Birth & Beyond Family Resource Center Assigned Level: 1 2

**Intervention Service Record**  Assigned Staff:

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| Staff Name: | | | Date: | | | | | | | In-person: Yes No | | | | | Client ID: | | | |
| **Consents Signed? Yes (*If not, please sign below. Level 2 needs to complete an Intake Packet if not already open to HV/FRC services.)*** | | | | | | | | | | | | | | | | | | |
| **I consent to the collection and exchange of information for program evaluation and funder reporting.** | | | | | | | | | | | | | | | | | | |
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| Caregiver’s Signature | | | | Date | |  | | |  | | | | | | | |  | |
| Funding *(highlight all that applies)*: Empowered Families RAACD DCFAS 6+ Community Member | | | | | | | | | | | | | | | | | | |
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| **Caregiver Information** | | | | | | | | | | | | | | | | | | |
| First Name: | | | | | Last Name: | | | | | | | | | DOB *(MM/D/YY):* | | | | |
| Gender: | | Ethnicity: | | | | | | | | | | | Primary Language: | | | | | |
| Address: | | | | | APT#: | | | City: | | | | | | | Zip Code: | | | |
| Phone: | | | | | | | | | Email *(optional):* | | | | | | | | | |
| Pregnant? No Yes, Due Date: | | | | | | |  | | | | | | | | | | | |
| Child’s First and Last Name | | Gender | | | DOB | | Child’s First and Last Name | | | | | | | | | Gender | | DOB |
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| # of Children Ages 0-5 years old: 6-12 years old: 13-17 years old: | | | | | | | | | | | | | | | | | | |
| Have you participated in BB services/classes at this FRC? Yes No | | | | | | | | | | | | Receiving Medi-Cal? Yes, No Unknown | | | | | | |
|  | | | | | | | | | | |  | | | | | | | |
| **Who referred you?** | | | | | | | | | | | | | | | | | | |
| Self10 Family/Friend/Neighbor1 B&B staff/volunteer/event30  Healthcare/Hospital40 HMG2  School/Teacher/District5 BCLC/Community Incubator6 CPS20 Other: | | | | | | | | | | | | | | | | | | |
| **Needs on Intake:** | | | | | | | | | | | | | | | | | | |
| 1 Lack/Loss of Housing  2 Financial/Public Assistance | 4 Mental Health/Depression  5 Alcohol & other drugs (AOD) | | | | | | | 7 Family Relationships  8 Legal | | | | | | 9 School Support  10 Overwhelmed with Parenting | | | | |
| 3 Medical/Prenatal Services | 6 Family Violence/Domestic Violence | | | | | | | | | | Other: | | | | | | | |

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| **What do you need (how can I help you)? Be Specific (i.e. state which family member needs the services).** |

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| **Start Date**: | **Closure Date**: | **Outcome**: 1Served 2Not Served |
| **Follow-up Services Provided**: 1Not Applicable 2Unsuccessful Attempts 3Successful  **Reason for Closure**: 1Completed IS Service 2Dropped out (Declined) 3Moved 4Unable to locate | | |
| **Data Entry Completed By/Date:** | | |