

INTAKE FORM

An intake form is to be completed by each parent and returned prior to the commencement of contact service. Please fill out this form and return it to contact@supervisedservices.com.au

Applicant full name

Address

Phone

Email

Post code

State

Child name (1)

Date of Birth

Child name (2)

Date of Birth

Child name (3)

Date of Birth

Child name (4)

Date of Birth

Child name (5)

Date of Birth

Child name (6)

Date of Birth

Relationship of Applicant to Child(ren)

Mother Father

Other (please specify)

Employment status: Please indicate

Full time Part time Casual

Pensioner/Centrelink Self employed

Other

Ethnicity & language other than english

Ethnicity

Language spoken other than English

Are you aboriginal or Torres Straight Islander Origin

No

Yes Aboriginal

Yes Torres Straight Islander

Prefer not to answer

Do you speak English? Yes No

Do you require an interpreter Yes No

If YES, specify type of interpreter required

Do you have a disability?

Yes No

If YES, Please specify

Do you need someone to help you with or be with you for certain activities (eg. Body movement activities)

Yes No

If YES, Please specify

Legal Representation

Name of Solicitor

Name of Law Firm

Postal Address

Phone

Email

Other parent/carer full name

Address

Phone

Email

Post code

State

Relationship to Child(ren)

Mother Father

Other (please specify)

Other parent/carer Legal Representation

Name of Solicitor

Name of Law Firm

Postal Address

Phone

Email

Has the child(ren) been the subject of child protection involvement by a state welfare authority?

Yes No

If YES, please list reasons for child protection involvement

Is there a current child protection involvement by a state child welfare authority?

Yes No

If YES, please provide Child Protection practitioners details

Name of Law Firm

Postal Address

Phone

Email

Disclaimer and signature

I certify that my answers are true and complete to the best of my knowledge. I agree that I will pay the costs into Supervised Service's bank account 24 hours prior to the Session.

Signature

Date

Account name: Supervised Services

BSB: 013 352

Account number: 169801268

Child Information

Number of children to be supervised for contact

Child 1

Name of Child 1

Date of Birth

Age

Gender

Ethnicity

Language spoken other than English

Address

Is an interpreter required? If so, what language?

Post code

State

Does the other parent/carer speak English?

Does the child have a disability? if so, please specify.

Is Child 1 Aboriginal or Torres Strait Islander?

No

Yes Aboriginal

Yes Torres Strait Islander

Prefer not to answer

Child's Legal Representation

Name of Solicitor

Name of Law Firm

Postal Address

Phone

Email

Has Child 1 been the subject of child protection involvement by a state welfare authority? Yes No

Is there current child protection involvement by a state child welfare authority? Yes No

If YES, please list reasons for child protection involvement

Parenting Arrangements

Are there any interim or final parenting orders? **If Yes, please attach a copy of existing parenting orders to your application.** Yes No

Who does the child live with?

What are your current arrangements for time with the child(ren)?

When was the last time you had contact with the child(ren)?

Medical Information

Does the child take any prescribed medication? Yes No

If YES, please specify type and frequency of medication.

Will the medication be required during the supervised contact? Yes No

What arrangements have been made for the supervised parent to administer the medication?

Please note that the supervisor is not responsible for administering medication. Arrangements for medication must be made between the parents before contact occurs and is required to be documented by a legal representative of either parent.

Child 2

Name of Child 2

Date of Birth

Age

Gender

Ethnicity

Language spoken other than English

Address

Is an interpreter required? If so, what language?

Post code

State

Does the other parent/carer speak English?

Is Child 2 Aboriginal or Torres Strait Islander?

No

Yes Aboriginal

Yes Torres Strait Islander

Prefer not to answer

Does the child have a disability? if so, please specify.

Child's Legal Representation

Name of Solicitor

Name of Law Firm

Postal Address

Phone

Email

Has Child 2 been the subject of child protection involvement by a state welfare authority? Yes No

Is there current child protection involvement by a state child welfare authority? Yes No

If YES, please list reasons for child protection involvement

Parenting Arrangements

Are there any interim or final parenting orders? **If Yes, please attach a copy of existing parenting orders to your application.** Yes No

Who does the child live with?

What are your current arrangements for time with the child(ren)?

When was the last time you had contact with the child(ren)?

Medical Information

Does the child take any prescribed medication? Yes No

If YES, please specify type and frequency of medication

Will the medication be required during the supervised contact? Yes No

What arrangements have been made for the supervised parent to administer the medication?

Please note that the supervisor is not responsible for administering medication. Arrangements for medication must be made between the parents before contact occurs and is required to be documented by a legal representative of either parent.

If there are more than two children, please attach extra pages answering the questions above for each child.

Please provide copies of current court orders including handwritten minutes

Parenting orders

Intervention orders

Children's court orders

Corrections orders

Indicate date of when service is required to commence?

Have you previously used any other supervision/contact agency? Yes No

If YES,

Name of Agency

Phone

Email

Reason for change of Agency

Current and Historical History of Concerns

Please indicate if the child(ren), parents or carer has been at risk of harm due to one or more of the following risk factors.

Family Violence	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Stalking Behaviour	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Mental Health	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Substance Abuse (alcohol and/or Drugs)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Access to or Possession of Firearms	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Assault of Family Members	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Criminal Charges/Convictions	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Intervention Orders	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Brrached Court Orders	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>

If you have answered yes to any of the above, please provide further details.

Please include facts, incident, date, persons involved and if the concern was reported to an external authority.

Disclaimer and signature

I certify that my answers are true and complete to the best of my knowledge. I agree that I will pay the costs into Supervised Service's bank account 24 hours prior to the Session.

Signature

Date