Participant ID (STAFF ONLY)

Referral Agency

Date: _____
Family Point of Contact:_____
Family Address:_____
Family Phone:_____ Family Email:_____
Are Community Response Forms Complete? ___ Yes ___ No

A coach from Families Care, COMPASS, or the SAFE Center will call you to schedule a time to meet.

The Buffalo County Community Partners Coaching Program is a free, participation-based service that helps individuals and families get the support they need. Coaches work with participants to set goals and meet regularly — in person, by phone, or virtually — to move toward sufficiency.

To keep receiving help and resources, participants must stay engaged by responding to calls or texts and letting their coach know if plans change. If contact cannot be made after several attempts, services will close, and support will end. The program is built on teamwork, with the coach and participant taking one step at a time toward a more stable future.

Reason for Referral:

Assistance in the following areas: ☐ Education ☐ Employment ☐ Housing ☐ Finances ☐ Life Skills
☐ Physical Health ☐ Mental Health ☐ Substance Abuse ☐ Dentist ☐ Parenting ☐ Transportation ☐ Legal
☐ Supportive Relationships ☐ Childcare ☐ Other:_____

Preferred Agency:

Please select the agency you would prefer out of the three we contract with to provide coaching services. These agencies do provide other services, but if you are contacted by them, it is for coaching.

_____ Families Care _____ Safe Center _____ Compass _____ No Preference

Coaching services are free and voluntary. If you have been referred for coaching from an agency after seeking financial assistance from community resources, ***the coaching agency will not fulfill the financial request****. Your coach may be able to help access resources from other sources,* ***but the contracted coaching agency will not directly pay for a financial need****.*

As a participant, I will: (Please initial in the blank next to each statement to show your agreement)

- *Treat my coach with respect.* _____
- *Meet regularly for up to three months, in person when possible.* _____
- *Respond to calls, texts, or emails promptly.* _____
- *Share my needs openly and be willing to try suggestions.* _____
- *Communicate with my coach if I need to reschedule.* _____
- *Complete surveys and final steps when my goals are met.* _____

_____ _____
Name of Person being served Signature of Person being served

_____
Date

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

Participant ID (STAFF ONLY)

Referral Agency

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

Are you currently pregnant or expecting a child? (Mother or Father):	____ Yes ____ No
Based on the people in your household, is your income below 200% of the poverty level? (1 person is $31,300; then add $11,000 for each additional family member):	____ Yes ____ No

Do you currently have any health insurance?

____ Yes, Private/ACA ____ Yes, Medicaid ____ Yes, Medicare ____ Medicaid application in progress ____ No

You authorize Buffalo County Community Partners, and Community Response Team member agencies to share information to verify eligibility and coordinate services. All information will remain confidential.

Your privacy and the protection of your personal information are our top priorities. Any information you share will be stored securely and only accessed by authorized staff for the purpose of improving services and supporting families.

Your name, your child's name, date of birth, or any other identifying information will never appear in shared reports. All reporting is conducted at the group level to ensure your identity remains confidential.

You will be invited to allow your information to be used by the program and its evaluation partners—such as the Nebraska Children and Families Foundation's Research and Evaluation Team—to better understand what's working and how services can be strengthened.

Do you give permission for us to give some of your information to the Nebraska Children & Families Foundation Research and Evaluation team and their partners?	____ Yes ____ No

_____ _____ / _____ / _____

Participant Signature Signature Date

Participant ID (STAFF ONLY)

Referral Agency

Lawful Presence in the United States Attestation

I attest as follows (***this will not affect your eligibility for Buffalo County Community Partners' support***):

____I am a citizen of the United States.

— OR —

____I am a qualified immigrant under the federal Immigration and Nationality Act. In addition to this Form, I have included a current and legible copy of the front and back of one or more of the available USCIS forms, (listed below), required for verification.

