



ELEVATE SURVIVORS & ALLIES (ESA)

SERVICE NEEDS INTAKE FORM (CONFIDENTIAL)

Independently Operated - Survivor-Led • Trauma-Informed • Community-Centered

This form helps ESA understand what support you want and what services you need. You can skip any question you don't want to answer.

SECTION 1 — BASIC INFORMATION

Date: ____ / ____ / ____

Intake Completed By (Staff/Mentor Name): _____

Participant Name (or Initials): _____

Preferred Name: _____

Pronouns (optional): _____

Age: _____ 14-17 18-24 25-34 35-44 45+

Phone: _____ Email (optional): _____

Safe way to contact you: Call Text Email No contact right now

Safe time to contact you: _____

Current Location (City/County): _____

Best language for services: English Spanish Other: _____

SECTION 2 — SAFETY CHECK (RIGHT NOW)

Are you safe right now? Yes No Not sure

Do you feel in danger from someone? Yes No

Do you need immediate help today? Yes No

If YES to immediate help, what do you need right now? (check all that apply)

- Safe shelter
- Emergency transportation
- Police/protection order support (*only if you want*)
- Medical care today
- Crisis emotional support
- Food/water
- Other: _____

Notes (optional):

SECTION 3 — WHAT BRINGS YOU TO ESA?

Which best describes what you're currently dealing with? (check all that apply)

- Human trafficking
- Domestic violence
- Sexual exploitation
- Sexual assault
- Stalking
- Housing instability/homelessness
- Substance use concerns
- Mental health / emotional distress
- Family conflict
- Legal issues
- Other trauma(s): _____

SECTION 4 — SERVICES NEEDED (SELECT ALL THAT APPLY)

A) Immediate Basic Needs

- Food
- Clothing
- Hygiene items
- Safe phone/minutes
- Transportation support
- Temporary safe place/shelter referral
- Safety planning
- Other: _____

B) Crisis Support & Stabilization

- Crisis de-escalation support
- Grounding tools/coping support
- Safety planning & risk screening
- Help make a plan for the next 24–72 hours
- Other: _____

C) Medical & Behavioral Health

- Medical care referral
- Mental health counseling referral
- Psychiatric services referral
- Substance use treatment referral
- Support attending appointments
- Other: _____

D) Housing & Stability

- Emergency shelter referral
- Transitional housing referral
- Rapid rehousing resources
- Help with applying for housing programs
- Support communicating with shelters/landlords
- Other: _____

E) Legal & Advocacy

- Protection order support
- Court accompaniment
- Victim advocacy services
- Immigration support referral
- Criminal justice support/safety planning
- Help with ID/documents
- Other: _____

F) Employment, Education & Life Skills

- Job readiness support
- Resume support
- GED/School support
- Training/workforce programs
- Budgeting / financial coaching
- Transportation planning
- Other: _____

G) Survivor-Led Mentoring & Support

- One-on-one mentoring
- Survivor support group
- Peer support
- Confidence building & goal setting
- Healthy relationships & boundaries
- Other: _____

H) Ongoing Care Coordination

- Help connecting to services
 - Follow-up check-ins
 - Warm handoffs to partner agencies
 - Help create a personal support plan
 - Other: _____
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SECTION 5 — TOP PRIORITIES

What are your top 3 needs right now?

1. _____
2. _____
3. _____

What would feel most helpful this week?

SECTION 6 — BARRIERS (WHAT MAKES IT HARD TO GET HELP?)

Are any of these barriers impacting you? (check all that apply)

- No transportation
 - No phone / limited minutes
 - Unsafe living situation
 - Fear of retaliation
 - No ID/documents
 - Childcare needs
 - Language barrier
 - Mental health challenges
 - Substance use challenges
 - No insurance
 - Past negative experience with services
 - Other: _____
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SECTION 7 — PREFERRED SUPPORT STYLE

How would you like ESA to support you? (check all that apply)

- Just information/resources today
- Help making calls together
- Warm handoff (ESA connects me directly)
- Accompaniment/support to appointments
- Weekly check-ins
- Biweekly check-ins
- Mentoring support
- Other: _____

Preferred meeting format: In-person Phone Virtual

Days/times that work best: _____

SECTION 8 — CONSENT & CONFIDENTIALITY

Do you consent to ESA providing services and support?

Yes No

Do you consent to ESA contacting you for follow-up?

Yes No

If yes, preferred method: Call Text Email

Do you consent to ESA coordinating with partner agencies to support your needs?

Yes No

If yes, agency name(s) (optional): _____

Signature (Participant or Initials): _____ Date: // _____

SECTION 9 — ESA STAFF USE ONLY

Intake Type: Outreach Walk-in Referral Phone Virtual

Referral Source: _____

Risk Level (non-clinical): Low Moderate High (*escalate*)

Immediate Actions Taken Today:

Referrals Provided / Warm Handoffs Completed:

Follow-Up Plan (who/what/when):

Staff Signature: _____ Date: _____

Please Share Any Additional Info That May Help Us Serve you Better.