**The Children's Advocacy Center of Portage County**

Intake Form

**To Be Completed by Children’s Advocacy Center (CAC)- DO NOT COMPLETE**

**Completed by Children’s Advocacy Center (CAC)**

**Date & Time of Appointment: Click or tap here to enter text.**

Patient ID # (or last 6 digits of SS

**Notified of Appointment**: **Participating in Appointment**:

[ ] Law Enforcement (LE) reminder [ ] No [ ] Yes [ ] Law Enforcement (LE)

[ ] Children Services (CPS) [ ] Child Protective Services (CPS)

[ ] Family reminder [ ] No [ ] Yes

[ ] **Child Abuse Report Made (if required)** If so, when: Click or tap to enter a date.

[ ]  **Akron Children’s Hospital (ACH) Notified (if referred)**

Were records requested: [ ] No [ ] Yes If so, when: Click or tap to enter a date.

Was an interview performed: [ ] No [ ] Yes If so, was it recorded: [ ] No [ ] Yes

Was an evidence kit obtained: [ ] No [ ] Yes Were labs tests done and prophylactics given, if so which ones: Click or tap here to enter text.

**Client Name**: First, Middle (if known), Last Name

**DOB**: Date Of Birth **Age:** Age at time of intake

**Race:**

* White
* Black or African American
* American Indian or Alaska Native
* Asian, Native Hawaiian or Other Pacific Islander
* Two or more races (person who identifies with more than one of the above)
* Hispanic or Latino
* Other- please specify

**Gender Identity**:

* Female
* Male
* Transgender (umbrella term used for people whose gender identity and/or expression is different from the sex they were assigned at birth)
* Any other specific gender identity
* Preferred pronouns if different from sex assigned at birth

**Mother**: Biological Mother **Father:** Biological Father

**Legal Guardian:** Indicate who has permanent or temporary legal custody of child

**Caregiver:** The person or institution currently caring for the child; child resides with

**Caregiver Relationship**: specify caregiver relationship to child, for example: parent, family member, foster family, etc.

**Caregiver Phone:** Contact phone number to be reached for scheduling reminders, cancellations, etc.

**Client Address:** Where the child currently resides

**Other Person(s) in Home/Involved**: Any other person living in the home and/or involved in the incident bringing the ACV to the Children’s Advocacy Center

**Other Person(s) Relationship to ACV**: Specify other person listed above relationship to child, for example: step-parent, family member, classmate, friend, mom’s friend, etc.

**Other Person(s) Age:** Specify the current age of the other person listed above

**If there are more than 3 people in the home, add them and their information here or at bottom of form.**

**Attending Appointment with client**: List name and relationship to client attending the appointment; only non-offending caregivers may attend the appointment with client

**If child has been to the Portage County CAC, enter Dates of Service (DOS)**: If unsure of dates, note client has been to the CAC but dates are not known

**Often the CAC offers families snacks and beverages, are there any allergies or dietary concerns?** List any known allergies, if unknown or unable to ask family, please note here

**A service dog may be available at appointments, are there any allergies or other concerns?** If unknown or unable to ask family, please note here

**What information regarding needs may improve the families experience at the CAC? Needs can be language barriers, developmental delays/disabilities, cultural views, religious restrictions, or any other information**. List any known barriers, if unknown or unable to ask family, please note here

**Alleged Perpetrator (AP):** First and Last Name

**Age**: Current Age

**Race**:

* White
* Black or African American
* American Indian or Alaska Native
* Asian, Native Hawaiian or Other Pacific Islander
* Two or more races (person who identifies with more than one of the above)
* Hispanic or Latino
* Other- please specify

**Relationship**: relationship of AP to client

**Approximate Abuse Time Frame**: If known, time in which abuse began and ended, currently occurring, one time incident, etc. If unknown or unable to ask family please note

**Last Contact with AP**: Clients last contact with alleged perpetrator. If unknown or unable to ask family please note

**City & County of Alleged Incident**:

**Referred by**: The person or agency that referred the client to the CAC

**Child Protective Services Worker**: DJFS social worker involved. Please indicate if case is screened out

**Law Enforcement**: Police Department where the incident occurred and officer or detective investigating the case

**Summary of concern** (In cases of suspected Physical Abuse: include description of injury to child: mechanism, object(s) used to inflict injury(s), location, visual evidence if present, action of injury(s), report of injury(s) as provided by child/witness): Brief explanation of what occurred to refer family to the Child Advocacy Center

**Any Additional Information**: Any information that will be helpful for the Child Advocacy Center in providing services to this family

**Completing Form (Name & Agency if Applicable):** First and Last Name of person completing this form

**Date**: Date the form was completed

Please submit completed intake via secure email to **BOTH:**

Jessica Gealy: Jessica.Gealy@UHHospitals.org

Rachel Lancaster: Rachel.Lancaster@UHHospitals.org

A CAC Team Member will contact you to confirm receipt, obtain any further information, and confirm scheduling as soon as possible, at maximum within 1 business day.