Absentee Shawnee Tribe
Domestic Violence/Sexual Assault/ Family Violence Prevention Intake

Date: _____ Client ID: _____

Referred by: _____

Name: _____
(First) (Middle) (Last) (Maiden Name)

DOB: _____ Gender: _____

[ ] Deaf /Hard of Hearing [ ] Immigrants/Refuge [ ] LGBTQ2S [ ] Veteran [ ] Disabled

[ ] Limited English Proficiency [ ] Other _____ If Other, Please Explain: _____

Address: _____
Street City State Zip Code

Contact # ( ) _____ Alternate Phone: ( ) _____

Race/Ethnicity: [ ] Native American [ ] Black [ ] White [ ] Hispanic [ ] PI [ ] Other

If Native American, What Tribe: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Live-In [ ] Widowed

Do you have any supplemental income: [ ] Yes [ ] No Specify: _____
Employed [ ] Yes [ ] No
Does the abuser know where you work? [ ] Yes [ ] No
Are there any children in common or in the home with the abuser? [ ] Yes [ ] No
Are you a victim of:

[ ] verbal abuse [ ] psychological abuse [ ] sexual abuse [ ] physical abuse [ ] stalking

List children in the chart below:

Name	DOB/Age	Race/Ethnicity	Gender	With whom do they live?	Ever been a victim of SV/DV?

For Office Use Only:

☐ VOCA _____ ☐ FVPSA _____ ☐ OVW _____

Abuser Information

Name: _____

What is your relationship to the abuser? _____

Assault Information (unless police report is available)

Assault Date: _____

Have you reported the assault to the local Police? [ ] Yes [ ] No

Have you filed or would you like to file a restraining order/protective order? [ ] Yes [ ] No

If No, why? _____

_____

Please read or have read to you the following statements. Please acknowledge your understanding of these statements and have the advocate answer any questions you have.

1. I am receiving services from Absentee Shawnee Tribe Domestic Violence/Sexual Assault Program of my own free will.

2. If at any point during my services at the Absentee Shawnee Tribe Domestic Violence/Sexual Assault Program an advocate feels that I am in need of emergency medical attention or emergency mental health attention, I agree to be examined and treated by a physician or mental health professional. I understand that Absentee Shawnee Tribe Domestic Violence/Sexual Assault will not accept responsibility for any expenses incurred.

3. I understand that Absentee Shawnee Tribe Domestic Violence/Sexual Assault advocates are mandatory reporters of child abuse, child neglect, potential suicidal or homicidal tendencies, and any abuse of an elderly or incapacitated adult. These instances over-ride confidentiality.

4. I understand that information related to me, my children and any services received by Absentee Shawnee Tribe Domestic Violence/Sexual Assault Program are protected by State and Federal Laws and are confidential. I understand that at no point shall I release the identity or information of any client or advocate at Absentee Shawnee Tribe Domestic Violence/Sexual Assault Program and if I do so, understand that I may be subject to termination from services and/or legal action.

6. I understand that my services at Absentee Shawnee Tribe Domestic Violence/Sexual Assault Program is determinant upon my ability to follow Absentee Shawnee Tribe rules and the ability to create a non-violent atmosphere free of physical abuse, sexual abuse and verbal abuse. In the event that I violate this statement of understanding, I realize that I will be terminated from services immediately.

8. I understand and agree that I can NOT hold Absentee Shawnee Tribe liable for any injuries sustained by me or my children while receiving services, being transported by Absentee Shawnee Tribe staff or volunteers, or participating in any outdoor or recreational activities. I will NOT hold Absentee Shawnee Tribe liable for any loss of personal property due to theft, disaster, or from a reasonable search and seizure.

With this signature, I am signifying that an advocate has fully explained each document, and answered all of my questions.

_____

Client Signature and/or Authorized Representative Date

_____

Advocate Signature Date

Absentee Shawnee Tribe Domestic Violence Program
Release of Confidentiality

I permit Absentee Shawnee Tribe Domestic Violence/Sexual Assault Program to release and receive information concerning my case to the following person(s) effective the date listed below. I understand that information can only be made available with in the listed time frame below. I also understand that I have the right to rescind this permission in writing at any time.

Name of Client:_____

Name Of Agency Receiving Information:_____

_____

Name and Title of Individual Receiving Information:_____

_____

Purpose of Release:_____

Start Date:_____ End Date:_____

_____ _____
Client Signature and/or Authorized Representative Date

_____ _____
Advocate Signature Date