

# Universal Intake Form

## Basic Household and Primary Contact Info

Date of Intake: \_\_\_\_\_

Intake Staff: \_\_\_\_\_

### Primary Contact Information

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

SS# (last 4) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Race (can list more than one) \_\_\_\_\_

Phone number(s): \_\_\_\_\_ Permission to text?  Yes  No Ethnicity:  Hispanic  Non-Hispanic/Not Latino

Email: \_\_\_\_\_ Languages: \_\_\_\_\_ Disability:  Disabled  Not Disabled  
Receiving Case Management?  Yes  No

#### Marital Status

- Single
- Married
- Separated
- Divorced
- Widowed
- Other

#### Health Insurance

- MaineCare
- Medicare
- Cub Care
- Direct Purchase
- Employer Based
- Military
- Other: \_\_\_\_\_

#### Veteran Status

- Active Duty
- Veteran
- Not Applicable

#### Highest Level of Education

- Less than 8<sup>th</sup> grade
- Some high school
- High School
- GED/HISET
- Some College
- Associate's
- Bachelor's
- Master's or Higher
- Other post-secondary

#### Employment

- Full-time (inc. self-emp)
- Part-time
- Migrant Seas. Farm Work
- Retired
- Unemployed <6 months
- Unemployed >6 months
- Not in Labor Force-Not Seeking Work

Employer (if applicable) \_\_\_\_\_

Currently enrolled in school?  Yes  No

School (if applicable) \_\_\_\_\_

### Basic Household Information

#### Housing Status

- Own  Homeless
- Rent  Other: \_\_\_\_\_
- Live with friends or family

#### Is your housing situation.... (check all that apply)

- Safe?  Affordable?
- Consistent?  Comfortable?

#### Type of Dwelling: Apartment House

- Mobile Home  Condo  Other: \_\_\_\_\_

#### Family Type

- Single person  Two-parent
- Two adults  Single parent female
- Multigenerational  Single parent male
- Non-related adults with children  Other: \_\_\_\_\_

#### Physical Address

Date Moved In (approximate): \_\_\_\_\_

County: \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

#### Mailing Address

Mailing address same as physical address.

Date Moved In: \_\_\_\_\_

County: \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

# Universal Intake Form

## Additional Household Members: Ages 14 and Older

*Repeat as needed for all household members*

There are no additional household members ages 14 or older.

### Additional Household Member Contact Information

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

SS# (last 4) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Race (can list more than one) \_\_\_\_\_

Phone number(s): \_\_\_\_\_ Permission to text?  Yes  No Ethnicity:  Hispanic  Non-Hispanic/Not Latino

Relationship to Primary Contact: \_\_\_\_\_ Email: \_\_\_\_\_ Languages: \_\_\_\_\_

**Marital Status**

- Single
- Married
- Separated
- Divorced
- Widowed
- Other

**Health Insurance**

- MaineCare
- Medicare
- Cub Care
- Direct Purchase
- Employer Based
- Military
- Other: \_\_\_\_\_

**Veteran Status**

- Active Duty
- Veteran
- Not Applicable

**Highest Level of Education**

- Less than 8<sup>th</sup> grade
- Some high school
- High School
- GED/HISET
- Some College
- Associate's
- Bachelor's
- Master's or Higher
- Other post-secondary

**Employment**

- Full-time (inc. self-emp) \_\_\_\_\_  
Employer (if applicable)
- Part-time
- Migrant Seas. Farm Work
- Retired
- Unemployed <6 months
- Unemployed >6 months
- Not in Labor Force-Not Seeking Work
- Currently enrolled in school?  Yes  No
- \_\_\_\_\_ School (if applicable)

**Disability Status:**  Disabled  Not Disabled

**Receiving Case Management?**  Yes  No

### Additional Household Member Contact Information

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

SS# (last 4) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Race (can list more than one) \_\_\_\_\_

Phone number(s): \_\_\_\_\_ Permission to text?  Yes  No Ethnicity:  Hispanic  Non-Hispanic/Not Latino

Relationship to Primary Contact: \_\_\_\_\_ Email: \_\_\_\_\_ Languages: \_\_\_\_\_

**Marital Status**

- Single
- Married
- Separated
- Divorced
- Widowed
- Other

**Health Insurance**

- MaineCare
- Medicare
- Cub Care
- Direct Purchase
- Employer Based
- Military
- Other: \_\_\_\_\_

**Veteran Status**

- Active Duty
- Veteran
- Not Applicable

**Highest Level of Education**

- Less than 8<sup>th</sup> grade
- Some high school
- High School
- GED/HISET
- Some College
- Associate's
- Bachelor's
- Master's or Higher
- Other post-secondary

**Employment**

- Full-time (inc. self-emp) \_\_\_\_\_  
Employer (if applicable)
- Part-time
- Migrant Seas. Farm Work
- Retired
- Unemployed <6 months
- Unemployed >6 months
- Not in Labor Force-Not Seeking Work
- Currently enrolled in school?  Yes  No
- \_\_\_\_\_ School (if applicable)

**Disability Status:**  Disabled  Not Disabled

**Receiving Case Management?**  Yes  No

# Universal Intake Form

## Additional Household Members: Children 13 and Under, including prenatal

There are no additional household members ages 13 or younger.

