



## Private Agency Low-Risk Child Visitation Intake Form

Purpose: This Intake Form is used by Coffs Coast Contact Services to determine eligibility for low-risk private contact visitation involving children. This service is voluntary and does not replace court authority or legal advice. This is a Fee for Service Childrens Contact Centre and is non government funded.

This form represents the first step in the intake process with Coffs Coast Contact Services. All negotiations, including those involving legal representatives, must be finalised prior to commencing this process. Completion of this form by both parties is required before Coffs Coast Contact Services can provide services. The form takes approximately 20 minutes to complete.

### 1. General Case Information

**Date of Intake:** \_\_\_\_\_

**Referral Source:** \_\_\_\_\_

### 2. Child Information

**Child Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Primary Residence:** \_\_\_\_\_

**Does the child identify as Aboriginal or Torres Strait Islander**

\_\_\_\_\_

### 3. Parent / Guardian Information (Party 1 is the Booking Party)

**Parent 1. / Guardian Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Legal Representatives Name and Firm** \_\_\_\_\_

**Email Address**

\_\_\_\_\_

**Parent 2. / Guardian Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Legal Representatives Name & Firm** \_\_\_\_\_

\_\_\_\_\_

**Email Address**

\_\_\_\_\_

(NB: Addresses will not be shared with the other parent)

#### **4. Visitation Details**

**Requested Schedule:** \_\_\_\_\_

\_\_\_\_\_

**Proposed Start Date/s:** \_\_\_\_\_

\_\_\_\_\_

**Proposed Location(s):** \_\_\_\_\_

\_\_\_\_\_

**\*Who is responsible for bringing essential items such as food and pram, sunscreen etc? Are there any special instructions?**

\_\_\_\_\_

#### **5. Low-Risk Screening (Enter Yes or No)**

**Any history of physical abuse?** \_\_\_\_\_

**Any history of sexual abuse?** \_\_\_\_\_

**Any protective orders in place?** \_\_\_\_\_

**Any CPS involvement?** \_\_\_\_\_

**Any criminal matters related to safety?** \_\_\_\_\_

**Any substance use concerns?** \_\_\_\_\_

**Any mental health concerns impacting safety?** \_\_\_\_\_

**Any prior visitation safety issues?** \_\_\_\_\_

**Details / Explanation (if any):**

\_\_\_\_\_

#### **6. Acknowledgements - Intake Office to read.**

1. I confirm that the information provided is accurate and complete.
2. I understand this is a private agency service and participation is voluntary.
3. I understand this service is intended for low- med risk situations.
4. I agree to follow all agency policies and safety guidelines.
5. I acknowledge this agency does not provide legal advice or make custody determinations.
6. I understand my booking day and time might not be available.
7. I understand my Visitation will not go ahead until Payment is received via Bank Deposit.
8. I understand the Intake Fee is non refundable if the visitation does not go ahead.
9. I understand Reports are Observational

designed for Low Risk visitations and are not investigative. 10. I understand Mobile phones must be switched off and there is to be no recording of the visit. 11. I understand once a Report is written it becomes non confidential to approved legal representatives and others involved in the process. 12. I understand all attendees must show some form of ID on Visitation arrival. 13. I understand coordination with all parties to ensure clarity and consistency is attempted however the Contact Centre will not be able to reflect unknown information within the context of the Visitation. 14. I understand attempts will be made to record the most relevant observations and some observations will be missed or not included. 15. I understand the ideas and expectations of the client/s and the CCS may often be conflicting and the service may not be able to offer exactly what each party requires or expects.

#### 7. Who is Paying the Intake Fees and Report fees?

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#### 8. Do you require a Report ?

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#### 9. Do you agree the Report will be sent to both parties legal representatives.

Y/N

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#### Payment Details

Account Name - Coffs Coast Contact Services

BSB- 637000

AC Number - 727982604

#### 9. Signatures

Parent 1. / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent 2. / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### 10.What is the purpose or goal/s of this visitation? List three.

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#### 11. OFFICE USE

Intake Form Completed by

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Date:

**Notes:**

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## **WHAT NEXT**

- **After your follow-up call, you'll receive a Service Agreement for signature outlining the roles and responsibilities of all parties (including the Coffs Coast Contact Services Monitor), payment terms, our cancellation policy, and circumstances where services may be terminated.**
- **Once the agreement is signed, we'll provide a proposed schedule for visits or changeovers based on your availability.**
- **After you confirm the schedule, a supervisor will be allocated and visits arranged, with regular updates provided throughout the process.**