Child Safe Visitations
Intake Application

Please complete to the best of your ability in English

Date_____

Applicant's Legal Information

Name:		
Case number:	Case Name:	Courtroom Number:
Court Location/County:	Number of Court Hearings attended so far:	
Next Court Hearing Date:	Restraining Order: **YES** **NO**	How Long?
Do you have an Attorney? **YES** **NO**	Attorney's Name:	Phone:
Attorney's Address:	Attorney's Email Address:	
City:	State:	ZIP Code:
Do you have a Social Worker? **YES** **NO**	Social Worker Name:	Phone:

Applicant's Personal Information

Specify Relationship to Child(ren): (circle one) **MOTHER** **FATHER** **LEGAL GUARDIAN**		
Status of relationship with other parent: (circle one) **DIVORCED** **SEPERATED** **NEVER MARRIED**		
Date of Marriage:	Date of Separation/Divorce:	
Do you have contact with other party? **YES** **NO**		
Current Address:		
City:	State:	ZIP Code:
Phone:	E-mail:	Best time to reach you:
Vehicle Make/Model:	Plate #:	Vehicle Color:
Occupation:	Employer:	
Address:		

City:	State:	ZIP Code:	Phone:

Cultural Information (This section is for cultural sensitivity purposes)

Religious Preference:	Language spoken other than English:

Race / Ethnicity: (circle one) WHITE (NON-HISPANIC) HISPANIC AFRICAN AMERICAN ASIAN MIDDLE EASTERN

NATIVE AMERICAN BI-RACIAL, SPECIFY OTHER, SPECIFY

Emergency Contact

Name of a person not residing with you:			
Address:			
City:	State:	ZIP Code:	Phone:
Relationship:			

Child(ren) Information			
Child #1 Name:			
Date of Birth:	Gender:	Age:	
Address:			
City:	State:	ZIP Code:	
Height:	Weight:	Hair Color:	Eye Color:
Diet Restrictions or Food Allergies: (please explain)			
Medical Conditions:			
Doctor Name:	Phone Number:		
Child #2 Name:			
Date of Birth:	Gender:	Age:	
Address:			
City:	State:	ZIP Code:	
Height:	Weight:	Hair Color:	Eye Color:
Diet Restrictions or Food Allergies: (please explain)			
Medical Conditions:			
Doctor Name:	Phone Number:		
Child #3 Name:			
Date of Birth:	Gender:	Age:	
Address:			
City:	State:	ZIP Code:	
Height:	Weight:	Hair Color:	Eye Color:
Diet Restrictions or Food Allergies: (please explain)			
Medical Conditions:			
Doctor Name:	Phone Number:		

*For Additional Children Please Use the Back of This Sheet

Signature & Authorization	
I authorize the verification of the information provided on this form. I have received a copy of this application.	
Signature of Applicant:	Date:
Print Name:	
Signature of Monitor:	Date:

*Notes: