FCASV Case Number(s): _____

# Florida Council Against Sexual Violence

Because Sexual Violence Shatters Lives, Wounds Communities, and Perpetuates Injustice

## Appendix 110 INTAKE FORM

### CLIENT INFORMATION

| | | |
|---|---|---|
| Client Name (last, first, middle): | | Preferred Name: |
| Pronouns: | Date of Birth: | Age: |
| Are you seeking services for yourself? ☐ Yes ☐ No | If no, for whom? Name: _____<br>Date of Birth: _____<br>Relationship to you: _____ | |

**SURVIVOR'S DEMOGRAPHIC INFORMATION:**

| | |
|---|---|
| Race/Ethnicity (Select all that apply) | ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino<br>☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Multiple Races ☐ Not Reported<br>☐ Unknown ☐ Declined to Specify |
| Gender | ☐ Male ☐ Female ☐ Transgender ☐ Intersex ☐ Non-Binary ☐ Other: _____ |
| Select all that apply | ☐ Deaf/Hard of Hearing ☐ Disability: Cognitive/Physical/Mental ☐ Homeless<br>☐ LGBTQ+ ☐ Immigrant/Refugee/Asylum Seeker ☐ Military/Veterans<br>☐ Limited English Proficiency (Language Spoken _____) |

| | | | |
|---|---|---|---|
| Mailing Address: | | | |
| Phone Number(s): | | Email Address: | |
| Preferred Method of Communication: | ☐ Phone | ☐ Email ☐ Mail | ☐ Text |
| Is it safe for you to receive mail at this address? ☐ Yes ☐ No<br>Are you okay with receiving text messages? ☐ Yes ☐ No | | Are you okay with receiving emails? ☐ Yes ☐ No<br>Is it safe to leave a voicemail? ☐ Yes ☐ No | |

Emergency Contact (Name & Information):_____

Do you authorize FCASV to contact you through this emergency contact in the event we cannot reach you? ☐ Yes ☐ No

### LEGAL MATTER

| | | | |
|---|---|---|---|
| Legal Issue: (Select all that apply) | ☐ Education | ☐ Immigration | ☐ Victim's Compensation |
| | ☐ Employment | ☐ Injunction | ☐ Victims' Rights |
| | ☐ Housing | ☐ Termination of Parental Rights | ☐ Other: _____ |

| | |
|---|---|
| Do you already have an attorney? ☐ Yes ☐ No | If yes, please include name and location? |

Briefly explain the legal issue(s) you are experiencing.

_____

_____

_____

_____

_____

What problems are you most concerned with addressing related to this legal matter?

_____

_____

_____

The contact information provided on this form will be used by FCASV staff only to remain in contact with you. It will not be disclosed to third parties and is considered confidential. You have the right not to provide the demographic information requested (sex, ethnicity, etc.). Your decision to not provide the demographic information requested will not impact the services provided to you by FCASV. This information, if provided, will be used by FCASV for federal funding reporting purposes only, and will not identify any individual client by name. No client names are provided by FCASV for federal reporting purposes.

In order of importance, what outcome(s) are you seeking?

_____

_____

_____

If seeking to initiate court action, what county will you be filing in? _____

| | |
|---|---|
| Pending/Related Cases: | Criminal Court? ☐ Yes ☐ No County: _____ Case No: _____<br>Is there a pending court date: _____<br>Prosecutor Name & Contact: _____<br><br>Civil Court? ☐ Yes ☐ No County: _____ Case No: _____<br>Is there a pending court date: _____ |
| Law Enforcement Information: | Have you reported to law enforcement? ☐ Yes ☐ No<br>If yes, which law enforcement agency: _____<br>Law Enforcement Case/Report Number: _____<br>Detective Name & Contact: _____ |

## OPPOSING PARTY/OFFENDER INFORMATION

***Note: This information will be used for FCASV internal conflict checks only.***

| | | | | | |
|---|---|---|---|---|---|
| Opposing Party (last, first, middle): | | | | Date of Birth/Age: | |
| Race/Ethnicity: (Select all that apply) | ☐ American Indian/Alaska Native<br>☐ Native Hawaiian/Other Pacific Islander<br>☐ Unknown | ☐ Asian<br>☐ White<br>☐ Declined to Specify | ☐ Black/African American<br>☐ Multiple Races | ☐ Hispanic/Latino<br>☐ Not Reported | |
| Gender | ☐ Male | ☐ Female | ☐ Transgender | ☐ Intersex | ☐ Non-Binary ☐ Other:_____ |
| Mailing Address: | | | | | |
| Phone Number(s): | | | Email Address: | | |
| Opposing Party Attorney (if known): _____ | | | | | |
| If there is more than one opposing party, list their information here: | | | | | |
| Relationship to you: | ☐ Acquaintance<br>☐ Family Member<br>☐ Stranger | ☐ Current/Former Spouse<br>☐ Household Member<br>☐ Other (*describe*):_____ | ☐ Current/Former Dating Relationship<br>☐ Current/Former Intimate Partner | | |

## SAFETY CONCERNS

Are you concerned about your safety? ☐ Yes ☐ No ☐ Unsure

What might help you feel safe or maintain a safe environment?

_____

_____

_____

## REFERRAL INFORMATION

How did you hear about FCASV?

| | |
|---|---|
| Referring Agency: | Advocate Name: |
| Advocate Contact Number: | Advocate Email Address: |

Do you authorize FCASV to discuss details regarding the status and outcome of this referral for legal services with the advocate and/or referring agency stated above? ☐ Yes ☐ No

**Signature**: _____ **Date:** _____

| ** THIS SECTION IS FOR FCASV OFFICE USE ONLY ** | | |
|---|---|---|
| **CONFLICT CHECK CERTIFICATION** *(To be completed by Statewide Victim Coordinator)*: | | |
| Intake Completed/Reviewed by: | | Date of Intake: |
| Conflict Check Exists: ☐ Yes ☐ No | | Conflict Check Verified by: |
| Assigned to: | Intake Outcome: ☐ Counsel & Advice Only ☐ Brief Services ☐ Full Representation | |
| Consultation Date & Time: | Referred to (if applicable): | |
| **SAFETY PLAN AT INTAKE PROCESSING** *(To be completed by Statewide Victim Coordinator)*: | | |
| Safety Plan Addressed: ☐ Yes ☐ No | | Date: _____ |
| Explain:<br>_____ _<br>_____ | | |