INTAKE FORM

KINSHIP
3920 Perkins Avenue
Huron, Ohio 44839
Phone (419) 625-2672
Fax (419) 625-3822

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Date: _____ Referring Agency: _____
Address: _____ City_____ County: _____

Residential Parent's/ Guardian Attorney: _____
Non Residential Parent's Attorney: _____

Circle Service(s) Requested:

*Emergency Supervised Parent time *Regular Supervised Parent time
*Supervised Exchanges *Parenting and Family Education
*Other: _____

PARTIES INVOLVED:

Party A (Parent(s)/ Adult (s))
(List residential parent first –A1 if applicable)

A1: RESIDENTIAL
NAME: _____
SSN_____
ADDRESS_____
_____
HOME PHONE_____
CELL PHONE_____
EMPLOYMENT_____
WORK SCHEDULE_____
_____
WORK PHONE_____
Can we call work? YES or No

A2: NON
NAME_____
SSN_____
ADDRESS_____
_____
HOME PHONE_____
CELL PHONE_____
EMPLOYMENT_____
WORK SCHEDULE_____
_____
WORK PHONE_____
Can we call work? YES or No

Party B (child (ren) (list separately)
(List residence type/name, ex. Foster Parents: Joe&Sally Smith or Grandparents: John Jones)

B1:
NAME_____
AGE/DOB_____
SSN_____
Residence type/Name_____
_____
_____
ADDRESS_____
_____
PHONE_____

B2:
NAME_____
AGE/DOB_____
SSN_____
Residence type/Name_____
_____
ADDRESS_____
_____
_____
PHONE_____

use back of page for additional children

Is it OK for the child (ren)'s residential parent(s)/caregiver(s) to see or have contact with the party that is visiting or dropping off / picking up the child (ren)? **YES or NO** (Circle)

Are there any Protection Orders in place? **YES or NO** (Circle)
If **YES**, please specify:
_____
_____

Brief Description of Presenting Situation:
_____
_____
_____
_____
_____
(Continue on back if needed)

If Drop Off / Pick Up, Specifications: (i.e. days & times) :
_____
_____
_____

Special Problems to watch for:
_____
_____
_____
_____
_____
(Include behavioral, medical, attitudinal, etc. of any family member)

Family members and/or other parties to the case **WHO MAY** participate in visits or drop off or pick ups. Please specify:
_____
_____
_____

Family members and/or other parties to the case **WHO MAY NOT** participate in visits or drop off or pick ups.
_____
_____
_____

Recommended **Length** of Supervised Parent time:
Circle one: 30 mins. 60 mins. 90 mins. Other_____

Recommended **Frequency** of Supervised Parent time:
Circle One: 1x per week 2 xs per week 1x every other week
Other_____

Recommended Level of Supervision:
Circle One:
Level 1: Monitor in room with family at all times.
Level 2: Monitor outside/nearby room checking in every 10 minutes.
Level 3: Monitor outside/nearby room checking in every 30 minutes.
Level 4: Monitor outside/nearby room available if needed.
Other: Please specify:
_____
_____
_____

Who should receive monitoring reports?
(Check all that apply & list name, address and phone)
_____Court(s)
_____
_____Social Worker(s)
_____
_____CASA_____
_____Attorney(s)
__AFTER_REVIEWED_BY_THE_COURT_____
_____
_____Counselor/Therapist(s)
_____
_____Other_____
_____

Requested frequency of reports:
_____

Please attach / supply copies (if applicable) when completed:

Signed Authorization for Release of info Form _____ Date received
(**All** parties listed in previous section **MUST** appear on this form in order for them to receive reports.)

Journal Entry_____/ Date Received: _____
Court Case Number_____/ Date Received: _____
Protection Order_____/ Date Received: _____
Case Plan_____/ Date Received: _____