

Supporting Emancipated Youth Services Intake Form

Basic Information

| | | | | | |
|------|-------------------------|--------|-----------------------|-------------|----------|
| Name | Date of Birth | Age | DCFS Emancipated Date | Case ID# | |
| SCR# | County of Court Closure | Gender | Race | Burgos/ICWA | Language |

1. What are your current service needs?

- Housing—Do you have a place in mind? Yes No
- Income
- Affordable health care (e.g. prenatal care, condoms, etc.)
- Transportation
- Vocational assistance and/or employment
- Education
- Support services (such as counseling, domestic violence, substance abuse etc.)
- Concerns about your immediate safety and well-being
- Have you been a target of any adverse act related to your gender, identity ethnicity, religious beliefs, or anything else?

2. Current Living Situation:

- A.** Current address: (Note if mailing address only)

- B.** Type of living arrangement—e.g., shelter, homeless, own residence, staying with family, staying with friends, etc.

- C.** What is the best way to contact you? (phone, mail, e-mail, etc.)

- D.** Previous address:

- E.** Reason for leaving previous address?

F. Where did you reside when you were emancipated from care?

G. Do you have any children? Yes No

i. If yes, what are their ages and where do they live?

ii. Do you have any contact with their other parent? Yes No

H. Is there any area where you cannot live?

3. Source of financial support

A. Are you currently employed? Yes No

i. If yes, where and how long?

Earned Income \$ _____

ii. If no, current income source?

B. Are you receiving any income assistance? Yes No

4. Medical Needs

A. Do you have any immediate medical needs? Yes No

B. If you need medical assistance where do you go?

5. Name of former caseworker and assigned agency?

6. How did you find out about the possibility of DCFS guardianship reinstatement?

7. CWS Referral was sent to the following office:

Name of Call Taker: _____

Date of Call: _____