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 Housing2 Financial/Public Assistance | 4 Mental Health/Depression5 Alcohol & other drugs (AOD) | 7 Family Relationships 8 Legal | 9 School Support10 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:**  |