*Repeat as needed for all household members*

### Additional Child Household Member Contact Information

\_\_\_\_\_  
First Name                                      Middle Name                                      Last Name                                      Suffix

\_\_\_\_\_  
SS# (last 4)                                      Date of Birth                                      Gender                                      Race (can list more than one)

Ethnicity:  Hispanic  Non-Hispanic/Not Latino      Languages: \_\_\_\_\_      Disability:  Disabled  Not Disabled

Health Insurance:  MaineCare  Medicare  Cub Care  Direct Purchase  Employer Based  Military  Other: \_\_\_\_\_

Relationship to Primary Contact: \_\_\_\_\_      Is DHHS Child Welfare currently involved?  Yes  No      Receiving Case Management?  Yes  No

### Additional Child Household Member Contact Information

\_\_\_\_\_  
First Name                                      Middle Name                                      Last Name                                      Suffix

\_\_\_\_\_  
SS# (last 4)                                      Date of Birth                                      Gender                                      Race (can list more than one)

Ethnicity:  Hispanic  Non-Hispanic/Not Latino      Languages: \_\_\_\_\_      Disability:  Disabled  Not Disabled

Health Insurance:  MaineCare  Medicare  Cub Care  Direct Purchase  Employer Based  Military  Other: \_\_\_\_\_

Relationship to Primary Contact: \_\_\_\_\_      Is DHHS Child Welfare currently involved?  Yes  No      Receiving Case Management?  Yes  No

### Expected family additions: pregnancies, adoptions, etc.

\_\_\_\_\_  
First Name                                      Middle Name                                      Last Name                                      Suffix

Date of Birth/Expected Due Date: \_\_\_\_\_      Gender: \_\_\_\_\_      Relationship to Primary Contact: \_\_\_\_\_

Bio mother receiving prenatal care?  Yes  No

**Additional Household Information**

Number of People in Household: \_\_\_\_\_

Est. Gross Monthly Household Income: \_\_\_\_\_

Do you have reliable transportation?  Yes  No

Does anyone in your household need more information or have unmet needs related to the following topics?	
Yes	No
	Budgeting/Financial Services
	Car Seats
	Case Management
	Child Care or Head Start
	Child Support
	Citizenship/Immigration
	Dental Care
	Disabilities
	Domestic Violence
	Education
	Employment
	English Language Learning
	Food/Hunger
	Health Care
	Heating/Energy Assistance
	Home Visiting for Children
	Housing
	Legal Assistance
	Mental Health
	Nutrition
	Parenting Education
	Substance Abuse/Addiction
	Transportation (inc. Driver's License)
	Weatherization & Home Repair
	Other:
	Other:

Is there anything else that's important for us to know about you or your family?

**I understand and agree to the following statements about this application:**

- The information is correct to the best of my knowledge.
- Information will be stored in a secured electronic record system by KVCAP.
- KVCAP will assure privacy and confidentiality per agency policies and relevant laws.
- KVCAP may access my information to:
  - Determine program eligibility
  - Support service delivery
  - Show compliance with funder requirements
- Personal information will be de-identified (no names) unless required for the specific program(s) I choose to participate in.
- Additional information may be required to determine eligibility for specific KVCAP programs.

\_\_\_\_\_  
Primary Applicant Signature

\_\_\_\_\_  
Date

# Universal Intake Form

## Household Benefits & Income

Repeat as needed for all household members

### Household Benefits

Please check all benefits received within the household.

- |                                   |   |   |                                       |
|-----------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> SNAP     | <input type="checkbox"/> Energy Assistance  | <input type="checkbox"/> Housing Choice Voucher       | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> WIC      | <input type="checkbox"/> Child Care Subsidy | <input type="checkbox"/> Permanent Supportive Housing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> HUD VASH | <input type="checkbox"/> Public Housing     | <input type="checkbox"/> Affordable Care Act Subsidy  | <input type="checkbox"/> Other: _____ |

### Income

Income sources include: employment, self-employment, SSI, SSDI, TANF, VA service-connected disability compensation, VA non-service connected disability pension, private disability insurance, worker's compensation, retirement income from Social Security, pension, child support, alimony or spousal support, unemployment insurance, EITC, other. SNAP and other benefits above may be counted as income in some programs.

This household has no income.

### Individual Household Member Income

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

This individual has no income.

	Income Source	Amount	Frequency					Documentation (if needed)
			Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annually	
1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Individual Household Member Income

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

This individual has no income.

