Outreach Intake

WS File # _____ Advocate: _____

ALL INFORMATION IS CONFIDENTIAL

Date:_____Time:_____am pm

Name: _____ Age: _____ Date **of Birth:** _____ Gender :(M or F):_____

Marital Status (S/M/D/C):_____ Sexual Orientation: Bisexual Gay Heterosexual Lesbian Not Provided Other

Address: _____City_____State_____ Zip Code_____

Home Telephone :(____) _____ Cell Phone :(____) _____ is it safe to contact you at the phone number? **Yes No**

Are you of Hispanic Ethnicity? Yes No Middle Eastern Ethnicity? Yes No Haitian Ethnicity? Yes No

Race:

____American Indian/Alaskan Native
____Asian
____Black/African American
____Multi-Racial
____Native Hawaiian/Other Pacific Islander
____Unknown
____Other
____White

Emergency Contact person: _____ Phone #:_____

Do you have any disabilities?____**YES** ___**NO** Do you need any special accommodations? _____

INCOME INFORMATION:

Yearly Household Income: $_____ Yearly Income WITHOUT Abuser: $_____

Number of Dependents: _____ Total Number of individuals in Household: _____

*******************Domestic Violence Partner/Perpetrator Information *******************

His/Her Name: _____ Date of Birth_____

Address: _____City/State: _____ Zip: _____ County: _____

Telephone: (____) _____ Gender: ____Male ____Female

Race_____ Hispanic? Yes No Height_____ Weight_____ Hair Color_____ Eye Color_____

Acknowledgement

I hereby request counseling and/or advocacy for myself/my child(ren) from Abuse Counseling and Treatment, Inc. (ACT). I hereby release all ACT personnel/volunteers from any and all responsibilities for my action, decisions, and the well-being of myself/child(ren). *I understand that my records are protected by Federal and State confidentiality regulations and cannot be disclosed without my written consent. The exceptions to these regulations include incidents that could be deemed potentially life threatening, such as incidents of child abuse, suspected abuse of vulnerable adult, threats of suicide or homicide, or as required by law, i.e. by order of the court. Exceptions also include medical personnel in a medical emergency, receipt of a search warrant that specifies the individual or object of the search and alleges that the individual or object is located at the shelter, firefighting personnel in a fire emergency, any other person necessary to maintain the safety and health standards in the domestic violence shelter, and communication to law enforcement officers when the information is directly related to a client's commission of a crime or threat to commit a crime on the premises of a domestic violence shelter.*

I have been provided information on Florida Confidentiality and Privilege Laws, as well as policies and procedures of ACT regarding access to my file information, photos/videotapes and participation in public appearances. I was assessed for lethality and a Safety plan was developed with me. I received a copy of the Grievance procedure for ACT.

I, _____, acknowledge that the information collected during this Intake Assessment by Abuse Counseling & Treatment, Inc. has been reviewed by me and is correct to the best of my knowledge. Thank you for taking the time to complete this form. This information will help us to better meet your needs. Your cooperation is greatly appreciated.

_____ _____
Client Signature **Date**

_____ _____
Counselor Signature **Date**

Abuse and Lethality Assessment

Participant Name: _____

Date: _____

This abuse/lethality assessment is designed as a tool for survivors of domestic violence to use in evaluating/recognizing the abusive behaviors they have experienced, as well as the potential for harm or death in their relationship.

The word "lethal" means causing death. This "Lethality Assessment" is a tool to assess the possibility that a domestic violence victim may be killed. As you review these questions, consider that the more you have marked, the more dangerous the relationship may be.

BACKGROUND

1. How long have you been with your partner? _____
2. How long has your relationship been abusive? _____
3. When was the first incident of abuse? _____
4. When was the most recent incident of abuse? _____
5. Does it seem that the threats are occurring more frequently? ☐ or NO
6. Does it seem like the abuse is getting worse? ☐ or NO
7. Did your partner witness domestic violence as a child? ☐ or NO
8. Is your partner a survivor of child abuse? ☐ or NO
9. Is your partner a survivor of sexual assault? ☐ or NO

PET/ANIMAL ABUSE

1. As a child, did your partner witness the harming or killing of a pet or animal? ☐ or ☐
2. Has your partner ever harmed, threatened to harm or killed a family pet or animal? ☐ or ☐
3. Have you ever felt unable to leave your relationship out of fear for the safety of a pet?

