



Getting to Know You

Family Service Universal Enrollment Tool

This intake form is meant to get to know you. The information you share will help us connect you to resources, services, and programs that can benefit you and your family.

Everything you share on this form is kept strictly confidential. Thank you for allowing us to take this journey with you!

(Please enter the information of the **PRIMARY** client or recipient of services)

Demographic Information

What brings you to Family Service? _____ Decline to share

Funder ID: _____ Family Service Location: _____ Enrollment Date: ____/____/____

First Name: _____ Last Name: _____

Middle Initial: _____ Date of Birth: ____/____/____

Gender

- | | | | | |
|--------------------------------------|---|---|---|-------------------------------------|
| <input type="checkbox"/> Woman | <input type="checkbox"/> Man | <input type="checkbox"/> Culturally Specific Identity (e.g. Two-Spirit) | <input type="checkbox"/> Transgender | <input type="checkbox"/> Non-Binary |
| <input type="checkbox"/> Questioning | <input type="checkbox"/> Different Identity | <input type="checkbox"/> Don't know | <input type="checkbox"/> Decline to Share | |

Sex Orientation: _____

Social Security Number: _____ Don't know or Don't have Decline to share

How did you learn about Family Service? _____

In the last six months, have you or your minor child/ren participated in a Family Service program? Yes No

Previous participation with Family Service for you or your minor child/ren:

Name: _____ Service: _____ For how long: _____

Name: _____ Service: _____ For how long: _____

Marital Status

- | | | | |
|----------------------------------|-------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Single | <input type="checkbox"/> Divorced | <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Common Law | <input type="checkbox"/> Partner | <input type="checkbox"/> Decline to share |

Race/Ethnicity

- | | | |
|--|--|--|
| <input type="checkbox"/> American Indian, Alaska Native, or Indigenous | <input type="checkbox"/> Asian or Asian American | <input type="checkbox"/> Black, African American, or African |
| <input type="checkbox"/> Hispanic/Latina/e/o | <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> White | <input type="checkbox"/> Don't know | <input type="checkbox"/> Decline to share |



So we may best serve you, how well do you speak English? (5 years or older):

- Very Well Well Not Well Not at all

Which language do you speak at home? _____

Do you speak a language other than English at home? Yes No Decline to share

How would you describe your household unit?

- Single Parent – Female Single Parent – Male Two Parent No Children
 Caregiver (ex: Grand-, foster-parent) Decline to share

Do you need help with day-to-day activities such as bathing, preparing meals, etc.?

- I don't need any help I get all the help I need I could use a little more help
 I need a lot more help Decline to share

Family Service has special services and resources available to certain populations such as military/veterans, migrant farmworkers, and refugees.

Are you or any member of your family on Active Duty or a Veteran? Yes No

Please list below if you, your spouse, your parents, or your children are/were in the military:

Name	Relationship to You	Active Duty or Veteran	Branch of Service

In the past year, have you been employed as a seasonal or migrant farmworker?

- Yes No Decline to share

Contact Information

Street Address: _____ Apt./Unit #: _____

Zip Code: _____ City: _____ State: _____

Email: _____ Mobile Phone: _____

Home Phone: _____ Work Phone: _____

Communication Preference: Text Email Phone

Do you have access to the Internet? Yes No

Emergency Contact

Relationship to you: _____ Name: _____

Office Phone: _____ Mobile/Home Phone: _____

Best way for us to reach them: _____

Education

Are you currently in school? Yes No If so where? _____

In which school district do you live? _____

What is the highest educational level you completed?

<input type="checkbox"/> 9 th grade or below	<input type="checkbox"/> High School	<input type="checkbox"/> GED	<input type="checkbox"/> Some College	<input type="checkbox"/> Trade or Technical Training
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Master's degree	<input type="checkbox"/> Other advance degree	<input type="checkbox"/> N/A

And for the second parent, if applicable?

<input type="checkbox"/> 9 th grade or below	<input type="checkbox"/> High School	<input type="checkbox"/> GED	<input type="checkbox"/> Some College	<input type="checkbox"/> Trade or Technical Training
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Master's degree	<input type="checkbox"/> Other advance degree	<input type="checkbox"/> N/A

Comments? _____

How many people live with you in your home? _____

Name	Relationship	DOB	Gender	School	Grade Level

Health and Healthcare

Do you have health insurance? Yes No Decline to share

Does the enrolled child/children have health insurance? Yes No Decline to share

Where do you go for medical needs/care? _____

Do you or your children have life threatening allergies? Yes No Decline to share

If yes, please provide the name and the allergy/ies: _____

Are there any other health concerns we should know about for you or your family's participation?

Yes No Decline to share

If yes, please explain: _____

How often do you feel the type of stress that makes you feel tense, restless, anxious, or unable to sleep because your mind is troubled? Not at all A little bit Somewhat Quite a bit Very Much

Decline to share

Family Economic Strength

How would you describe your employment status?

Full-time Part-time Occasionally employed Not employed Retired Decline to Share

What is your living situation today? I have a steady place to live

I have a place to live today, but I am worried about losing in the future

I don't have a steady place to live (I am temporarily staying with others, in a hotel, etc.)

Decline to share.

Please tell us more specifically about your living situation? Own Rent Public housing

Shared housing with family/friends Temporary (shelter, staying with others) Homeless

Do you have internet access in your home? Yes No Sometimes Decline to share

If no, how do you access the internet? _____

How do you and your family get to where you need to go? If using public transportation, please list number of transfers. My own vehicle Public Transportation(bus) # of transfers _____

Other Decline to share

In the past 12 months, has lack of reliable transportation kept you from medical appts, meetings, work, or from getting things needed for daily living?

Never Sometimes Often Decline to share

Knowing your household income will help us determine possible services you may be eligible for. Please circle the number of people living in your home and circle the closest figure to your total annual household income level:

Household Size (circle)	Total Annual Household Income (circle)			
	Under \$5,000	Under \$9,999		
1	\$12,760	\$17,609	\$19,140	\$25,520
2	\$17,240	\$23,791	\$25,860	\$34,480
3	\$21,720	\$29,974	\$32,860	\$43,440
4	\$26,200	\$36,156	\$39,300	\$52,400
5	\$30,680	\$42,338	\$46,020	\$61,360
6	\$35,160	\$48,521	\$52,740	\$70,320
7	\$39,640	\$54,703	\$59,460	\$79,280
8+	\$44,120	\$60,886	\$66,180	\$88,240

Do you currently participate in any of the following?					
<input type="checkbox"/> SNAP - Supplemental Nutrition Assistance Program (food stamps)	<input type="checkbox"/> TANF - Texas Temporary Assistance for Needy Families	<input type="checkbox"/> CHIP - Children's Health Insurance Program	<input type="checkbox"/> WIC - Women, Infants, and Children	<input type="checkbox"/> Earned Income Tax Credit	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Head Start Services	<input type="checkbox"/> Parenting Education	<input type="checkbox"/> Affordable Health Care	<input type="checkbox"/> CCA - Child Care Assistance	<input type="checkbox"/> Decline to share	

Neighborhood Supports

If you have a phone, does your phone number change frequently?

Yes No Decline to share

Would you be willing to keep us updated about your phone status?

Yes No Decline to share

Per our agency protocol, we are required to ask: Are you a registered sexual offender? Yes No

SOCIAL DETERMINANTS OF HEALTH SURVEY

Social & Community Engagement - As we learn more about you, it is important for us to know about your social life and support systems. This will help us better understand the connections you already have in place as well as those that may be helpful to you in the future.

Are you blind or have serious difficulty seeing, even with glasses?

Yes No Decline to share

Are you deaf or have serious difficulty hearing?

Yes No Decline to share

How often do you feel lonely or isolated from those around you?

Never Rarely Sometimes Often Always Decline to share

Are you a refugee? Yes No Decline to share

If so, country of origin? _____

Would you like resources designated for refugees, migrant farmworkers, or military/veterans?

Yes No

Health & Healthcare - Understanding your health and well-being status will better help us understand your situation. Health and well-being are the foundation from which positive experiences grow.

How do you take care of your health? _____

Would you like help enrolling in health insurance? Yes No

Do you need help communicating your concerns with your doctor?

Yes No Decline to share

Have you and/or your child/ren had the flu shot this season (October-March)?

Yes No Decline to share

As a mother and/or father, what was your age when giving birth to first child?

Mother _____ Father _____ N/A Decline to share

In the last 30 days, how many days a week did you engage in moderate exercise like walking quickly, running, riding a bike, swimming, and/or strength training (e.g. lifting weights)? _____ days

Do you use tobacco/vaping products? Yes No Decline to share

Is there a family history of alcoholism and/or substance abuse?

No Substance Abuse Alcoholism Decline to share

Education - Through this section we hope to learn about your educational experiences and help you target the next steps, whether it be for you or for your family.

