

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

WHAT IS YOUR URGENT NEED? (please check all that apply)	
<input type="checkbox"/> Daily Living (clothing, hygiene, phone) <input type="checkbox"/> Dentist <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Finances <input type="checkbox"/> General Life Skills <input type="checkbox"/> Housing <input type="checkbox"/> Legal Help	<input type="checkbox"/> Mental Health (therapist, psychologist, etc.) <input type="checkbox"/> Parenting Assistance <input type="checkbox"/> Physical Health (doctor) <input type="checkbox"/> Substance Use <input type="checkbox"/> Supportive Relationships <input type="checkbox"/> Transportation <input type="checkbox"/> Utilities <input type="checkbox"/> 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

DEMOGRAPHIC QUESTIONS

GENDER IDENTITY - Do you currently describe yourself as:

Woman

Prefer Not to Say

Man

Prefer to Self Identify: _____

RACE / ETHNICITY (please check all that apply)

Native American or Alaska Native

Native Hawaiian or Pacific Islander

Asian

White

Black or African American

Prefer Not to Say

Hispanic or Latino

Prefer to Self Identify:

Middle Eastern or North African

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

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 [NCFE]. 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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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?
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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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Updated 7/8/2024

Community Partners Response Participant Information

I am currently receiving the following services and supports (check all that apply):	<input type="checkbox"/> Education Services	<input type="checkbox"/> Mental Health Services
	<input type="checkbox"/> Employment Services	<input type="checkbox"/> Substance Use Services
I am currently receiving the following types of public assistance (check all that apply):	<input type="checkbox"/> Food Services	<input type="checkbox"/> Transportation Services
	<input type="checkbox"/> Housing Services	<input type="checkbox"/> Other Specify: _____
Are you currently covered by Health Insurance?	<input type="checkbox"/> Legal Services	<input type="checkbox"/> NA/None
	<input type="checkbox"/> Medical Services	<input type="checkbox"/> Prefer Not to Answer
If yes, Health Insurance Type?	<input type="checkbox"/> Aid to Dependent Children/TANF	<input type="checkbox"/> Utilities Assist/LIHEAP
	<input type="checkbox"/> Childcare subsidy/Title XX	<input type="checkbox"/> WIC
What is your current housing status?	<input type="checkbox"/> Food Stamps (SNAP)	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Housing Voucher/Section 8	<input type="checkbox"/> NA/None
Are you a veteran or have active-duty military status?	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Prefer Not to Answer
If yes, Health Insurance Type?	<input type="checkbox"/> State Children's Health Insurance Program	
What is your highest level of school completed?	<input type="checkbox"/> Employer-Provided	
	<input type="checkbox"/> Private Pay Health Insurance	
Are you a domestic violence survivor?	<input type="checkbox"/> Indian Health Services Program	
If yes, when did the experience occur?	<input type="checkbox"/> Homeless	<input type="checkbox"/> At-risk of losing housing
If yes, are you currently fleeing?	<input type="checkbox"/> At-risk of homelessness	<input type="checkbox"/> Fleeing Violence
Do you struggle with any of the following?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there someone who doesn't live with you we can contact if we can't reach you?	<input type="checkbox"/> Yes, please list below	<input type="checkbox"/> No
Name	Relationship to you	Phone
Do any of your children have a disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently pregnant or expecting a child? (mother or father)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Unsure	<input type="checkbox"/> 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)	<input type="checkbox"/> Money/Bills/Budgeting <input type="checkbox"/> Relationships and/or my love life <input type="checkbox"/> Food/Nutrition			<input type="checkbox"/> Stress, Anxiety, and/or Depression <input type="checkbox"/> Parenting/My kids (if applicable) <input type="checkbox"/> 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 <i>(expenses include costs like rent, utility bills, food, transportation, child care, and medical expenses)</i>						
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. <i>(If you do not have children, answer for just yourself)</i>						
Over the past three months, I have found a job and/or worked when I needed to						

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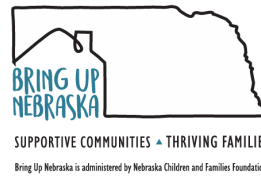


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For each of the following, mark the response that most closely matches how you feel				
Hope	Not at all true	Somewhat true	Mostly True	Completely True
If I should find myself in a jam, I could think of many ways to get out of it.				
At the present time, I am energetically pursuing my goals.				
There are lots of ways around any problem that I face.				
Right now, I see myself as being pretty successful.				
I can think of many ways to reach my current goals.				
At this time, I am meeting the goals I have set for myself.				

How often in the last 30 days did you...				
	Never	Sometimes	Most of the time	Always
Review and evaluate your spending habits?				
Track down where money was spent?				
Estimate your monthly household income and expenses?				
Identify your own financial goals for the future?				
Pay your bills on time?				
Follow your financial goals?				
Follow a weekly or monthly budget?				
Make payments toward your debt?				
Use a bank account?				
Pay more than the interest on your loans, credit, etc.?				

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

Accessing Services	Not at all true	Somewhat true	Mostly True	Completely True
If I need help, I know where to go and/or who to talk to.				

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

Resilience	Not at all true	Somewhat true	Mostly True	Completely True
I tend to bounce back quickly after hard times.				
I have a hard time making it through stressful events.				
It does not take me long to recover from a stressful event.				
It is hard for me to snap back when something bad happens.				
I usually come through difficult times with little trouble.				
I tend to take a long time to get over set-backs in my life.				

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Community Partner Response Flex Fund 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.

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	
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Are you willing to meet with a coach to support your goals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please explain:	
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IN OFFICE USE ONLY

Date of Payment:	Payment Method:	<input type="checkbox"/> Gift Card
	<input type="checkbox"/> Check <input type="checkbox"/> Credit Card	<input type="checkbox"/> 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: