|  |  |
| --- | --- |
|  | **Tennessee Department of Children’s Services****Initial Intake, Placement and Well-Being Information and History** |

| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |
| --- | --- | --- | --- | --- | --- |
| Initiated By: |       | Title: |       | Date: |       |
| Revised By: |       | Title: |       | Date: |       |
| Person Providing Information to DCS: |       | Relationship to Child/Youth: |       |
|  |
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| --- | --- | --- | --- |
| **Current insurance coverage** | [ ]  Yes [ ]  No [ ]  Unknown  | **If yes, provide details:** |       |

 |
| **Child/Youth Information** |
| **Name of Child/Youth:** |    | **E-mail Address:** |       | **SSN:** |       |
| **DOB:** |  | **Sex****:**  |       | **Race:** |  | **Hispanic:** | [ ]  Yes [ ]  No | **U.S. Citizen:** | [ ]  Yes [ ]  No Provide Birth Certificate Verification |
| **Is Child/Youth of Native American Descent?** | [ ]  Yes [ ]  No [ ]  Unable to Determine | **If “Yes” Tribal Affiliation** |       |
| **Child/Youth’s Marital Status *(check one)*** | [ ]  Never Married [ ]  Divorced [ ]  Widowed [ ]  Married [ ]  Separated |
| **Has Youth been placed in out of home care prior to this custody episode? If yes please list dates and placements:**  | [ ]  Yes [ ]  No |
| **Current Description of the Child/Youth** |
| **Physical Description Date** |       | **Primary Language Spoken** |       |
| **Height** |       | **Weight** |       | **Hair Color** |       | **Eye Color** |       |
| **Religion:** |       | **Identifying Marks or Tattoos:** |       |

|  |  |
| --- | --- |
| **Special Needs/Disabilities:**  |       |
| **Special Medical Equipment:** |       |
| **Scheduled Appointments: (*date, provider, location, type of appt*)**  |       |
| **Allergies/Adverse Reactions:**  | [ ]  Yes [ ]  No  |
| **Medication:** |       | **Describe reaction:** |       |
| **Food:** |       | **Describe reaction:** |       |
| **Insect Sting:** |       | **Describe reaction:** |       |
| **Other:** |       | **Describe reaction:** |       |

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| --- | --- | --- | --- |
| **Medical modified/Religious diet?** | [ ]  Yes [ ]  No | **If yes, describe** |  |

|  |
| --- |
| **Medications: Prescribed and Over the Counter** |
| **Current medications (*name, route, frequency, dosage & days of meds left)*** |       |
|       |
| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Are meds given in school?**  | [ ]  Yes [ ]  No  | **Which meds?** |       |
| **Consent signed for psychotropic meds:** | [ ]  Yes [ ]  No [ ]  N/A  | **Next med appointment:** |       |
| **Has Foster Parent received medication:** | [ ]  Yes [ ]  No  | **Explain:** |       |
| **Health History of Child** Explain any items checked Now/Past in "COMMENTS" section |
| No | Now | Past |   |  | No | Now | Past |   |
| **[ ]**  | **[ ]**  | **[ ]**  | Birth defects |  | **[ ]**  | **[ ]**  | **[ ]**  | Gastrointestinal problems |
| **[ ]**  | **[ ]**  | **[ ]**  | Vision problems |  | **[ ]**  | **[ ]**  | **[ ]**  | Kidney/urinary problems |
| **[ ]**  | **[ ]**  | **[ ]**  | Hearing problems  |  | **[ ]**  | **[ ]**  | **[ ]**  | Hepatitis/liver problems |
| **[ ]**  | **[ ]**  | **[ ]**  | Skin problems |  | **[ ]**  | **[ ]**  | **[ ]**  | Cancer |
| **[ ]**  | **[ ]**  | **[ ]**  | Head injuries |  | **[ ]**  | **[ ]**  | **[ ]**  | Tuberculosis (TB) |
| **[ ]**  | **[ ]**  | **[ ]**  | Headaches |  | **[ ]**  | **[ ]**  | **[ ]**  | Autism/Asperger's (circle one) |
| **[ ]**  | **[ ]**  | **[ ]**  | Sickle cell disease |  | **[ ]**  | **[ ]**  | **[ ]**  | Developmental delays |
| **[ ]**  | **[ ]**  | **[ ]**  | Anemia/blood disorder |  | **[ ]**  | **[ ]**  | **[ ]**  | Learning disability |
| **[ ]**  | **[ ]**  | **[ ]**  | Epilepsy/seizures |  | **[ ]**  | **[ ]**  | **[ ]**  | Sleep problems |
| **[ ]**  | **[ ]**  | **[ ]**  | Bedwetting |  | **[ ]**  | **[ ]**  | **[ ]**  | Incontinence: [ ]  Urine [ ]  Stool |
| **[ ]**  | **[ ]**  | **[ ]**  | Diabetes |  | **[ ]**  | **[ ]**  | **[ ]**  | Other medical *(describe below)* |
| **[ ]**  | **[ ]**  | **[ ]**  | Asthma/Respiratory Disease |  | **[ ]**  | **[ ]**  | **[ ]**  | Accidents *(describe below)* |
| **[ ]**  | **[ ]**  | **[ ]**  | Heart murmur |  | **[ ]**  | **[ ]**  | **[ ]**  | Hospitalizations *(describe below)* |
| **[ ]**  | **[ ]**  | **[ ]**  | Heart problems |  | **[ ]**  | **[ ]**  | **[ ]**  | Surgeries *(describe below)* |
| **[ ]**  | **[ ]**  | **[ ]**  | High blood pressure |  | **[ ]**  | **[ ]**  | **[ ]**  | Problems with anesthesia |
| **[ ]**  | **[ ]**  | **[ ]**  | Physical disabilities |  | **[ ]**  | **[ ]**  | **[ ]**  | Other developmental disabilities |
| **Child/Youth is currently hospitalized:** | [ ]  Yes [ ]  No  | **If yes, where and why:** |       |
|       |
| **Comments/Additional health information/ongoing health related services:** |       |
|       |
| **Childhood Illnesses** |   |   |   |   |   |   |
| No | Yes | Approx date |   |  | No | Yes | Approx date |   |
| [ ]   | [ ]   |        | Measles |  | [ ]   | [ ]   |        | Chicken pox |
| [ ]   | [ ]   |        | German measles |  | [ ]   | [ ]   |        | Scarlet fever |
| [ ]   | [ ]   |        | Mumps |  | [ ]   | [ ]   |        | Rheumatic fever |
| **Trauma Screening** |   |   |   |
| Indicate *known* history of abuse/adverse experiences. Explain any yes answers in "COMMENTS" section |
| No | Yes |   | No | Yes |   |
| [ ]  | [ ]  | Neglect | [ ]  | [ ]  | Domestic violence |
| [ ]  | [ ]  | Physical assault/abuse | [ ]  | [ ]  | School violence |
| [ ]  | [ ]  | Sexual assault/abuse | [ ]  | [ ]  | Community violence |
| [ ]  | [ ]  | Emotional abuse | [ ]  | [ ]  | Extreme interpersonal violence |
| [ ]  | [ ]  | Traumatic loss/separation | [ ]  | [ ]  | Natural disaster |
| [ ]  | [ ]  | Extended illness/medical trauma | [ ]  | [ ]  | Impaired caregiver (substance abuse/mental illness) |
| [ ]  | [ ]  | Serious injury | [ ]  | [ ]  | Other trauma, describe:       |
| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |

Has abuse been reported? [ ]  Yes [ ]  No ***If no, call CPS 877-237-0026***

|  |  |
| --- | --- |
| **Comments/Additional health information:** |       |
|       |

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| **Child Strengths**  |
|       |

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| --- |
| **Behavioral/Mental Health History**  |
| No | Now  | Past |   |
| [ ]   | [ ]   | [ ]   | Intense anger, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Oppositional, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Negative Peer Association, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Extreme Attention Seeking, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Makes False Statements, if yes, describe       |
| [ ]   | [ ]   | [ ]   | School Difficulties, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Damage of Property, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Habitual Lying, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Stool Smearing, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Stealing, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Runaway, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Hoarding, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Problems with concentration and attention,if yes, describe       |
| [ ]   | [ ]   | [ ]   | Excessive Hyperactivity/does not respond to safety instructions, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Requires Constant Supervision, if yes describe       |
| [ ]   | [ ]   | [ ]   | Anxiety, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Depression, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Seeing or hearing things that aren't there, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Fire-setting, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Animal cruelty, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Animal fear, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Self-injurious behavior/Other Self Harm, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Aggressive, dangerous or destructive behaviors, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Sexual aggression, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Had homicidal thoughts, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Had suicidal thoughts, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Attempted suicide If yes, describe       |
| [ ]   | [ ]   | [ ]   | Had other mental health or behavioral problems, if yes, describe       |
| [ ]   | [ ]   | [ ]   | Other mental health diagnosis, if yes, describe       |

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| **Has the Child/Youth received counseling or therapy?** | [ ]  Yes [ ]  No  |
| **If yes, where?** |       |
| **Has the Child/Youth had a Psychological Evaluation:** | [ ]  Yes [ ]  No  |
| **If yes, diagnosis, when, where?** |       |
|       |
| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |

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| **Has the Child/Youth been hospitalized for mental health problems/acute hospitalization?** | [ ]  Yes [ ]  No  |
| **If yes, diagnosis, when, where?** |       |
|       |
| **Has the Child/Youth/Family received in-home services?** | [ ]  Yes [ ]  No  |
| **If yes, when, where?** |
|       |

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| **Has the Child/Youth previously been placed in a residential treatment facility?** | [ ]  Yes [ ]  No  |
| **If yes, when, where?** |
|       |

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| **Alcohol/Drug Abuse History** |
| No | Now | Past  | Frequency | (Xs per day/week/month)  |
| [ ]  | [ ]  | [ ]  |       | Alcohol |
| [ ]  | [ ]  | [ ]  |       | Tobacco smoke/chew *(circle one or both)* |
| [ ]  | [ ]  | [ ]  |       | E-cigarettes/vapor cigarettes |
| [ ]  | [ ]  | [ ]  |       | Marijuana |
| [ ]  | [ ]  | [ ]  |       | Narcotics |
| [ ]  | [ ]  | [ ]  |       | Stimulants |
| [ ]  | [ ]  | [ ]  |       | Methamphetamine |
| [ ]  | [ ]  | [ ]  |       | Hallucinogens |
| [ ]  | [ ]  | [ ]  |       | Steroids |
| [ ]  | [ ]  | [ ]  |       | Huffing |
| [ ]  | [ ]  | [ ]  |       | Ecstasy |
| [ ]  | [ ]  | [ ]  |       | Street drugs, unknown |
| [ ]  | [ ]  | [ ]  |       | Prescription drugs prescribed for another, specify:       |
| [ ]  | [ ]  | [ ]  |       | Over-the-counter medication, specify:       |
| [ ]  | [ ]  | [ ]  |       | Other, specify:       |
| **Additional Comments:** |       |

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| **Has child been identified as high risk?**  | [ ]  Yes [ ]  No |
| **Has a Safety Plan been completed on child identified as high risk?**  | [ ]  Yes [ ]  No [ ]  N/A  |

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| **Birth History** (for all children) |
| **Birth Weight:** |       | **Birth Length:** |       | **[ ]  Full term or** **[ ]  Premature birth (<36 weeks)** |       | weeks |
| **Did mother receive prenatal care:**  | [ ]  Yes [ ]  No  | **Month of pregnancy for 1st prenatal visit:** |       |
| **Pregnancy/Birth complications:** |       |
| **Was there prenatal substance abuse:**  | [ ]  Yes [ ]  No  | **Substance and frequency:** |       |
| **Birth hospital and location:** |       |

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| **Minor Female** |
| **Age of 1st Period:** |       | **Date of Last Period:** |       |
| **Pregnancies #** |       | **Live births #** |       | **Full term** |       | **Premature (# weeks)** |       |
| **Miscarriages #** |       | **Abortions #** |       | **Currently pregnant:** | [ ]  Yes [ ]  No  | **If yes, due date:** |       |

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| --- | --- | --- | --- | --- | --- |
| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |

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| --- | --- | --- |
| **Does the youth have children?** | [ ]  Yes [ ]  No If yes, answer below questions: |  |
| **Youth’s Children’s Names** | **DOB** | **In DCS Custody?** | **Male/****Female?** | **Race** | **Name of Person Child Lives with and Relationship** | **Name of Child’s Other Parent** | **Contact Information of Other Parent** |
|       |       | Yes [ ] No [ ]  | Male [ ] Female [ ]  |       |       |       |       |
|       |       | Yes [ ] No [ ]  | Male [ ] Female [ ]  |       |       |       |       |
|       |       | Yes [ ] No [ ]  | Male [ ] Female [ ]  |       |       |       |       |

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| **Does minor parent have visitation with their child(ren)?** | [ ]  Yes [ ]  No  |
| **If yes, list any visitation restrictions:**  |       |

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| --- |
| **Gender and Sexual Identity** |
| **Does the Child/Youth identify him/herself as gay, lesbian, transgender, or non-binary?** | [ ]  Yes [ ]  No  |
| **If yes, describe answer** |       |

|  |
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| **Sexual Activity** |
| **Is child sexually active?**  | [ ]  Yes [ ]  No | **Use birth control?**  | [ ]  Yes [ ]  No | **Method:** |       |

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| **Dating Violence** |
| **Has Child/Youth experienced controlling, abusive or aggressive behavior in a dating relationship?** | [ ]  Yes [ ]  No  |
| **If yes, explain:** |       |

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| **Medical** |
| **Does the Child/Youth have a regular medical provider (pediatrician, family doctor, etc.)?** | [ ]  Yes [ ]  No  |
| **If yes, name of medical provider:** |       | **Date of last visit:** |       |

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| **Immunizations** |
| **Are immunizations up-to-date?** | [ ]  Yes [ ]  No  | **Is the immunization record available?** | [ ]  Yes [ ]  No  |
| **Religious/medical exemption?** | [ ]  Yes [ ]  No (parent/guardian must provide a notarized statement) |

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| **Dental** |
| **Does the Child/Youth have a regular dental provider?** | [ ]  Yes [ ]  No  | **Does the Child/Youth wear braces?** | [ ]  Yes [ ]  No  |

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| --- | --- | --- | --- |
| **If yes, name of dental provider:** |       | **Date of last exam:** |       |
| **If braces, name of orthodontist:** |       | **Date of last exam:** |       |

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| **Vision** |
| **Does the Child/Youth wear glasses?** | [ ]  Yes [ ]  No  | **Does the Child/Youth wear contacts?** | [ ]  Yes [ ]  No  |

|  |  |  |  |
| --- | --- | --- | --- |
| **If yes, name of vision provider:** |       | **Date of last visit:** |       |

**This concludes the Well-Being Section.**

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| --- | --- | --- | --- | --- | --- |
| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |

**This information does not go to Health Care Provider.**

|  |
| --- |
| **Education and Independent Living** |
| **Student graduated high school?** | [ ]  Yes [ ]  No [ ]  GED [ ]  HISET [ ]  Student Home Schooled |
| **What school does the student attend? (name, city, county)** |       |
| **Student’s age** |       | **Current grade** |       | **Student receives special education services? [ ]  Yes [ ]  No** |
| **If yes, name the disability** |       |

|  |  |  |
| --- | --- | --- |
| No | Yes |   |
| [ ]   | [ ]   | Is the student taking GED classes  |
| [ ]   | [ ]   | Does the student have a history of skipping school?  |
| [ ]   | [ ]   | Is the student in an alternative school?  |
| [ ]   | [ ]   | Is the student serving a zero tolerance expulsion (drugs, weapons and/or assault)?  |
| [ ]   | [ ]   | Is the student serving a suspension for issues other than zero tolerance? If yes, what is the reason and duration of suspension?       |

|  |  |
| --- | --- |
| **Student strengths (check all that apply)** | **Areas needing improvement (check all that apply)** |
| [ ]  Mathematics | [ ]  Mathematics |
| [ ]  Reading | [ ]  Reading |
| [ ]  Athletics | [ ]  Athletics |
| [ ]  Attendance in school | [ ]  Attendance in school |
| [ ]  Other, specify       | [ ]  Other, specify       |

|  |  |
| --- | --- |
| **Other things you would like to share regarding your student’s schooling?**  |  |
|  |

