LEGAL SERVICES OF NORTH FLORIDA, INC.

FOR OFFICE USE ONLY — Limited English Proficiency (LEP) ☐

Case No. ______________________________ Date ________________ Case Code _________ Office________

Domestic Violence ____ Y ____N Attorney Assigned ____________ Funding Source _________ ACCEPTED ☐

Disclose Client Info ____Y ____N REJECTED ☐

☐All criteria considered pursuant to Litigation Manual, Page 19. Shelter Referral ________________

CLIENT INTAKE INFORMATION

____
Last Name First Middle

________________/_______________________
Street Address Mailing Address County

____
City State Zip

Phone Number: _____________/_______________
1st 2nd

Date of Birth: _______/_______/______________

Social Security Number: ______ - ______ - ______

Number Residing in Household

____________ + ___________ = ____________
Adults Children Total

SEX

☐ Female
☐ Male

RACE

☐ Black
☐ White
☐ Asian
☐ Hispanic
☐ American Native

DISABLED

☐ Yes
☐ No

U.S. VETERAN

☐ Yes ☐ No

U.S. Citizen or Alien Elig. ☐ Yes ☐ No

I am a citizen of the United States.

_____________________________ ________________
SIGNATURE OF APPLICANT DATE

ADVERSE PARTY: ___________________________

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

INCOME

Fill in Amounts Per Month

SOURCE	APPLICANT Yes	No	Amount	SPOUSE Yes	No	Amount	OTHER Yes	No	Amount	TOTAL
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 Infirmity $__________
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.

INTAKE FACT SHEET

(This **MUST** be filled out in order for us to review your case.)

Name: ________________________________ Date: ___________________________

Type of Case: (Please check category, answer questions, and explain details of the problem below.)

□Bankruptcy	□Employment	□Visitation	□Custody
□Property	□Divorce	□Guardianship	□Landlord/Tenant
□Child Support	□Power of Attorney	□Contract	□Will
□Purchase of Goods	□Social Security/SSI	□Probate	□Adoption
□Emancipation	□Collections	□Tax Issue	□Other____________________

Do you wish to obtain advice only? □YES □NO

Have you received a Summons? □YES □NO If yes, give date of service: __________________

Is this case and/or any parties involved **OUTSIDE** the State of Florida? □YES □NO

If yes, please explain:____

*For **Social Security** Cases Only: Are you at the appeals level? □YES □NO

DETAILS (Please explain the situation or problem **COMPLETELY**.)___________________________

____

____

____

____

____

____

____

____

____

____

____**(if necessary, use reverse side)**

Person being sued or person suing you (Opposing Party):____________________________________

____

List any legal documents you have regarding this matter and attach copies: ________________________

____

____

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:

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.