

**Extended Family Support Program Intake Protocol  
Needs Assessment**

Provider: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Client: \_\_\_\_\_ SCR ID#: \_\_\_\_\_

**Reason Services Were Requested**

- Parent's whereabouts are unknown
- Parent is deceased
- Parent is incarcerated
- Parent is physically and/or mentally unable to care for the children
- Parent's substance use diminishes their capacity to care for the children
- Other: \_\_\_\_\_

**Services Requested**

**Service Date**

- \_\_\_\_\_ Assistance obtaining guardianship
- \_\_\_\_\_ Assistance enrolling my relative's child in my local school district
- \_\_\_\_\_ Assistance obtaining the IDHS child only grant
- \_\_\_\_\_ Assistance obtaining daycare
- \_\_\_\_\_ Assistance obtaining medical benefits, SNAP or other entitlements
- \_\_\_\_\_ Assistance obtaining beds for my relative's child
- \_\_\_\_\_ Assistance obtaining dressers, clothes or other items for my relative's child
- \_\_\_\_\_ Assistance obtaining adequate housing
- \_\_\_\_\_ Assistance obtaining counseling for my relative's child
- \_\_\_\_\_ Assistance obtaining assistance from kinship support groups
- \_\_\_\_\_ Assistance obtaining IDOA services for Older caregiver
- \_\_\_\_\_ Provide list of service providers in area
- \_\_\_\_\_ Referral for community services: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

**Please have the client read the following:**

**"I have received a copy of the EFSP brochure and understand the services offered."**

\_\_\_\_\_  
Client Signature Date

Caseworker: \_\_\_\_\_ Phone #: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**"We, the caseworker and supervisor, have not altered this form after the client signed it except to enter service dates and our contact information in the space provided above and our signatures below."**

\_\_\_\_\_  
Caseworker Signature Date

\_\_\_\_\_  
Supervisor Signature Date