

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	
					<input type="checkbox"/> Hispanic	U.S. VETERAN
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		
				I am a citizen of the United States.		
Date of Birth: _____ / _____ / _____						
Social Security Number: _____ - _____ - _____						
Number Residing in Household				SIGNATURE OF APPLICANT _____ DATE _____		
Adults	+ Children	= Total		ADVERSE PARTY: _____		

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:

APPLICATION FOR DIVORCE

APPLICANT:

Name: _____ SSN: _____

Address: _____
Street City State Zip

Phone Number: _____ Alt. Phone _____ Date of Birth: _____

Employer: _____
 Employer's Address: _____
 Employer's Phone: _____

How long have you lived in Florida? _____ What County? _____

Marital Status _____ Sex _____ Referred by _____

Are you a previous client of Legal Services? _____ Do you have a restraining Order? _____

SPOUSE:

Name: _____ SSN: _____

Address: _____
Street City State Zip

Phone Number: _____ Date of Birth: _____

Employer: _____
 Employer's Address: _____
 Employer's Phone: _____

Give a physical description of your spouse: _____

Is your spouse in the military? Yes No If yes, what branch? _____

APPLICANT and SPOUSE

Income Status:

Wages (Yours) \$ _____ per mo.	S.S.I. \$ _____ per mo.	TANF \$ _____ per mo.
Wages (Spouse) \$ _____ per mo.	Retire/Pen. \$ _____ per mo.	Stu. Grant. \$ _____ per mo.
Wages (Other Household Member) \$ _____ per mo.	Unemp. Ben. \$ _____ per mo.	Child Supp. \$ _____ per mo.
	Social Security \$ _____ per mo.	VA Retire. \$ _____ per mo.

Date of Marriage: _____ / _____ / _____ Place of Marriage: _____
Mo. Day Yr. City State

Date of Separation: _____ / _____ / _____ If not separated, explain why: _____

CHILDREN:

How many children do you and your spouse have together (including adopted children) ? _____

List those children below:

<u>NAME</u>	<u>DATE OF BIRTH</u>	<u>SEX</u>	<u>PLACE OF BIRTH</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List the addresses and dates (month and year) where each child above has lived for the last FIVE (5) years. Be as complete and accurate as possible. (Use another sheet, if necessary.)

<u>Mo./Yr.</u>	<u>To</u>	<u>Mo./Yr.</u>	<u>Street Address</u>	<u>City/State</u>	<u>Name of Children Who Lived There</u>	<u>Name & Relationship of Adults Child(ren) Lived With</u>
_____	_____	_____	_____	_____	_____	_____

<u>Mo./Yr.</u>	<u>To</u>	<u>Mo./Yr.</u>	<u>Street Address</u>	<u>City/State</u>	<u>Name of Children Who Lived There</u>	<u>Name & Relationship of Adults Child(ren) Lived With</u>
_____		_____	_____	_____	_____	_____
_____		_____	_____	_____	_____	_____
_____		_____	_____	_____	_____	_____

Have any of these children been the subject of any custody case? Yes No
 If yes, where and when? _____

Who are the children presently living with? _____
 Do you need child support? _____ Are you receiving child support? _____
 How many children do you have that are not your spouse's? _____
 Are you pregnant? Yes No If yes, is your husband the father? _____

PROPERTY:

Are you or your spouse buying or own real property? Yes No
 If yes, who name is on the title/deed? _____

Was it purchased before the marriage or during the marriage? _____

Where is the property located? City: _____ County: _____ State: _____

Do you or your spouse jointly own any personal property (i.e., furniture, jewelry, TV, etc.)? Yes No
 If yes, list all personal property purchased during the marriage:

If you or your spouse own any automobiles (car, truck, etc.) Or a mobile home, please list them below:

<u>Make/Model</u>	<u>Year</u>	<u>Name(s) on the Title</u>	<u>Who Has Possession</u>
_____	_____	_____	_____
_____	_____	_____	_____

DEBTS:

Do you and your spouse have any debts (owe money to anyone) jointly or separately? Yes No
 If yes, list all debts (use additional sheet if more space is needed):

<u>Owed To (Person or Business)</u>	<u>Amount Owed</u>	<u>Name on Debts</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

CRIMINAL RECORD:

Do you have a criminal record? Yes No If yes, explain: _____

Have you ever been charged with sexual or physical abuse (include any investigations by DCF)? Yes No
 If yes, please explain:

Has your spouse ever been charged with sexual or physical abuse (include any investigations by DCF)? Yes No
 If yes, please explain:

MISCELLANEOUS:

Have you consulted or hired another attorney? _____ If yes, who is it? _____
 Do you want your maiden name back? _____ If yes, maiden name is: _____
 Is there any possibility of you and your spouse getting back together? Yes No

 SIGNATURE Date

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.