Participant ID (STAFF ONLY)

Community Partners Response Intake Form

Referral Agency

FULL LEGAL NAME	
First Name	Middle Name
Last Name	Preferred Name (if different)

HOW DID YOU HEAR ABOUT US? (SELECT ONLY ONE)

☐ Doctor / Medical Provider	☐ Internet Search
☐ Therapist / Mental Health Provider	☐ Family Member or Friend
☐ Case Manager – Child Welfare	☐ Teacher / School Staff
☐ Case Manager – Medicaid / Insurance Provider	☐ Childcare Provider
☐ Case Manager – SNAP or Other Economic Benefits	☐ Lawyer / Legal Services
☐ Other (Please complete the box below)	☐ Non-Profit Social Services Provider / Church

Other (if applicable)

WHAT IS YOUR URGENT NEED? (please check all that apply)

☐ Daily Living (clothing, hygiene, phone)	☐ Mental Health (therapist, psychologist, etc.)
☐ Dentist	☐ Parenting Assistance
☐ Education	☐ Physical Health (doctor)
☐ Employment	☐ Substance Use
☐ Finances	☐ Supportive Relationships
☐ General Life Skills	☐ Transportation
☐ Housing	☐ Utilities
☐ Legal Help	☐ Other (Please complete the box below)

Other (if applicable)

CONTACT INFORMATION

Phone Number _____ - _____ - _____	Email Address		
Birth Date _____ / _____ / _____	Street Address (if you do not have stable housing, please only enter your zip code)		
City	State	County	Zip Code

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DEMOGRAPHIC QUESTIONS

GENDER IDENTITY - Do you currently describe yourself as:

- ☐ Woman
- ☐ Man
- ☐ Prefer Not to Say
- ☐ Prefer to Self Identify: _____

RACE / ETHNICITY (please check all that apply)

- ☐ Native American or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Prefer Not to Say
- ☐ Prefer to Self Identify: _____

PLEASE ANSWER A FEW QUESTIONS ABOUT YOUR FAMILY

Number of Adults in the Home: _____

Number of Children Under 19 Years in the Home: _____

NAME OF EACH CHILD UNDER 19 YEARS OLD	CHILD'S BIRTH DATE

We will not share your personal information with anyone outside of the Collaborative without your permission. Group level data will be reported to the Research and Evaluation team at the Nebraska Children and Families Foundation [NCFF]. This includes things like the age and race/ethnicity of people who connect to resources and support through the Collaborative. No specific information about you or your family will be shared publicly. Your information may be shared with our partners if you are referred to them, but only with your permission. You can change who can see your data at any time using the FindHelp® platform. Any information that you already shared will stay shared, but no new information will be shared with that partner.

_____ _____ / _____ / _____

Participant Signature Signature Date

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BUFFALO COUNTY community partners

Referral Agency

Community Partners Response Participant Information

I am currently receiving the following services and supports (check all that apply):	☐ Education Services ☐ Employment Services ☐ Food Services ☐ Housing Services ☐ Legal Services ☐ Medical Services	☐ Mental Health Services ☐ Substance Use Services ☐ Transportation Services ☐ Other Specify:_____ ☐ NA/None ☐ Prefer Not to Answer
I am currently receiving the following types of public assistance (check all that apply):	☐ Aid to Dependent Children/TANF ☐ Childcare subsidy/Title XX ☐ Food Stamps (SNAP) ☐ Housing Voucher/Section 8 ☐ Medicaid ☐ Unemployment	☐ Utilities Assist/LIHEAP ☐ WIC ☐ Other:_____ ☐ NA/None ☐ Prefer Not to Answer
Are you currently covered by Health Insurance?	☐ Yes	☐ No
If yes, Health Insurance Type?	☐ Medicaid ☐ State Children's Health Insurance Program ☐ Employer-Provided ☐ Private Pay Health Insurance ☐ Indian Health Services Program	☐ Medicare ☐ Veteran's Administration (VA) Medical Services ☐ COBRA ☐ State Health Insurance ☐ Other:_____
What is your current housing status?	☐ Homeless ☐ At-risk of homelessness	☐ At-risk of losing housing ☐ Fleeing Violence ☐ Stably Housed
Are you a veteran or have active-duty military status?	☐ Yes	☐ No
What is your highest level of school completed?	☐ No schooling ☐ 5th or 6th grade ☐ 9th grade ☐ 11th grade ☐ High school diploma ☐ Post-Secondary	☐ Nursery to 4th grade ☐ 7th or 8th grade ☐ 10th grade ☐ 12th grade ☐ GED
Are you a domestic violence survivor?	☐ Yes	☐ No
If yes, when did the experience occur?	☐ Within past three months ☐ 6 to 12 months	☐ Three to six months ☐ More than a year ago
If yes, are you currently fleeing?	☐ Yes	☐ No
Do you struggle with any of the following?	☐ Injured Brain ☐ Language Barriers ☐ Emotional Neglect ☐ Behavioral/Mental Health ☐ Chronic Health Issues	☐ Alcohol Use ☐ Substance Use ☐ Both Alcohol/Substance Use ☐ HIV/AIDS ☐ Physical Mobility ☐ Developmental

Is there someone who doesn't live with you we can contact if we can't reach you?

