



Phone Number for Intake: 318-232-2232  
Fax Number: 318-301-3734  
Email Address: admin@thedragonflyharbor.org

### Services Request Intake

Note: This information is confidential and will be used by the staff at The Dragonfly Harbor only.

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#### Contact Information

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Client Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Client Telephone number: \_\_\_\_\_

Can messages be left at this number? Yes \_\_\_\_\_ No \_\_\_\_\_

Is text available at this number? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Are you a survivor of?

- Sex Trafficking
- Labor Trafficking
- Both
- Other \_\_\_\_\_

Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Relation: \_\_\_\_\_

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

Please note that the Emergency contact person will be called by the office if needed for emergency purposes.

Do we have permission to mail you materials? Yes \_\_\_\_\_ No \_\_\_\_\_

## Survivor Services/Needs Checklist

### Services

- Trauma Focused Mental Health Counseling
- Case Management
- Financial Literacy Program
- Parenting Classes
- Life Skills
- Referral for Medication Management
- Job/Career Assistance
- Educational Assistance
- Housing Assistance
  - Emergency Housing
  - Short Term Housing
  - Transitional Housing
- Program Referral
  - \_\_\_\_\_
- Coordination of Care with other agencies or providers
- Help applying for assistance such as SSI, Food stamps, Medicaid, etc.
- Accommodations or Language Assistance
  - \_\_\_\_\_

### Needs

- Hygiene Bag
- Household goods
- Help with essentials - food, utilities, etc.
- Help with essential fees or deposits

Services Already in Place: Please select any of the following services that you are already receiving

- Housing Assistance
- Medication Management
- Trauma focused counseling
- Food Stamps/food assistance
- SSI/Disability
- Insurance/Medicaid
- Other \_\_\_\_\_

Please provide any additional information regarding services or needs selected above that may help us serve you well:

Do you have insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please provide insurance information if needing case management or counseling services. If you need help applying for medicaid, please state that below.

#### Insurance Information

Primary Insured Person: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to client: \_\_\_\_\_ SSN# \_\_\_\_\_  
Insurance company: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group # if applicable: \_\_\_\_\_  
Customer Service Number: \_\_\_\_\_  
Guarantor (Policy holder): \_\_\_\_\_

#### Coordination of Care

We strive to provide the best quality treatment possible for our clients. We recognize that this may be achieved through coordination of care efforts and a team approach. Better care can be provided when providers work together. We ask that you disclose other providers that may need to be an important part of your treatment team. Release of Information Forms are available to help us coordinate care efforts with these providers. Please note that some agencies may be able to request information without your consent and we are required to comply such as DCFS or other court involved or appointed individuals.

Name and number of Primary Care

Physician: \_\_\_\_\_

Name and number of Psychiatrist or other medication management provider:

\_\_\_\_\_

Government, Legal, or other Agencies which may be involved and need collaboration from us. Please check all that apply and provide names and contact info as applicable:

- DCFS

Name of worker: \_\_\_\_\_

Contact info: \_\_\_\_\_

- OJJ

Name of worker or court contact: \_\_\_\_\_

Contact info: \_\_\_\_\_

- FINS

Name of case manager: \_\_\_\_\_

Contact info: \_\_\_\_\_

- CASA

Name of advocate: \_\_\_\_\_

Contact info: \_\_\_\_\_

- Mental Health Attorney or Other attorney

Name of attorney: \_\_\_\_\_

Contact info: \_\_\_\_\_

- Probation Officer

Name of officer: \_\_\_\_\_

Contact info: \_\_\_\_\_

- Other agency or resource such as wrap around, etc.

\_\_\_\_\_

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### Disability, Accommodation, or Language Services

Please let our office know if you need accommodations for any disabilities or necessary accommodations that may apply. Please let us know if you need interpretation or translation services to be able to receive the service you require. We will do our best to serve you or find resources and services if possible to provide the best experience we can.