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| **Presenting and Previous Court Actions on Youth (Unruly/Delinquent Youth only)** |
| **Current Dispositional Information** |       |
| **Disposition Judge** |       | **Special Judge** |       |
| **Current Disposition Court** |       |
| **Current Disposition Decision** |       | **Disposition Date** |       |
| **Have you been or are you currently on probation?** | [ ]  Yes [ ]  No | **If yes, where** |       |
| **Defense Attorney** |       |
| **Current Adjudication Type** |       | **Current Adjudication Date** |       |
| **Adjudicated Charge – Current and Previous** | **Date Occurred** | **Disposition Date** | **Disposition** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Pending Charges** | **Court Date Set** | **Date (if yes)** |
|       | [ ]  Yes [ ]  No |       |
|       | [ ]  Yes [ ]  No |       |
|       | [ ]  Yes [ ]  No |       |
| **Violation of Probation (VOP) or Violation of Valid Court Order (VVCO) *(explain if applicable)*** |
|       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |

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| --- | --- |
| **Narrative** |  |
| **Legal/Probation Services Previously Offered to Child/Youth** |
| **Date** | **Type** | **Outcome** |
|       |  |  |
|       |  |  |
|       |  |  |
| **Safety (Unruly/Delinquent Youth only)** |
| **A) Maltreatment Allegations or Unruly Behaviors/Delinquency** |
| **Other *(explain)*** |  |
| **Narrative** |  |
| **Strengths *(Signs of Safety)*** |  |
| **Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*** |  |
| **B) Domestic Violence** |
| **Narrative** |  |
| **Strengths *(Signs of Safety)*** |  |
| **Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **FSW Name** |  | **Contact #** |  |
| **Office Address** |  |
| **Supervisor** |  | **Contact #** |  |

|  |  |
| --- | --- |
|       |       |
| *DCS / Provider Staff* | *Date* |
| I acknowledge receipt of the Intake, Placement, and Well-Being Information and History. I further acknowledge my legal duty to maintain confidentiality of this information and history and any additional information I may receive pursuant to Tennessee Code Annotated §37-2-415, The Foster Parent Rights Act. |  |
|       |       |
| *Foster Parent* | *Date* |

|  |  |
| --- | --- |
|       |       |
| *Foster Parent* | *Date* |

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| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |
| --- | --- | --- | --- | --- | --- |

**Do not provide this section to the Foster Parent or the Health Care Provider.**

**Has the child/Youth been adopted:** [ ]  Yes [ ]  No**:** **Was the child/Youth in Permanent Guardianship:** [ ]  Yes [ ]  No

**Receiving Adoption Assistance or Subsidized Permanent Guardianship:** [ ]  Yes [ ]  No**:** If yes, **Amount:**

(If yes, immediately notify the Permanency Specialist, Child Welfare Benefits Counselor Regional and Central Office Fiscal Staff).

|  |  |
| --- | --- |
|  **Adoption/Guardianship Completed by DCS:** | [ ]  Ye [ ]  Yes [ ]  No (If no List Name of the Agency)       |
| **Removal Date:** |         | **New Placement:** |       | **Date of Placement:** |       | **Legal Custody Date:** |       |
| **Removal****County:** |       | **Adjudication Type:****Brief Description:** | [ ]  Dependent and Neglect [ ]  Unruly [ ]  Delinquent [ ] N/A      |

|  |  |
| --- | --- |
| **Removal Reason:** | [ ]  Alcohol Abuse (Child); [ ]  Alcohol Abuse (Parent); [ ]  Caretaker Inability to Cope due to Illness or Other: [ ]  Child’s Disability; [ ]  Drug Abuse (Child); [ ]  Drug Abuse (Parent); [ ]  Inadequate Housing; [ ]  Incarceration of Parents; [ ]  NAS Prosecution (only select upon DCS attorney instruction); [ ]  Physical Abuse (alleged/reported); [ ]  Relinquishment; [ ]  Sexual Abuse (alleged/reported); [ ]  Truancy |

|  |  |
| --- | --- |
| **Removal Street Address** |       |
| **City** |       | **County** |       | **State** |    | **Zip Code**  |       |
| **Kinship Exception Request** |
| **Was KER approved?** | [ ]  Yes [ ]  No | **If yes, by whom?** |  |
| **Was the KER temporary or long term?** | **[ ]  temporary [ ]  long term** |
| **MSW Consult was completed with:** |  |

|  |
| --- |
| **Family Information** |
| **Both parents living?** | [ ]  Yes [ ]  No  | **If no, date(s) of death:** |       |
|       |
| **Household income to determine IV-E eligibility: (including SS Benefits, SSI for child, AFDC, Foodstamps, Child Support, etc.) If additional supports are received, please indicate in whose name the payment/support is made.** |       |

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| **Child/Youth Parent(s)/Caretaker(s)****Indicate Parent/Caregiver’s Preferred Method for Receiving Documents** |
| **Birth Mother’s Name** |        | **Primary Caregiver** | [ ]  Yes [ ]  No |
| **Email Address** |       | [ ]  Yes [ ]  No |
| **Maiden Name** |       | **Social Security No.** |       | **DOB** |       | **Message Contact #** |       |
| **Address** |        | [ ]  Yes [ ]  No |
| **City, State, Zip** |       | **Contact #** |       |
| **Employer** |       | **Address** |       |
| **City, State, Zip** |       | **Contact #** |       |
| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |

|  |  |
| --- | --- |
| **Birth mother married when child/Youth was born?**  | [ ]  Yes [ ]  No [ ]  Unable to Determine |
| **Birth mother ever been married?** | [ ]  Yes [ ]  No [ ]  Unable to Determine | **If so, where and to whom?** |       |
| **Birth mother ever been divorced?** | [ ]  Yes [ ]  No [ ]  Unable to Determine | **If so, where and from whom?** |       |
| **Birth mother’s race:** |  |
| **Is there a father listed on the birth certificate?** | [ ]  Yes [ ]  No |
| **Has DNA testing ever been done?** | [ ]  Yes [ ]  No | **If so, what were the results** **and where was it done?** |       |
| **Has there ever been a legal father identified (either mother was married at the time of birth or a father has been legitimated through the court)?** | [ ]  Yes [ ]  No |
| **Legal Father’s Name** |        | **Primary Caregiver** | [ ]  Yes [ ]  No |
| **Email Address** |       | [ ]  Yes [ ]  No |
| **Social Security No.** |       | **DOB** |       | **Message Contact #** |       |
| **Address** |         | [ ]  Yes [ ]  No |
| **City, State, Zip** |       | **Contact #** |       |
| **Employer** |       | **Address** |       |
| **City, State, Zip** |       | **Contact #** |       |
| **Legal Father’s Race:** |  |
| **Marital Status of Parents** | **[ ]  Married** **[ ]  Separated** **[ ]  Divorced** **[ ]  Other** |
| **Putative/Alleged Father’s Name** |       |
| **Email Address** |       | [ ]  Yes [ ]  No |
| **Social Security No.** |       | **DOB** |       | **Message Contact #** |       |
| **Address** |        | [ ]  Yes [ ]  No |
| **City, State, Zip** |       | **Contact #** |       |
| **Employer** |       |       | **Address** |       |
| **City, State, Zip** |       | **Contact #** |       |
| **Putative/Alleged Father’s Race:** |  |
| **Caregiver’s Name *(if different from above)*** |        | **Relationship** |       |
| **Email Address** |       | [ ]  Yes [ ]  No |
| **Social Security No.** |       | **DOB** |       | **Message Contact #** |       |
| **Address** |       | [ ]  Yes [ ]  No |
| **City, State, Zip** |       | **Contact #** |       |

| **Child Name:** |  | **Child DOB:** |  | **Person ID:** |  |
| --- | --- | --- | --- | --- | --- |

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| --- | --- | --- | --- | --- |
| **Employer** |       |       | **Address** |       |
| **City, State, Zip** |       | **Contact #** |       |
| **Relative Contact Person For Child/Youth (other than parent)** |
|  | **Contact #** |       |
| **Relationship** |  |

|  |  |
| --- | --- |
| **Child/Youth Siblings:**  | **In Custody** |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |
| **Name** |       | **SSN** |       | **DOB** |       | **Sex** |  | **Race** |       | [ ]  Yes [ ]  No |