



Today's Date: _____

Time: _____

My Father's Business Resource Navigation

Please complete electronically/ print

Referred by? _____

PARTICIPANT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TOTAL # OF PEOPLE LIVING IN HOUSEHOLD: _____

PHONE: _____ EMAIL: _____

REASON FOR VISIT: _____

To be completed at Intake:

By signing my name on this form, I certify that the following personal information is accurate and current. Additionally, I understand that all communication between the participant and the Resource Navigator is confidential, except the following: My Father's Business Resource Navigators are mandated reporters and required to report suspected or reported abuse of a child/ vulnerable adult, or any indication of intent to harm self or others.

Client Signature (required age 12 and older): _____

Parent/ Primary Caregiver Signature: _____
(if client is underage of 18)

I hereby authorize the exchange/release of information pertaining for my son/daughter/ self between My Father's Business Resource Navigator and _____ . This consent
(Name of organization/individual)
is valid until: _____
(30- days from date signed)

Client Signature (Required age 12 and older) _____ Date _____

Parent/ Primary Caregiver Signature _____ Date _____
(if client is underage of 18)

We Handle Our Father's Business by planting seeds in young people to save lives and change eternities

STAFF USE ONLY

Age of community member: _____ 6-18 yrs. _____ 19-25 yrs. _____ 25 yrs. (+)

Resources accessed: SNAP benefits Cash Assistance Illinois Medicaid Insurance

Social Determinants: Intergenerational Family Unemployed Homeless
 Criminal Justice Hx Working poor Single- parent family

Step 1: Check boxes for services requested		Step 2: Check boxes for service delivery completed or engaged
Clothing Support	<input type="checkbox"/>	<input type="checkbox"/>
Court Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Food Support	<input type="checkbox"/>	<input type="checkbox"/>
Resource Navigation	<input type="checkbox"/>	<input type="checkbox"/>
Social Mentorship	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual Fellowship	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Tutoring	<input type="checkbox"/>	<input type="checkbox"/>
Miscellaneous	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>The above supports and service delivery are facilitated by MFB Staff and assigned volunteers.</i></p> <p>Go to step 3- if additional community resources and referrals needed</p>		

Step 3: Check Req. boxes for additional supports facilitated by community partners and providers *(Req.- request; Ref.- referred; Rcvd.- received)				
Service Needs	Req.	Ref.	Rcvd.	Name of provider/ community resource
Benefits Enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Continued Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Job Readiness/ Workforce Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Service Team Assigned:

Navigator Name: _____ Signature: _____