	Income Source	Amount	Frequency					Documentation (if needed)
			Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annually	
1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Staff verification of income information

\_\_\_\_\_  
Name Signature Date

Applicant Name: \_\_\_\_\_ Option Preference:  Pre-K  Child Care  Home Visiting  Not Sure

Does your child(ren) have another parent not living in your household?  Yes  No *If yes, please complete reverse side of this application.*

**Additional Child Info**

Child 1 Name: \_\_\_\_\_ MaineCare ID or Other Health Insurance Name and ID: \_\_\_\_\_

Does your child have a diagnosed special need (IFSP/IEP, therapies, etc.)?  
 Yes  No If yes, please describe:

Does your child have any health, nutritional or developmental concerns including allergies and asthma?  Yes  No If yes, please describe:

Child 2 Name: \_\_\_\_\_ MaineCare ID or Other Health Insurance Name and ID: \_\_\_\_\_

Does your child have a diagnosed special need (IFSP/IEP, therapies, etc.)?  
 Yes  No If yes, please describe:

Does your child have any health, nutritional or developmental concerns including allergies and asthma?  Yes  No If yes, please describe:

Child 3 Name: \_\_\_\_\_ MaineCare ID or Other Health Insurance Name and ID: \_\_\_\_\_

Does your child have a diagnosed special need (IFSP/IEP, therapies, etc.)?  
 Yes  No If yes, please describe:

Does your child have any health, nutritional or developmental concerns including allergies and asthma?  Yes  No If yes, please describe:

**I understand that this application serves as an application for preschool, Early Head Start, Head Start or Early Head Start-Child Care Partnership services and may be shared with collaborative partners. I understand that this information may be provided to the State of Maine for the administration of this program.**

**Parent/Guardian Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**I give permission for KVCAP C&FS to conduct the following screenings for my child: ♦ Height/Weight ♦ Blood Pressure ♦ Hearing/Vision ♦ Developmental**  
**The results of screenings will be discussed with parents/guardians along with any recommendations for follow-up that may be indicated from the screenings.**

**Parent/Guardian Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Please provide the following with application – assistance is available if needed**

- Copy of Official Birth Certificate (Certificate of Vital Record)
- Copy of the current Immunization record
- Proof of Household Income (Paystubs, TANF, SSI, Unemployment, Child Support, etc)
- Copy of MaineCare card or other Health Insurance card



*KVCAP Child & Family Services offers programming through Head Start and Early Head Start partnerships.*

**Parent/Guardian Not Living in the Home**

_____ First Name		_____ Last Name		_____ Relationship to Child	
_____ SS# (last 4)		_____ Date of Birth		_____ Gender	
_____ Race (can list more than one)		_____ Phone number(s): _____		Permission to text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____ Email: _____		_____ Languages: _____		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Not Latino	
				Disability: <input type="checkbox"/> Disabled <input type="checkbox"/> Not Disabled	
				Receiving Case Management? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Marital Status**

- Single  
 Married  
 Separated  
 Divorced  
 Widowed  
 Other

**Health Insurance**

- MaineCare  
 Medicare  
 Cub Care  
 Direct Purchase  
 Employer Based  
 Military  
 Other: \_\_\_\_\_

**Veteran Status**

- Active Duty  
 Veteran  
 Not Applicable

**Highest Level of Education**

- Less than 8<sup>th</sup> grade  
 Some high school  
 High School  
 GED/HISET  
 Some College  
 Associate's  
 Bachelor's  
 Master's or Higher  
 Other post-secondary

**Employment**

- Full-time (inc. self-emp)  
 Part-time  
 Migrant Seas. Farm Work  
 Retired  
 Unemployed <6 months  
 Unemployed >6 months  
 Not in Labor Force-Not Seeking Work

\_\_\_\_\_  
Employer (if applicable)\_\_\_\_\_  
Currently enrolled in school?  Yes  No\_\_\_\_\_  
School (if applicable)**Parent/Guardian Not Living in the Home**

_____ First Name		_____ Last Name		_____ Relationship to Child	
_____ SS# (last 4)		_____ Date of Birth		_____ Gender	
_____ Race (can list more than one)		_____ Phone number(s): _____		Permission to text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____ Email: _____		_____ Languages: _____		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Not Latino	
				Disability: <input type="checkbox"/> Disabled <input type="checkbox"/> Not Disabled	
				Receiving Case Management? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Marital Status**

- Single  
 Married  
 Separated  
 Divorced  
 Widowed  
 Other

**Health Insurance**

- MaineCare  
 Medicare  
 Cub Care  
 Direct Purchase  
 Employer Based  
 Military  
 Other: \_\_\_\_\_

**Veteran Status**

- Active Duty  
 Veteran  
 Not Applicable

**Highest Level of Education**

- Less than 8<sup>th</sup> grade  
 Some high school  
 High School  
 GED/HISET  
 Some College  
 Associate's  
 Bachelor's  
 Master's or Higher  
 Other post-secondary

**Employment**

- Full-time (inc. self-emp)  
 Part-time  
 Migrant Seas. Farm Work  
 Retired  
 Unemployed <6 months  
 Unemployed >6 months  
 Not in Labor Force-Not Seeking Work

\_\_\_\_\_  
Employer (if applicable)\_\_\_\_\_  
Currently enrolled in school?  Yes  No\_\_\_\_\_  
School (if applicable)