

# CENTRAL NAVIGATION INTAKE FORM



| 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"/> Internet Search                              |
| <input type="checkbox"/> Therapist / Mental Health Provider             | <input type="checkbox"/> Family Member or Friend                      |
| <input type="checkbox"/> Case Manager – Child Welfare                   | <input type="checkbox"/> Teacher / School Staff                       |
| <input type="checkbox"/> Case Manager – Medicaid / Insurance Provider   | <input type="checkbox"/> Childcare Provider                           |
| <input type="checkbox"/> Case Manager – SNAP or Other Economic Benefits | <input type="checkbox"/> Lawyer / Legal Services                      |
| <input type="checkbox"/> Other (Please complete the box below)          | <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"/> Mental Health (therapist, psychologist, etc.) |
| <input type="checkbox"/> Dentist                                 | <input type="checkbox"/> Parenting Assistance                          |
| <input type="checkbox"/> Education                               | <input type="checkbox"/> Physical Health (doctor)                      |
| <input type="checkbox"/> Employment                              | <input type="checkbox"/> Substance Use                                 |
| <input type="checkbox"/> Finances                                | <input type="checkbox"/> Supportive Relationships                      |
| <input type="checkbox"/> General Life Skills                     | <input type="checkbox"/> Transportation                                |
| <input type="checkbox"/> Housing                                 | <input type="checkbox"/> Utilities                                     |
| <input type="checkbox"/> Legal Help                              | <input type="checkbox"/> Other (Please complete the box below)         |
| Other (if applicable)  |  |

| CONTACT INFORMATION              |       |   |          |
|----------------------------------|-------|---|----------|
| Phone Number                     |       | Email Address   |          |
| Birth Date<br>____ / ____ / ____ |       | 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:

|                                |   |
|--------------------------------|---|
| <input type="checkbox"/> Woman | <input type="checkbox"/> Prefer Not to Say              |
| <input type="checkbox"/> Man   | <input type="checkbox"/> Prefer to Self Identify: _____ |

### RACE / ETHNICITY (please check all that apply)

|   |  |
|---|--|
| <input type="checkbox"/> Native American or Alaska Native | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> White                               |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Prefer Not to Say                   |
| <input type="checkbox"/> Hispanic or Latino               | <input type="checkbox"/> Prefer to Self Identify: _____      |
| <input type="checkbox"/> 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: _____ |
|-------------------------------------|--|

Are you currently pregnant or expecting a child (mother or father)?  Yes  No  Prefer Not to Say

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

What is your highest level of education?

|  |  |   |
|--|--|---|
| <input type="checkbox"/> Some college, no degree         | <input type="checkbox"/> Less than High School           | <input type="checkbox"/> High School Diploma or GED |
| <input type="checkbox"/> Bachelor's Degree               | <input type="checkbox"/> Certificate or trade credential | <input type="checkbox"/> Prefer not to answer       |
| <input type="checkbox"/> Graduate of Professional Degree | <input type="checkbox"/> Associate Degree                |   |

Based on the number of individuals in your household, is your income below 200% of the poverty level?  Yes  No

Do you currently have any health insurance? (select one option)  Yes, Private/ACA  Yes, Medicaid  Yes, Medicare  
 Medicaid In Process (application filled out)  No  Choose Not to Answer

Do you have a disability?  Yes  No      Does your child have a disability?  Yes  No

The staff member assisting me reviewed and explained the Data Sharing Disclosure (located at top of Intake Form in orange.) If they have not reviewed, please ask them to do so before continuing.

Yes, Confirmed

Participant, Parent, or Guardian Consent: I give permission to share information with Nebraska Children and Families Foundation Research and Evaluation Team and evaluation partners. My privacy will be protected, and my name, my child's name, date of birth or any other identifying information will not be included in reports.

Yes

No

Minor Assent (Only complete if the participant is a minor, if the participant is NOT a minor select N/A): \*"As a minor participating in this program, I give permission for my information to be shared and used to help improve the program." \*

Yes

No

N/A

\_\_\_\_\_  
Participant Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Guardian Signature for Participants under age 19

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Signature Date