

Client I.D.# _____

☐ Victim☐ Significant Other**SCREENING/INTAKE DATA ENTRY FORM****CLIENT INFORMATION/DEMOGRAPHICS****VICTIM/SIGNIFICANT OTHER RESIDENCY** (use to complete Location Tab in InfoNet)**Name:** _____ **DOB** _____**Address:** _____
Street City State Zip Code**Township:** _____ **County:** _____**Phone:** _____ **Effective Date:** _____

(Required fields for InfoNet Database)

First Contact Date: _____**Age (at first contact):** _____**Gender Identity:** (Check only one) ☐ Female ☐ Male ☐ Unknown ☐ 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*☐ Other: _____**Race/Ethnicity:** Client should self-identify. Please check ALL that apply:☐ American Indian or Alaska Native☐ Asian☐ South Asian (NEW in FY21 – *Subgroup of Asian*)☐ Black/African American☐ Hispanic/Latinx☐ Native Hawaiian or Other Pacific Islander☐ White☐ MENA (Middle Eastern / North African) – *Note federal agencies consider this a subgroup of White, but still allow client to self-identify (or not self-identify) with any category(ies).*☐ Unknown**Sexual Orientation:** (Check only one) ☐ Heterosexual/Straight ☐ Homosexual/Gay/Lesbian ☐ Bisexual☐ Queer: *Refers broadly to lesbians, gay, bisexual people and others who may not identify with the terms above but do identify with this term*☐ Other: _____☐ Unknown *Note: If client uses the term "Questioning" to describe their sexual orientation, please use the "Other" category above and write in this term.*

If significant other, significant other of: ☐ Adult Victim ☐ Child Victim (age 17 and under)

*If significant other, relationship to victim: _____

Health Insurance:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Medicaid/Cash Grant | <input type="checkbox"/> None |
| <input type="checkbox"/> Medicaid/No Cash Grant | <input type="checkbox"/> Not Reported |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Private | |

Employment:

- ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Not Reported ☐ Unknown

Education:

- | | |
|--|---|
| <input type="checkbox"/> College Grad or More | <input type="checkbox"/> Current Student K-12 |
| <input type="checkbox"/> Some College | <input type="checkbox"/> Not of School Age |
| <input type="checkbox"/> Current College Student | <input type="checkbox"/> Not Reported |
| <input type="checkbox"/> High School Grad | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Less than High School | |

Marital Status:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Married | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Common Law Marriage | <input type="checkbox"/> Not Reported |
| <input type="checkbox"/> Legally Separated | <input type="checkbox"/> Unknown |

Pregnant:

- | | |
|------------------------------|---------------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Not Reported |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |

College/University Student (currently):

☐ Yes ☐ No

PRESENTING ISSUES

*Primary presenting issue: _____

Primary offense date (or start of abuse): _____

End date of abuse (if applicable): _____

*Primary offense location: _____

County of Victimization: _____

*Other presenting issues: _____

REFERRAL

*Referral Source: _____

LANGUAGE & DISABILITY NEEDS

Indicate any physical or mental disability or difficulty identified by the client or his/her legal guardian.

☐ None identified

Check all that apply:

- ☐ Hard of hearing/deaf
- ☐ Low vision/blind
- ☐ Requires non-English language services – Primary language: _____
- ☐ Requires wheelchair accessibility
- ☐ Developmental disability
- ☐ Mental/emotional disability
- ☐ Other disability – Specify: _____

INCOME

Primary Income Source:

- | | |
|--|---|
| <input type="checkbox"/> Alimony/Child Support | <input type="checkbox"/> TANF/AFDC |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Other Income _____ |
| <input type="checkbox"/> General Assistance | <input type="checkbox"/> Not Reported |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> SSI | |

Other Income Sources (check as many as applies):

- | | |
|--|---|
| <input type="checkbox"/> Alimony/Child Support | <input type="checkbox"/> TANF/AFDC |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Other Income _____ |
| <input type="checkbox"/> General Assistance | <input type="checkbox"/> Not Reported |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> SSI | |

SERVICES REQUESTED (Check all that apply)

- ☐ Sexual Assault Counseling
 - ☐ Individual ☐ Group ☐ Family
- ☐ Sexual Assault Therapy
 - ☐ Individual ☐ Group ☐ Family
- ☐ Medical Advocacy
- ☐ Legal or Court Advocacy
- ☐ Other (explain) _____

INITIAL SUMMARY (to be completed as a part of the intake process)

Summarize the client's reasons for seeking services and indicate what follow-up action will occur (e.g., appointment scheduled).

(Signature of Worker Completing Intake)

(Date)

OFFENDER

Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown

☐ Trans Male to Female ☐ Trans Female to Male ☐ Genderqueer

Race/Ethnicity:

- ☐ Asian/Pacific Islander
☐ South Asian (NEW in FY21 – *Subgroup of Asian*)
☐ Black
☐ Hispanic/Latinx
☐ Native American
☐ White
☐ MENA (Middle Eastern/North African) – *Note federal agencies consider this a subgroup of White.*
☐ Multiracial
☐ Other _____
☐ Unknown

Age at Victim Intake: _____

(If you know the approximate age of the offender (i.e., between 20 and 30), enter the average age of this range – 25)

County of Residence: _____

***Relationship to Victim:** _____

Registered Sex Offender at time of Offense? ☐ Yes ☐ No ☐ Unknown ☐ Not Reported

Offender ID _____

(Randomly generated in InfoNet)