

LEGAL SERVICES OF NORTH FLORIDA, INC.

FOR OFFICE USE ONLY			Limited English Proficiency (LEP) <input type="checkbox"/>		
Case No. _____	Date _____	Case Code _____	Office _____		
Domestic Violence <input type="checkbox"/> Y <input type="checkbox"/> N	Attorney Assigned _____	Funding Source _____	ACCEPTED <input type="checkbox"/>		
Disclose Client Info <input type="checkbox"/> Y <input type="checkbox"/> N			REJECTED <input type="checkbox"/>		
<input type="checkbox"/> All criteria considered pursuant to Litigation Manual, Page 19. Shelter Referral					

CLIENT INTAKE INFORMATION

Last Name _____	First _____	Middle _____	SEX	RACE	DISABLED
/			<input type="checkbox"/> Female	<input type="checkbox"/> Black	<input type="checkbox"/> Yes
Street Address _____	Mailing Address _____	County _____	<input type="checkbox"/> Male	<input type="checkbox"/> White	<input type="checkbox"/> No
				<input type="checkbox"/> Asian	U.S. VETERAN
				<input type="checkbox"/> Hispanic	
City _____	State _____	Zip _____		<input type="checkbox"/> American Native	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number: _____ / _____			U.S. Citizen or Alien Elig. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Birth: _____ / _____ / _____			I am a citizen of the United States.		
Social Security Number: _____ - _____ - _____			SIGNATURE OF APPLICANT _____ DATE _____		
Number Residing in Household			ADVERSE PARTY: _____		
_____ + _____ = _____					
Adults	Children	Total			

Is your work seasonal? Yes No
 If so, what was your income last year? _____

INCOME

Fill in Amounts Per Month

SOURCE	APPLICANT			SPOUSE			OTHER			TOTAL
	Yes	No	Amount	Yes	No	Amount	Yes	No	Amount	
Employment										
Welfare/SSI										
Soc. Sec.										
Unemployment										
VA										
Other										
TOTAL										

ASSETS

DO YOU OWN (Fill in an amount next to each item.)

If none, list 0)

\$ _____ Cash \$ _____ Bank Accounts
 \$ _____ Equity Value of Real Property (Other Than Residence)
 \$ _____ Equity Value of Personal Property (Boats, Campers, etc.)
 \$ _____ Vehicle (Not Used for Household Transportation/Employment)
 \$ _____ Other
 \$ _____ TOTAL If over assets, is waiver in file? Y N

EXPENSES

Work Transportation: \$ _____
 Child Care/Support: \$ _____
 Medical \$ _____/% of Income _____
 Age/Physical Infirmary \$ _____
 Fixed Debts/Obligations (List) _____

 TOTAL _____

IF YOU HAVE A COMPLAINT OR QUESTION ABOUT THE MANNER OR QUALITY OF SERVICE, OR DENIAL OF SERVICE, YOU MAY ASK FOR REVIEW OF YOUR COMPLAINT UNDER THE PROGRAM'S GRIEVANCE PROCEDURE.

URGENT

Has your DCF Food Stamp,
Medicaid or Welfare office
closed?

or

Cut back on workers or hours?

or

Limited what you can do there?

or

Said you can't see workers there
anymore?

or

Changed the way its office works
now?

If so, let us know! Fill out the information on the back of this form and return it with your application. Fill out what you can, it doesn't have to be completed perfectly.

This information may be shared with Florida Legal Services, Inc., (FLS) in Tallahassee, Florida. We are working together with FLS to figure out how cutbacks are affecting people getting public assistance.

Use the back of the form to write on if you need to.

1. Your name: _____

2. Your address: _____

3. Your phone number: _____

4. Kind of DCF benefits you get (circle all that apply): Food Stamps Welfare Medicaid

5. Are you or someone in your family disabled? If yes, please tell us who is disabled and what disability they have:

6. Can all the adults in your family speak, read and write English? (circle one) Yes No

7. Do you have a computer at home with internet access? (circle one) Yes No

8. Address of your *current* DCF office: _____

9. Did your old DCF office close ? (circle one) Yes No

If you said yes:

A. Tell us where your office **used** to be located: _____

B. Around when did it close? _____

C. Tell us what office you have to go to **now**: _____

D. If this office change is a problem for you, tell us how it is problem:

10. Did DCF cut back on workers at your DCF office? (circle one): Yes No

If you said yes:

A. Tell us what cuts they made and around when they made them:

B. If worker cuts cause a problem for you, tell us how it causes a problem:

11. Did your DCF office shorten office hours or limit what you can do there (like see workers face-to-face) or change in some other way from how the office used to work?

