

Social Services Intake

Date: _____ Time: _____ Name of individual taking down information: _____

Reporter Information:

Reporter Name: _____ Relationship to Subject(s) of Report: _____

Reporter Phone Number: _____ Best time(s) to be reached: _____

Reporter Address: _____

Eligibility for Protective Services:

Adults and Children over 1 year of age:

1) Is the Subject of this report an enrolled member of a federally recognized tribe: Y N*

2) Does the Subject of this report live in a designated service area: Y N*

**If one or more questions are checked "No" the Subject of this report is not eligible for services.*

Is the Subject of this report eligible for services: Y N

Unenrolled newborns up to 1 year of age:

1) Is the Subject of this report eligible for enrollment? Y N**

2) Are the parents tribal members? Y N**

3) Is the Subject of this report identified as drug affected or in need of protection? Y N**

4) Does the Subject of this report live in a designated service area: Y N**

***If one or more questions are checked "No" the Subject of this report is not eligible for services.*

Is the Subject of this report eligible for services: Y N

If determined ineligible for services:

Refer reporter to appropriate contacts to make the report. Document which service(s) you referred the reporter to:

Montana Child Abuse Hotline: 866-820-5437

Montana Adult Protective Services: 800-551-3191

Montana Public Assistance Helpline: 888-706-1535

Other: _____

Social Services Intake

Subject(s) of This Report (Adult or Child(ren)):

Name	Address (include specific information that would help caseworker find the house)	Age	Sex	Enrolled in school (if applicable)	School	Grade
				<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> Y <input type="checkbox"/> N		

Household Composition and Person(s) Responsible for Care:

Name	Age	Sex	Relationship to Subject(s) of Report	Phone Number	Is this person responsible for the care of Subject(s) of Report?
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N

Alleged Offender(s):

Name: _____

Relationship to Subject(s) of Report: _____

Address: _____

Phone Number: _____

Name: _____

Relationship to Subject(s) of Report: _____

Address: _____

Phone Number: _____

Social Services Intake

Cross Referral to Local Law Enforcement:

Date: _____ Time: _____ Name of individual sending cross referral: _____

Supervisor or caseworker to contact for follow-up: _____ Phone number: _____

Cross Referral to Federal Bureau of Investigation (FBI):

Date: _____ Time: _____ Name of individual sending cross referral: _____

Supervisor or caseworker to contact for follow-up: _____ Phone number: _____