____I-327 (Reentry Permit)
____I-551 (Permanent Resident Card)
____I-571 (Refugee Travel Document)
____I-766 (Employment Authorization Card)
____Certificate of Citizenship
____Naturalization Certificate
____Machine Readable Immigrant Visa (with Temporary I-551 Language) Temporary
____I-551 Stamp (on passport or I-94)
____I-94 (Arrival/Departure Record)
____Unexpired Foreign Passport (must include an I-94)
____I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status
____DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status

I hereby attest that my response and the information provided on this form are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Print Name _____
(First, Middle, Last)

Signature _____

Date _____

Participant ID (STAFF ONLY)

BRING UP NEBRASKA
SUPPORTIVE COMMUNITIES ▲ THRIVING FAMILIES
Bring Up Nebraska is administered by Nebraska Children and Families Foundation.

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
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?	☐ Less than high school ☐ High school diploma or GED ☐ Some college, no college ☐ Certificate or trade credential	☐ Associate degree ☐ Bachelor's degree ☐ Graduate or professional degree ☐ Prefer not to answer
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:_____
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
Do you currently have an open case with the DHHS Child Welfare system (this will not affect your eligibility):	☐ Yes	☐ No	☐ Unsure

Participant ID (STAFF ONLY)

Referral Agency

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

Participant ID (STAFF ONLY)

Referral Agency

Community Partner Response Pre Survey

INSTRUCTIONS: All parts of the Pre 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.

Date:	
Full Name:	

Concrete Supports

In the past month, were you unable to pay for any of the following? Select all that apply

____Rent or Mortgage ____Utilities or bills (electricity, gas, phone, etc.) ____Groceries/food (including baby formula, diapers)

____Childcare/daycare ____Medicine, medical expenses, or co-pays ____Basic household or personal hygiene items

____Transportation (gas, bus passes, shared rides) ____I was able to pay for all of these

In the past month, have you experienced any of the following? Select all that apply

____Delayed or did not receive medical or dental care ____Evicted from home or apartment

____Lived in a shelter, hotel/motel, abandoned building, or vehicle

____Moved in with others due to inability to afford rent/mortgage/bills

____Lost access to regular transportation (e.g., vehicle totals or repossessed)

____Unemployed when you needed and wanted a job ____None of these apply to me

I have people or resources I trust if my family or I need any of the following. Select all that apply.

____Help with housing or utilizes assistance ____Help with purchasing food ____Help finding a job

____Help finding quality medical or dental care ____Help with transportation ____Mental Health Support or resources

____Advice about money, bills, or budgeting ____Advice about relationships and/or my love life

____Advice about stress, anxiety, and/or depression ____Advice about parenting or my kids ____None of these

How often do you experience the following?

	Never	Rarely	Sometimes	Often	Almost Always
I have trouble affording what I need each month					
I am able to afford the food I want to feed my family					
I feel connected to my community					
I feel safe in my neighborhood					
Someone in my family threatens to harm me					
Additional stress due to your own or family member's alcohol or drug use					
Additional stress due to your own or a family member's health status					

Participant ID (STAFF ONLY)

Referral Agency

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.?				

Hope Scale					
Please mark how much you agree or disagree with each statement					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I can think of many ways to get out of a jam					
I energetically pursue my goals					
There are lots of ways around any problem					
Even when things are tough, I can stay motivated to achieve my goals					

Participant ID (STAFF ONLY)

Referral Agency

Resilience Scale					
Please mark how much you agree or disagree with each statement					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
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 setbacks in my life					

Protective Factors					
For each statement, select the option that best describes your experience. *(Only complete this section if you are a parent/guardian.)*					
	Not at all like my life	Not much like my life	Somewhat like my life	Quite a lot like my life	Just like my life
The future looks good for our family					
In my family, we take time to listen to each other					
There are things we do as a family that are special just to us					
My child misbehaves just to upset me					
I feel like I'm always telling my kids "no" or "stop"					
I have frequent power struggles with my kids					
How I respond to my child depends on how I'm feeling					
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 achieve 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					

Participant ID (STAFF ONLY)

Referral Agency

Community Partner Response Flex Fund Form

Please attach or 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			
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:**