If you or your child/ren (who is/are enrolled in the program) has/have a developmental delay, disability affecting education (e.g., attentional, learning differences, etc.), and/or an Individualized Family Service Plan (IFSP), and/or an Individualized Education Plan (IEP), please tell us more.

Not Applicable Decline to share None

Name	Disability Description	Frequency

Because of a physical, mental, and/or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions (if 15 years or older)? Yes No Decline to share

Family Economic Strength - We have programs to help people target financial goals, like paying off a credit card, establishing a budget, and purchasing a home. Also tied to financial goals are employment opportunities – both play a role in economic stability. The information you share may suggest your participation in one or more of these programs.

Within the past 12 months, how often were you worried your food would run out before you got money to buy more?

Never true Sometimes true Often true Decline to share

Within the past 12 months, has the electric, gas, oil, or water company threatened to shut off the services in your home?

Yes No Its already shut off Decline to share

Do you or your spouse/partner want help with school/job training (e.g., completing high school diploma, child development assoc. credential)?

Yes No Decline to share

Neighborhood Supports - The places and spaces in which you live, work, and enjoy time with your family and friends make up your neighborhood supports. This gives us a little more insight into how your services may be individualized.

Do you live in a federally recognized tribal reservation in Texas?

Yes No Decline to share

Do you live in a Colonia (an unincorporated settlement near the U.S./Mexican border)?

Yes No Decline to share

Are there other resources in the community that you are accessing?

(ex: YMCA/Foodbank/Library/Public parks)

Yes No

In the last year have you seen or experienced violence where you live?

Never Rarely Sometimes Fairly often Frequently Decline to share

Are you registered to vote?

Yes No Decline to share

Would you like information on how to register to vote?

Yes No Decline to share

Can we help link you to any of the following resources, programs, and services?

Alcoholism	Food/Nutrition	Marital/Couple help	Special Needs
Child Care/Early Childhood	GED & HSE	Parent-Child Counseling	Substance Abuse
College Readiness	Grief/Loss Counseling	Parenting help	Transportation
Divorce assistance or child custody	Health Insurance	Personal Care needs (hygiene, clothing, etc.)	Utilities
Enrichment Activities for children	Housing/Rent	Personal/Emotional help	Victim Assistance/Victim of a Crime
Family Issues	In-home Older Adult or Disabled Adult Care Services	Public Benefits Application	Youth Development/Education
Family Violence	Job Training	Reading	
Financial/Money Management	Legal Issues	Sexual Abuse	

Total Potential Linkages? _____

Internal linkages to Family Service's resources, programs, and services: _____

External linkage(s) to resources, programs, and services: _____

Notes: _____

Adverse Childhood Experiences Survey (ACEs)

Before your 18th birthday:	Yes	No
1. Did you ever experience a major disaster?	<input type="checkbox"/>	<input type="checkbox"/>
2. Were you ever bullied as a child?	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you lose a parent or close caregiver through death or divorce?	<input type="checkbox"/>	<input type="checkbox"/>
4. Did a household member go to prison?	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you ever experience any type of discrimination?	<input type="checkbox"/>	<input type="checkbox"/>
6. Did you feel neglected?	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you feel that you were not loved?	<input type="checkbox"/>	<input type="checkbox"/>
8. Was anyone in your home mentally ill or attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
9. Were you ever homeless?	<input type="checkbox"/>	<input type="checkbox"/>
10. Was anyone in your home an alcoholic or drug user?	<input type="checkbox"/>	<input type="checkbox"/>
11. Did you ever witness violence in your community?	<input type="checkbox"/>	<input type="checkbox"/>
12. Did you experience domestic violence in your home?	<input type="checkbox"/>	<input type="checkbox"/>
13. Did you ever witness a brother or sister being abused?	<input type="checkbox"/>	<input type="checkbox"/>
14. Were you ever emotionally abused?	<input type="checkbox"/>	<input type="checkbox"/>
15. Where you ever physically abused?	<input type="checkbox"/>	<input type="checkbox"/>
16. Were you ever sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>

ACEs Total (number of Yes responses): _____

Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I tend to bounce back quickly after hard times.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
I have a hard time making it through stressful events.	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
It does not take me long to recover from a stressful event.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
It is hard for me to snap back when something bad happens.	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
I usually come through difficult times with little trouble.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
I tend to take a long time to get over set-backs in my life.	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

Scoring: Total the responses and divide by 6 (score will range from 1-5)

My score: _____