☐ Yes, please list below	☐ No	☐ Unsure	☐ Prefer not to say		
Name		**Relationship to you**		**Phone**	

Do any of your children have a disability?	☐ Yes	☐ No	☐ If yes, how many:_____
Are you currently pregnant or expecting a child? (mother or father)	☐ Yes ☐ No	☐ Unsure ☐ Prefer Not to Say	
Do you or your children QUALIFY for Medicaid, Title XX, and/or free and reduced lunch, even if you don't receive any of them?	☐ Yes	☐ No	☐ Unsure ☐ Prefer Not to Say

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Community Partner Response Participant Information

INSTRUCTIONS: All parts of the Participant Information Survey should be completed at the start of participation in Community Response or the Connected Youth Initiative. The form may be completed with the assistance of a Central Navigator or other service provider, if needed.

For each of the following, mark the response that most closely matches how you feel.

Please complete all of the following information:	
Date:	
Full Name:	

SOCIAL CONNECTIONS	**A. NOT AT ALL LIKE MY LIFE**	**B. NOT MUCH LIKE MY LIFE**	**C.SOMEWHAT LIKE MY LIFE**	**D. QUITE A LOT LIKE MY LIFE**	**E. JUST LIKE MY LIFE**	**N/A I DO NOT HAVE KIDS**
I have people who believe in me.						
I have someone in my life who gives me advice, even when it's hard to hear.						
When I am trying to work on achieving a goal, I have friends who will support me.						
When I need someone to look after my kids on short notice, I can find someone I trust						
I have people I trust to ask for advice about: (check all that apply)	☐ Money/Bills/Budgeting ☐ Relationships and/or my love life ☐ Food/Nutrition			☐ Stress, Anxiety, and/or Depression ☐ Parenting/My kids (if applicable) ☐ None of the above		

CONCRETE SUPPORTS	**A. NOT AT ALL LIKE MY LIFE**	**B. NOT MUCH LIKE MY LIFE**	**C.SOMEWHAT LIKE MY LIFE**	**D. QUITE A LOT LIKE MY LIFE**	**E. JUST LIKE MY LIFE**
I was able to cover all my expenses last month *(expenses include costs like rent, utility bills, food, transportation, child care, and medical expenses)*					
The transportation I use is reliable and consistent					
My housing situation is affordable, safe, and stable					
Over the past three months, my children and I have been able to see a doctor when we needed to. *(If you do not have children, answer for just yourself)*					
Over the past three months, I have found a job and/or worked when I needed to					

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Community Partners Response Participant Employment Information

Please complete all of the following information:

Are you currently employed? ☐ Yes, full-time ☐ Yes, part-time

☐ No, but searching for a job ☐ No, not searching for a job. Why?_____

How many jobs do you currently have?	How many hours per week do you work?	What is your estimated monthly income?

Who is your current employer(s)?

If you have a personal need, are you comfortable approaching your employer about any of the following:

☐ Childcare ☐ Daily Living ☐ Dentist ☐ Education ☐ Employment ☐ Finances ☐ General Life Skills ☐ Housing ☐ Legal Help

☐ Mental Health ☐ Parenting ☐ Physical Health ☐ Relationships ☐ Substance Abuse ☐ Transportation ☐ Utilities

Are you interested in receiving one on one support (parenting, budgeting, mentoring, etc.)?

☐ Yes, I am interested in receiving support ☐ No, I am not interested in receiving support

What other assistance do you need to meet your basic needs?

Do you give permission for Buffalo County Community Partners to contact your employer to follow-up with them regarding the information listed on this form? ☐ Yes ☐ No

What resources has your employer offered you that have been most helpful to you and your family?

What do you wish your community or employer knew about your hopes for your family?

By signing below, you agree that all the information on this page is accurate, and give permission for Buffalo County Community Partners to contact other partnering agencies regarding your request.

_____

Printed Name Signature Date

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Community Partner Response Support Services Form

Please attach/send any leases, bills, and documents with this form.

Please complete all of the following information:	
Date:	
Full Name:	

How can we help? What is your need? About how much does it cost? Please include as many details as you can.
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Where should we send the payment? – will be required to complete a W9	
Vendor Name	
Vendor Contact Name	
Vendor Phone Number	
Vendor Address	

Please indicate any support you have received from the following agencies, if any, in the blanks below:			
Community Action:_____	Jubilee Center:_____	DHHS:_____	S.A.F.E. Center:_____
Salvation Army:_____	NE ERA Program:_____	Other: (Agency:_____	Amount:_____)
Total Amount Requested from Flex Funds			
Are you willing to meet with a coach to support your goals?	☐ Yes	☐ No	☐
If yes, please explain:	☐	☐	

IN OFFICE USE ONLY		
Date of Payment:	**Payment Method:** ☐ Check ☐ Credit Card	☐ Gift Card ☐ Other: _____

Housing Amount:	**Detailed need:**	**Employment Amount:**	**Detailed need:**
Utilities Amount:	**Detailed need:**	**Physical/Dental amount:**	**Detailed need:**
Daily Living Amount:	**Detailed need:**	**Mental Health Amount:**	**Detailed need:**
Education Amount:	**Detailed need:**	**Parenting Amount:**	**Detailed need:**
Transportation Amount:	**Detailed need:**	**Other/Coaching Amount:**	**Detailed need:**