(Circle one): Yes No

If you said yes:

A. Tell us what DCF is doing differently and around when they started doing this:

B. If the change(s) causes a problem for you, tell us how the change(s) causes a problem:

BANKRUPTCY QUESTIONNAIRE

Personal Information			
Name: _____	_____ Married	_____ Divorced	
Address: _____ _____	_____ Single	_____ Spouse	_____ Deceased
Phone: _____	_____ Own home or purchasing		
	_____ Rent		
Number of persons you support, including yourself: _____			

Assets

(List all items, even if you still owe on them)

Instructions: Fill out the assets chart below, using one line for each asset. List collective items together (for example, tables, chairs, and beds, list as "furniture"), except for items worth more than \$500, which must be listed separately. If you need more space, use extra sheets of paper.

ITEM: All cash, money in banks, autos, trailers, boats, furniture, real estate (including houses), farm machinery, appliances, cash value of insurance, money owed by you, and any other thing of value you own or have in your possession. Include things you own or possess by yourself and things you own or possess jointly with any other person, including the spouse.

LOCATION: Where is each item (or group of items) now?

INITIAL COST/VALUE: Cost or value of item when you received it, even if you did not pay for it.

PRESENT VALUE: Value of item now, without deduction for lien or debt.

Item	Location	Initial Cost Value	Present Value

DEBTS

Instructions: Fill out the debts chart below, using one line for each debt. Use extra sheets if needed.

OWED TO: Bank, loan company, credit cards company, person, etc., to which payments are owed

AMOUNT: The total amount remaining to be paid.

OWED FOR: Reason the debt exists (auto purchase, house payment, rent, taxes, personal loans, etc.)

PAYMENTS: Amount of each payment and how often it should be made.

DEBT SECURITY: For each amount owed, list all property mortgaged or pledged. Generally, if a particular property can be repossessed or retaken for failure to pay is secured property.

Owed To	Amount	Owed For	Payments \$ per _____	Debt Security

Income

Yourself
Your Spouse

Others in
Household

Amount Monthly	Source (work, child support, etc.)

Answer all questions: If a question does not apply to you or your situation, place an "X" in the space provided for the answer.

DOMESTIC VIOLENCE CLIENT QUESTIONNAIRE

In order to serve you better, it helps us to know what experiences you may be having now, or had in the past, that could be defined as domestic and/or sexual violence. Below you will find questions that ask you to share with us whether you have had certain experiences. We take these matters very seriously and understand sharing this information may be difficult. Please answer these questions openly as it will help us handle your case in the most effective way possible. **Be assured that this questionnaire is protected by attorney-client privilege and will therefore be kept private and confidential.**

NAME: _____

DATE: _____

1. Has your spouse/significant other ever been physically violent (e.g. hitting, slapping, kicking, pushing, shoving, hair-pulling; restraining, etc.):
 - with you Yes No
 - your children Yes No
 - other people Yes No

2. Has your spouse/significant other ever threatened to cause you physical harm?
 Yes No
If yes, please describe: _____

3. Has your spouse/significant other ever damaged your property? Yes No
If yes, please describe: _____

4. Has your spouse/significant other ever harmed any family pets? Yes No
If yes, please describe: _____

5. Does your spouse/significant other keep you away from family and friends? Yes No

6. Are you afraid to file for divorce, paternity/custody, or for an Injunction for Protection? Yes No

7. Has anyone, including your spouse/significant other, ever done anything sexual to you against your will:
 Yes No
Has anyone ever done anything sexual to you when you were a child? Yes No

8. Have you ever received counseling for domestic and/or sexual violence issues? Yes No

9. Were you referred to our office by Refuge House? Yes No

10. Is it safe for you to receive mail from us at your address? Yes No If no, please provide an alternate address where you can receive mail from us?

11. May we leave messages at your phone number(s)? Yes No If no, please provide us an alternative phone number, where we can leave messages, if one is available. _____

BRAIVE Grant Questionnaire
THE MILITARY GRANT

1. Are you military personnel, family member, or caregiver of a military personnel recently returning from deployment to Afghanistan or Iraq? Yes No
2. Are you military personnel, family member, or caregiver of a military personnel injured as a result of deployment to Afghanistan or Iraq? Yes No
3. Are you a family member of a military personnel deployed or preparing for deployment within 120 days to Afghanistan or Iraq? Yes No
4. Are you a family member of a military personnel killed in action during deployment to or training in Afghanistan or Iraq? Yes No
5. Are you an augmentee or other individual without a typical support structure, family member of an augmentee or other individual without a typical support structure, or caregiver of an augmentee or other individual without a typical support structure deployed to Iraq or Afghanistan? Yes No

Augmentee--An individual who is on special assignment to fill shortage or because of specialized knowledge or skills.

IMPORTANT: include with all paperwork submitted to LSNF for application for legal assistance.