 Licensure** ☐**Yes** ☐**No** **Obtained Level 1 Licensure** ☐**Yes** ☐**No**

Referral Source Name: _______________
Cell Phone: _________________________
Email: _____________________________

Supervisor Name: _______________
Cell Phone: _____________________
Email: _________________________

Current relationship with family: ____

Purpose of this referral (narrative): ____

Recommended service needs for the family:

____

____

Family/Child Information:
Primary Caretaker Name: __________________
Cell: ________________

Street Address: __________________________

City: _____________ ST: FL

Zip Code: _______ Phone: (___) ___ -____

Relationship to child: ____________________

Email:________________________________

☐ **Caregiver speaks Spanish only**
Secondary Caretaker Name: ________________
Cell: ________________

Street Address: ___________________________

City: _____________ ST: FL

Zip Code: _______ Phone: (___) ___-____

Relationship to child: __________________

***All Household Members'* Full Names**	**DOB**	**Sex**	**Race**	**Relationship to Caregiver**	**Length of Stay**	**Last Grade Completed**	**Enrolled In school Y/N**
							_______
							_______
							_______
							_______
							_______
							_______
							_______
							_______