



Please email to Dave Stewart: dstewart@firstlightsc.org
If you have any questions, call 864-231-7273.

CAC Intake Form

Name: _____ Intake Date: _____

DOB: _____ Age: _____ Sex: _____ Race: _____

Source of Referral: _____

Do client/custodians have special considerations we need to be aware of? (i.e. disability, language barrier, etc.)

No ____ Yes ____ Explain _____

Language: _____

Child's Custodian/Placement: _____ Relationship to Child: _____

Address: _____

Phone: (Home) _____ (Work) _____ (Other) _____

Parent/Guardian 1: _____

P/G 1 Address/Phone: _____

Parent/Guardian 2: _____

P/G 2 Address/Phone: _____

Who has **legal** custody? _____ Who has **physical** custody? _____

For DSS, when is your case decision due? _____

Alleged Offender: _____ Relationship to Child: _____

Offender Age: ____ DOB: _____ Offender Race: _____ Date of Allegations: _____

Allegations Sexual Abuse Physical Abuse Witness to Domestic Violence Witness to violence Other: _____

Summary of Allegations: (Please provide full disclosure/details)

Has this incident been cross reported to DSS or LE? Yes No

If yes, what department was it reported to? _____

Has the child been removed from **all** contact with alleged offender? Yes No

What were the circumstances of disclosure?

- o Child disclosed/revealed abuse- To whom: _____
- o Child displayed behaviors- Describe behaviors: _____
- o Abuse was witnessed- By whom: _____
- o Results of medical exam- Where/when was medical exam conducted? _____
- o Other- Please explain: _____

Previous services given by other agencies? (i.e. medical exams, forensic interviews or counseling)

Yes No If Yes, please describe: _____

DSS Contact: _____ Phone: _____ Fax: _____ Case# _____

LE Contact: _____ Phone: _____ Fax: _____ Case# _____

Counselor: _____ Phone: _____ Fax: _____ Case#: _____

Services Requested: __ Forensic Interview __ Medical __ Case Staffing __ Counseling