   ☐ or ☐

PHYSICAL ABUSE (Check ALL that Apply):

Please check any physical abuse you have experienced with your partner:

☐ Hit	☐ cut	☐ burned
☐ kicked	☐ shot	☐ smothered
☐ thrown around	☐ pushed	☐ punched
☐ slapped	☐ choked	☐ restrained
☐ Spitting	☐ pulled hair	☐ thrown things
☐ Biting	☐ twisted arm	☐ Other: _____

How often is your partner physically violent? _____

Have you ever blacked out due to the abuse? ☐ or ☐

Have you ever needed medical attention due to an abusive incident? ☐ or ☐

Have you ever needed the police? ☐ or ☐

Additional Information discussed: _____

_____

EMOTIONAL (Check ALL that Apply):

Check any types of emotional abuse you have experienced with your partner:

- ☐ Forced acts you weren't comfortable doing
- ☐ controlled your activities
- ☐ attacked your self –esteem
- ☐ intentionally frightened you
- ☐ destroyed property
- ☐ verbally abused you
- ☐ called you names
- ☐ made you feel crazy
- ☐ forced humiliating acts
- ☐ abused you in front of others
- ☐ abused you in front of the children
- ☐ screaming and yelling
- ☐ punching walls
- ☐ Other: _____

How often does the emotional abuse occur? _____

Additional Information discussed: _____

_____

PSYCHOLOGICAL (Check ALL that Apply):

Check any types of psychological abuse you have experienced with your partner:

Threatening Behavior:

- ☐ Destroy property
- ☐ Threatens deportation
- ☐ Displays weapons
- ☐ take children away
- ☐ harm the children
- ☐ kill the children
- ☐ injure family and friends
- ☐ hurt you
- ☐ kill you
- ☐ hurt himself
- ☐ kill himself
- ☐ harm a pet

Has he followed through on any threats? ☐ or ☐

If yes, describe _____

Additional Information discussed: _____

_____

Isolation:

- ☐ Controls freedom to leave the home
- ☐ Isolates you from school, church, meetings
- ☐ Isolates you from friends or family
- ☐ listens to phone calls
- ☐ opens mail
- ☐ monitors e-mail, text messages
- ☐ follows you around
- ☐ questions your whereabouts
- ☐ Denies access to a car
- ☐ Denies access to a telephone
- ☐ Denies access to a job
- ☐ Controls finances

How frequently are you psychologically abused? _____

Additional Information discussed: _____

_____

SEXUAL ABUSE (Check ALL That Apply):

Have you ever been sexually abuse as a child or adult? YES ☐ or NO ☐

If yes, age at first incident: _____

If exact age is unknown, please pick an age range at first incident:

- ☐ Unknown
- ☐ Child (0-12)
- ☐ Teen (13-17)
- ☐ Adult 1 (18-29)
- ☐ Adult 2 (30-44)
- ☐ Adult 3 (45-59)
- ☐ Adult 4 (60-64)
- ☐ Adult 5 (65-99)

Are you an adult survivor of incest? ☐ or ☐

Has your partner ever:

- ☐ Forced you to have sex
- ☐ tied you up against your will
- ☐ used objects against your will
- ☐ attacked sexual body parts
- ☐ treated you like a sex object
- ☐ forced acts which felt uncomfortable
- ☐ accused you of having affairs
- ☐ called you a whore or a slut
- ☐ withholds sexual affection
- ☐ had affairs

How frequently are you sexually abused? _____

Additional Information discussed: _____

_____

LETHALITY

Please answer the following:

1. At this time do you feel your abuser knows where you are? ☐ or ☐

   Concerns: _____

2. Have you ever left your abuser before? ☐ or ☐

   If yes, how many times? _____

   What behaviors/actions did he/she display? _____

   _____

3. At this time do you have concerns that your abuser may stalk you (if he knows your daily/weekly routine)? ☐ or ☐
4. Has your partner ever threatened suicide? ☐ or ☐
5. Has your partner ever threatened to kill you? ☐ or ☐
6. Have you ever been afraid your partner would kill you? ☐ or ☐
7. Do you believe your partner is capable of killing another person? ☐ or ☐

8. Does your partner have weapons or access to weapons? ☐ or ☐
9. Does your partner have fits of rage? ☐ or ☐
10. Is your partner a jealous person? ☐ or ☐
11. Does your partner appear obsessed with you? ☐ or ☐
12. Does your partner use drugs or alcohol? ☐ or ☐
13. Does the abuse escalate with substance abuse? ☐ or ☐
14. How often are drugs or alcohol used? _____
15. Do you believe you can leave the house safely when the abuse begins to escalate? ☐ or ☐
16. Has partner been violent with others? ☐ or ☐
17. Has your partner ever been violent with law enforcement? ☐ or ☐
18. Has your partner ever been arrested for domestic violence? ☐ or ☐

    If yes, how many times? _____
19. Is there a No Contact Order in place? ☐ or ☐
20. Is there a warrant out on your partner because of domestic violence? ☐ or ☐

    If yes, where is the warrant from (City, County)? _____
21. Have you ever obtained an Injunction for Protection (IFP)/ restraining order? ☐ or ☐

    Do you feel you need an IFP now? ☐ or ☐

Comments: _____

_____

_____

Thank you for completing the Abuse and Lethality Assessment. If you have any questions, please speak with your counselor.

_____ _____

Participant Signature Date

_____ _____

Counselor Signature Date

Abuse Counseling & Treatment, Inc.

Escape Plan

Participant Name: _____

Date: _____

Has anyone ever discussed safety planning with you before? ☐ or ☐

Has anyone ever taught you emergency and escape action? ☐ or ☐

My Escape Plan includes:

- ☐ Documentation
- ☐ Cellular Phone/Calling cards
- ☐ Clothing
- ☐ Escape bag
- ☐ Important Items (keys, credit cards etc)
- ☐ Important telephone Numbers
- ☐ Medications
- ☐ Money
- ☐ Personal items
- ☐ Safe place
- ☐ Other: _____
- ☐ Other: _____

Discuss other items needed to escape safely: _____

_____

Additional information discussed: _____

_____

_____

_____ _____

Participant Signature **Date**

_____ _____

Counselor Signature **Date**

Abuse Counseling & Treatment, Inc.

Comprehensive Safety Plan

Participant Name: _____

Date: _____

Has anyone ever discussed safety planning with you before? ☐ or ☐

Has anyone ever taught you emergency and escape action? ☐ or ☐

Discuss how you have maintained safety in the past:

_____

_____

At this time, what changes do you feel you should make to try to stay safe?

_____

_____

Personal Safety Planning:

- ☐ Obtain 911-phone
- ☐ Utilize Buddy System
- ☐ Maintain Confidentiality
- ☐ Create an Escape Bag
- ☐ Develop an Escape Plan
- ☐ Maintain/Obtain Injunction for Protection
- ☐ Call 911 – Emergency Services
- ☐ Maintain No Contact Order
- ☐ Routine Revision
- ☐ Maintain/Obtain Safe Shelter
- ☐ School Safety (Children's Safety)
- ☐ Situational Awareness
- ☐ Maintain Work Place Safety
- ☐ Other : _____

Financial Safety Planning:

- ☐ Close Joint Bank Accounts
- ☐ Change passwords for online banking
- ☐ Close credit cards
- ☐ Close Utility accounts (Ex: Electric)
- ☐ Open new checking account
- ☐ Change PIN on debit card
- ☐ Open new savings account
- ☐ Open new credit cards
- ☐ Obtain new employment
- ☐ Open new Utility accounts; Consider security passwords
- ☐ Check Credit Reports
- ☐ Change automatic deposits (Ex: SSDI)
- ☐ Child Support received via Dept. of Revenue
- ☐ Child Support waived/Good Cause Exemption
- ☐ Other: _____

Technological Safety Planning:

- ☐ Change password on E-mail accounts
- ☐ Change cell phone number
- ☐ Obtain SafeLink Wireless Cellular Phone
- ☐ Social Media – Change passwords
- ☐ Social Media – Block users Ex: Facebook
- ☐ Disable GPS on cell phone
- ☐ Turn off Bluetooth on devices (Ex: iPhone)
- ☐ Other: _____

Victim Services:

- ☐ Address Confidentiality
- ☐ Relocation Program
- ☐ Victim Compensation
- ☐ Victim Information and Notification Everyday
- ☐ Other: _____

Education provided:

- ☐ Lethality
- ☐ Other: _____

Referrals provided:

- ☐ Advocacy Unit
- ☐ Crisis Hotline
- ☐ Domestic Violence Division
- ☐ Non-Residential Services
- ☐ Other: _____

Additional Information Discussed: _____

_____

_____

_____ _____

Participant Signature Date

_____ _____

Counselor Signature Date

Outreach – Service Plan

This is the initial examination you and an outreach counselor will have in regards to goal setting. We understand that at this time you may be unaware of the goals you will need and want to set in the future. This is only a brief look at possible needs. As your time progresses here at the ACT, you and your counselor will develop more concrete service plans.

Are you employed: yes_____ no_____?

Monthly Income Level: Household: _____ Individual: _____

Goals

- ☐ Children's needs
- ☐ Dental care
- ☐ Documentation
- ☐ Economic assistance
- ☐ Education
- ☐ Employment Income
- ☐ Housing
- ☐ Immigration
- ☐ Legal Assistance
- ☐ Medical care
- ☐ Mental health care
- ☐ Probation/Parole Compliance
- ☐ Relocation
- ☐ Safety
- ☐ Victim Services – Relocation
- ☐ Victim Services – Victim's Compensation
- ☐ Victim Services – Other
- ☐ Other

List any additional goals: _____

What would you like to achieve and/or learn through our services?

What challenges do you think you will face in achieving your goals?

Prioritize your goals:
List details (steps) on how you will achieve your stated goals:

Safety Plan: Discuss any goals related to the development/implementation of your safety plan:

Initial Referrals by staff:

Initial education provided:

VICTIM SERVICES:

Do you have a domestic violence arrest report within the past 30 days? Yes or No

Victim Services Programs (Office of the Attorney General)

- ☐ Relocation Program explained to client
- ☐ Victim Compensation Program explained to client
- ☐ Address Confidentiality Program explained to client

Client requests to apply for a program offered through the Office of the Attorney General:

Yes or No

Pre-Qualification Guidelines for the Domestic Violence Relocation Program (Office of the Attorney General)

- ☐ Relocation program explained to client
- ☐ Client pre-qualifies for relocation
- ☐ Client does not meet pre-qualification guidelines
- ☐ Client requests Relocation Program services
- ☐ Client declines Relocation Program Services
- ☐ Not Applicable

Additional Information discussed: _____

_____

_____ _____

Client Signature **Date**

_____

Date

_____

Counselor Signature

Submit