

HEALING HEARTS OF FAMILIES U.S.A. MINISTRIES INC.



OUTREACH OFFICE: 2071 McAfee Road Decatur, GA 30032
404-289-5277

INTAKE (HELP)

Date: _____
Name: First _____ Last _____ Middle _____

Address: _____ If unhoused *Last day lived here:* _____

City: _____ State: _____ Zip: _____

☐ Self ☐ Guardian informal ☐ Guardian Court Temp or ☐ Permanent ☐ Foster

Contact Number (s) Ph: _____ **D.O.B.:** _____ **SS # or last 4** _____

☐ Born Male ☐ Born Female ☐ Other adults with you _____ How many children? _____

Are you Male ☐ Female ☐ Other Identifier ☐ _____

Child(ren) in your care-How many Boys: _____ Ages: _____ / Girls: _____ Ages: _____

Is the primary caregiver of the children incarcerated ☐ Yes ☐ No

Check all that apply, I currently live in an: ☐ -Apartment ☐ -Home ☐ -Shelter ☐ - I am Homeless One night or more / ☐ - Alone ☐ with partner ☐ With Children ☐ With parent ☐ Staying with Friends/Relatives ☐ Was Incarcerated released homeless when? _____

This was a referral from: ☐ My-Self ☐ Agency _____ ☐ Site _____

☐ Friend/ Neighbor Name: _____ Contact Number: _____

Faith Organization or ☐ Program Site ☐ Name: _____

History: Domestic Violence: ☐ Yes / ☐ No / **Previous Incarceration:** ☐ Yes ☐ No

I need help with: ☐ CHILDCARE ☐ CLOTHING ☐ FOOD ☐ FURNITURE ☐ EMPLOYMENT
☐ FINANCIAL ☐ HEALTH CARE ☐ HOUSING ☐ JOB SKILLS ☐ LEGAL ☐ STORAGE
☐ TRANSPORTATION ☐ ID Type: _____ ☐ SAFE SHELTER FOR SELF ☐
CHILDREN ☐ OTHER: _____

Describe incident or problem that led to your need for assistance: _____

(*We Complete this part*) Recommendation/Plan: _____

Intake by: _____

Date: _____



Consumer Name: _____ Pg 2

COMPLETE ONLY PARTS THAT APPLY OR PLACE N/A IF NOT

Have you (the person needing help) used drugs or alcohol in the past 3 months? Yes () No ()

INCOME: Are you working? Yes () No () Where? _____

Hours week _____ Income: _____ Monthly Bills total: _____

Do You have transportation Yes () No ()

Have you ever had children removed from your home Yes () No () Agency: _____

Who currently cares for your children? _____ Relationship: - _____

Do you have a relationship with caregiver of your child(ren) ()Y () No () N/A

1.) Name: _____ Phone: _____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

YOUR EMERGENCY CONTACT

2.) Name: _____ Phone: _____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

Do you think it would benefit you to have someone to help guide your plans and family matters during the resolution/transition process? () Yes () No () Don't Know

Describe your normal day: I wake up at: _____ am/pm and do what? I _____

I go to bed between list the (time) _____. And _____

I have the following regular appointments: On _____ at _____ and on _____ at _____ with _____. () Dr. () Psychologist () School

What would I think would really help me in the next 3-4 months is: _____

I understand and agree that my information in part will be shared only with organizations that may provide assistance to me and/or my family and I agree to have it shared. _____ () Yes () No

Consumer Signature

Date

Do not complete below here-- Intake Coordinator: _____ Date: _____

Accepted? () Yes () No Fee if any: \$ _____ Completed Program? () Yes () No

Rejected Reason: _____ Date: _____

Print-Referred by: _____ Title: _____, Agency: _____ Phone: _____

() Prison () Faith Organization () Fiscal Sponsor Other: _____

Outreach office Address: 2071 McAfee Road, Decatur GA 30034

HEALING HEARTS OF FAMILIES U.S.A. MINISTRIES INC.



Date : _____ Pg3

(404) 404-289-5277

www.healingheartusa.org

Email: healinghearts_us@yahoo.com

COMPLETE ONLY IF YOU HAVE VIOLENCE/ABUSE/ OR REENTRY INCARCERATION NEEDS

Client Name: First: _____ Last: _____
Address: _____ Phone: (____) _____ Cell (_) Msg. (_)
City: _____ State: _____ Zip: _____ () Prison _____

Court History: () Yes No ()

Prison _____ **Offense:** _____ **Term:** _____
How many times have you been arrested? _____ Convicted? _____ Violence () Yes () No
Probation Term _____ **Supervision/ Parole Term** _____ **Officer Fax #:** _____
Probation Officer: _____ **Phone Number:** _____
Court Ordered Program(s): _____ , _____ , _____

Personal/ Family History:

- 1) Was your offense directly or indirectly the result of drug or alcohol abuse? () Yes () No
- 2) Are you? Married () Separated () Divorced () In Committed Relationship () Single ()
Are you ordered to pay any spousal support? () Yes () No , How much monthly? _____
- 3) Do you have child support? () Yes () No Do you have supervision or probation () Yes () No
By Court Order? () Yes () No , How much monthly? _____
- 4) Do you have a history of domestic violence, meaning were you ever in a relationship where
you fought, verbally degraded or intimidated your mate? Yes () No ()
- 5) Were you raised in a violent home? () Yes () No Drug/Alcohol environment? () Yes () No
- 6) Were you homeless prior to incarceration? () Yes () No How long? _____
- 7) Do you have any history of battery? () Yes () No Child abuse? () Yes () No
- 8) Do you have any history of sexual assaults? () Yes () No, With children? () Yes () No
- 9) Are you currently employed? () Yes () No, Type of work? _____
- 10) Where do you want to be three years from today? _____ ,
and what does it take to get there from where you are now? _____

Are you court ordered () Yes / () No . If yes, how do you feel about being court ordered to take this
program? Finish the sentence, I feel ... _____

Do not complete below here-- Intake Coordinator: _____ Date: _____

Accepted? () Yes () No Fee if any: \$ _____ Completed Program? () Yes () No

Rejected Reason: _____ Date: _____

Print-Referred by: _____ Title: _____, Agency: _____ Phone: _____

() Prison () Faith Organization () Fiscal Sponsor Other: _____

Intake 2026