

### CHILD PROTECTIVE SERVICES INTAKE WORKSHEET

<b>1. Type of Report (Check all that apply)</b> <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Medical Neglect <input type="checkbox"/> Mental Injury _____ <input type="checkbox"/> Out of Home Maltreatment <input type="checkbox"/> SFC <input type="checkbox"/> Other _____	<b>2. Priority (Mark X in appropriate box)</b> <table style="margin-left: auto; margin-right: auto; text-align: center;"> <tr> <td></td> <td>A</td> <td>S</td> <td>P</td> </tr> <tr> <td><input type="checkbox"/> High Priority</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 3</td> </tr> <tr> <td><input type="checkbox"/> Med Priority</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td><input type="checkbox"/> Low Priority</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 1</td> </tr> </table>		A	S	P	<input type="checkbox"/> High Priority	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> Med Priority	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> Low Priority	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<b>3. Law Enforcement Notified?</b> <input type="checkbox"/> Yes (List Date) _____  <input type="checkbox"/> No <input type="checkbox"/> N/A Comments: _____	<b>4. Date Received</b>  <b>6. Date Accepted</b>	<b>5. Time Received</b> <p style="text-align: center;"><b>AM</b></p> <b>7. Time Accepted</b>
	A	S	P																	
<input type="checkbox"/> High Priority	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3																	
<input type="checkbox"/> Med Priority	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2																	
<input type="checkbox"/> Low Priority	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1																	
			<b>8. Received by</b>																	

<b>9. CIS Clearance</b>	<b>10. Case Number</b>
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<b>11. Children</b>	Name	Suspected Maltreated	DOB (Age)	Sex/Race	School	Soc Sec Number	Living with
		Yes <input type="checkbox"/> No <input type="checkbox"/>					
		Yes <input type="checkbox"/> No <input type="checkbox"/>					
		Yes <input type="checkbox"/> No <input type="checkbox"/>					
		Yes <input type="checkbox"/> No <input type="checkbox"/>					
		Yes <input type="checkbox"/> No <input type="checkbox"/>					

<b>12. Family</b>	Casehead	Suspected Maltreator	DOB (Age)	Soc Sec Number	Sex/Race		
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
	<b>Primary Client</b>	Home Address			Telephone (home)		
		City	State	Zip	(cell/pager/other)		
		Employer Name			Telephone (work)		
		Employer Address	City	State	Zip		
	<b>Spouse/Paramour</b>	Spouse/Paramour		Suspected Maltreator	DOB (Age)	Soc Sec Number	Sex/Race
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
Home Address			Telephone (home)				
City		State	Zip	(cell/pager/other)			
Employer Name			Telephone (work)				
Employer Address		City	State	Zip			

<b>13. Household Members - Associates Interested Parties</b>	Name/Address	Suspected Maltreator	Relationship	Telephone
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		

<b>14. Child's Whereabouts</b>	<b>15. Directions to Home</b>
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16. Referral Source	Name	Relationship to Child	Telephone
	Address City                  State                  Zip		
17. Referral Information: Describe circumstances of alleged maltreatment, information known about family function, relationship between parent and children, and likely response from the family.			
Collateral Contacts			
19. Worker Comments:			
Worker Signature			Date
18. Validation:	Reason Screened Out:		Accepted - Specify:
Screened Out? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referred for Service - Specify:			Worker Assigned:
20. Supervisor Comments:			
Supervisor Signature			Date