**Family Place Intake Form (ADULT)**

All Family Place services are free and voluntary. Please complete this Family Place Intake Form so that we can better serve you.

<table>
<thead>
<tr>
<th>Physical Address</th>
<th>Homeless; if homeless please provide last known address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Mobile Phone:</td>
</tr>
<tr>
<td>Email Address:</td>
<td>Do you need an email account? Y or N</td>
</tr>
</tbody>
</table>

**Is your physical address your primary residence**  
☐ No  ☐ Yes, if yes how many months/years: ____________

**Age:**  
☐ less than 18  ☐ 18-29  ☐ 30-54  ☐ 55-64  ☐ 65+

**Marital Status**  
☐ Single  ☐ Married  ☐ Divorced  ☐ Widowed

**Gender:**  
☐ Male  ☐ Female

**Race:** Which group do you most identify with? (Check ONE selection)  
☐ White/Caucasian  ☐ Black/African American  ☐ Asian/Pacific Islander  ☐ American Indian  
Other __________________________

**Ethnicity:** Which group do you most identify with? (Check ONE selection)  
☐ Not Hispanic/Latino  ☐ Mexican  ☐ Puerto Rican  ☐ Cuban  ☐ South American  
Other __________________________

**Education:** Please check the highest level completed: (Check ONE selection)  
☐ Elementary/Middle School  ☐ High school diploma or GED  ☐ Technical/Community College  
☐ 4 year College/Bachelor’s degree  ☐ Graduate/Advanced Degree  ☐ Some College

**Employment Status:** (Check ONE selection):  
☐ Employed Full-time  ☐ Employed Part-time  ☐ Unemployed  ☐ Self-employed  ☐ Not Seeking work

**Household Income:** (Check ONE selection)  
☐ Less than $10,000  ☐ $10,000 to $19,999  ☐ $20,000 to $29,999  ☐ $30,000 to $49,999  
☐ $50,000 to $74,999  ☐ $75,000 to $99,999  ☐ $100,000 or more

**What is your family size?**  
☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ more than 7

**How many children do you have under the age of 18?**  
☐ none  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ more than 5

**How many children do you have under the age of 3?**  
☐ none  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ more than 5

**Are you pregnant?**  
☐ No  ☐ Yes, if yes how many months: ____________ AND due date: ____________
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Please tell us what you CURRENTLY have right now (Check ALL that apply):

- [ ] Driver’s license, state issued ID card or passport
- [ ] DCF ACCESS online account
- [ ] Food or Cash Assistance
- [ ] CPC or DCF involvement
- [ ] Healthy Start or Healthy Families*
- [ ] Women, Children and Infants (WIC) assistance

How is your healthcare covered? (Check ALL that apply):

- [ ] I don’t have health insurance
- [ ] Medicaid for self
- [ ] Medicaid for children
- [ ] Military coverage/VA
- [ ] Medicare
- [ ] Pay cash
- [ ] West Volusia Hospital Authority Card
- [ ] Health insurance that you pay on your own
- [ ] Other ________________________________
- [ ] Health insurance from your job or a family member’s job
- [ ] Other ________________________________

Please tell us what you NEED help with at this time (Check ALL that apply)

- [ ] Assistance with finding health insurance
- [ ] DCF ACCESS online account
- [ ] Food or Cash Assistance
- [ ] Driver’s license, state issued ID card or passport
- [ ] Prenatal care
- [ ] Post-partum care
- [ ] Family planning/birth control
- [ ] Pediatric care
- [ ] Mental health/counseling
- [ ] Substance abuse services-drug & alcohol
- [ ] Housing
- [ ] Transportation
- [ ] Employment
- [ ] Education/Literacy
- [ ] Citizenship/Immigration
- [ ] Support services
- [ ] Legal assistance
- [ ] Parent Partner or Café Dialogue
- [ ] Don’t feel safe where I live
- [ ] Referral to other services
- [ ] Other needs not listed (Please write below):

Florida law requires that information contained in medical and/or client records be held in strict confidence and is not to be released without written authorization. By signing this form, you agree that we can share this participant information with community providers that can assist with services. The authorization you sign below on this page will remain in effect for six months from today’s date or until you or your family no longer require services from the Healthy Start Family Place. You have the right to withdraw your authorization at any time.

Print First and Last Name:

Signature: Date:

For Family Place use only

Intake Staff Name: Date:

Partner Partner Referral: Y or N

HS Referral signed: Y or N

Folder created: Y or N

Well Family System (WFS): Y or N

WFS ID numbers: # Services: # Referrals:

Comments: