## ERMA'S HOUSE APPLICATION SUPERVISED EXCHANGE

Please complete this application and return it to Erma's House Visitation Center, 1046 Brown Street, Dayton, Ohio 45409.

After applications have been received from custodial <u>and</u> non-custodial party Erma's House staff will contact you to schedule an intake interview.

PLEASE PRINT	DATE:			
REFERRED BY:				
☐ JUVENILE COURT ☐ DOMESTIC RELATIONS COURT ☐ CHIL	.DREN'S SERVICES			
□ OTHER				
NAME(S):	_ Custodial □ Non-Custodial			
□ MOTHER □ FATHER □ LEGAL GUARDIAN □ FOSTER PAR	RENT OTHER			
DATE OF BIRTH: AGE: _				
CURRENT ADDRESS:				
CURRENT ADDRESS: STREET	CITY ZIP CODE			
TELEPHONE NUMBER:	_ □ HOME □ CELL			
ALTERNATE TELEPHONE NUMBER:	_ □ HOME □ CELL			
BEST TIME TO CONTACT YOU:	_			
May we leave a message at your telephone number(s)? ☐ Yes	□No			
EMPLOYMENT:	JOB TITLE:			
Work Number:	May we call you at work? ☐ Yes ☐ No			
MODEL OF CAR:LICENSE PLATE NUMBER:				
DEMOGRAPHIC INFORMATION				
MARITAL STATUS: SINGLE MARRIED DIVORCED	☐ WIDOW(ER) ☐ SEPARATED			
RACE OR ETHNIC GROUP:    AFRICAN AMERICAN   ASIAN	□BI-RACIAL □ CAUCASIAN □HISPANIC			
☐ American Indian ☐ Other ( <i>Ple</i>	EASE SPECIFY)			
EDUCATION COMPLETED: GROS	S ANNUAL INCOME:			
COUNTY OF RESIDENCE: ZIP CO	DDE:			
HEALTH INSURANCE:   PRIVATE   PUBLIC   BOTH PRIVA	TE/PUBLIC UNINSURED			

## PLEASE LIST ALL CHILDREN WHO WILL BE PARTICIPATING IN SUPERVISED EXCHANGES.

		CHILD 1		
FIRST NAME:		_Last Name:		
GENDER:	□MALE	DATE OF BIRTH:		
RACE OR ETHNIC GROUP:	☐ AFRICAN AMERICAN	☐ ASIAN ☐ BI-RACIAL	☐ CAUCASIAN ☐ HISPANIC	
	☐ AMERICAN INDIAN	OTHER (PLEASE SPECIFY)_		
HEALTH INSURANCE:   PRI	VATE   Public	☐ BOTH PRIVATE/PUBLIC	UNINSURED	
		CHILD 2		
FIRST NAME:		_Last Name:		
GENDER:     FEMALE	□MALE	DATE OF BIRTH:		
RACE OR ETHNIC GROUP:	☐ AFRICAN AMERICAN	☐ ASIAN ☐ BI-RACIAL	□ Caucasian □Hispanic	
	☐ AMERICAN INDIAN	☐ OTHER ( <i>PLEASE SPECIFY</i> )_		
HEALTH INSURANCE:   Pri	VATE   Public	☐ BOTH PRIVATE/PUBLIC	UNINSURED	
CHILD 3				
		CHILD 3		
FIRST NAME:		LAST NAME:		
		_LAST NAME:		
GENDER:     FEMALE	□MALE	_LAST NAME:		
GENDER:     FEMALE	☐ MALE  ☐ AFRICAN AMERICAN	LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL		
GENDER:     FEMALE	☐ MALE  ☐ AFRICAN AMERICAN  ☐ AMERICAN INDIAN	LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL	□ Caucasian □Hispanic	
GENDER: ☐ FEMALE  RACE OR ETHNIC GROUP:	☐ MALE  ☐ AFRICAN AMERICAN  ☐ AMERICAN INDIAN	LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL  OTHER (PLEASE SPECIFY)	□ Caucasian □Hispanic	
GENDER: ☐ FEMALE  RACE OR ETHNIC GROUP:  HEALTH INSURANCE: ☐ PRI	☐ MALE  ☐ AFRICAN AMERICAN  ☐ AMERICAN INDIAN  VATE ☐ PUBLIC	LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL  OTHER (PLEASE SPECIFY)  BOTH PRIVATE/PUBLIC  CHILD 4	□ Caucasian □Hispanic	
GENDER: ☐ FEMALE  RACE OR ETHNIC GROUP:  HEALTH INSURANCE: ☐ PRI	☐ MALE  ☐ AFRICAN AMERICAN  ☐ AMERICAN INDIAN  VATE ☐ PUBLIC	LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL  OTHER (PLEASE SPECIFY)  BOTH PRIVATE/PUBLIC  CHILD 4  LAST NAME:	□ CAUCASIAN □HISPANIC □ UNINSURED	
GENDER: FEMALE  RACE OR ETHNIC GROUP:  HEALTH INSURANCE: PRI  FIRST NAME:  GENDER: FEMALE	☐ MALE  ☐ AFRICAN AMERICAN  ☐ AMERICAN INDIAN  VATE ☐ PUBLIC  ☐ MALE	LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL  OTHER (PLEASE SPECIFY)  BOTH PRIVATE/PUBLIC  CHILD 4  LAST NAME:	CAUCASIAN HISPANIC  UNINSURED	
GENDER: FEMALE  RACE OR ETHNIC GROUP:  HEALTH INSURANCE: PRI  FIRST NAME:  GENDER: FEMALE	□ MALE □ AFRICAN AMERICAN □ AMERICAN INDIAN  VATE □ PUBLIC □ MALE □ AFRICAN AMERICAN	LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL  OTHER (PLEASE SPECIFY)  BOTH PRIVATE/PUBLIC  CHILD 4  LAST NAME:  DATE OF BIRTH:  ASIAN BI-RACIAL	CAUCASIAN HISPANIC  UNINSURED	

PLEASE LIST ADDITIONAL CHILDREN ON A SEPARATE SHEET OF PAPER IF MORE THAN FOUR CHILDREN WILL BE PARTICIPATING IN SUPERVISED EXCHANGES.

PLEASE DESCRIBE YOUR CURRENT EXCHANGE ARRANGEMENTS:				
HAVE THERE BEEN PROBLEMS WITH THE CURRENT	Γ ARRANGEMENT?			
LIST POSSIBLE TIMES AND DAYS FOR SUPERVISED	EXCHANGES:			
DO YOU HAVE ANY CONCERNS ABOUT THE CHILD'S	S INVOLVEMENT IN SUPERVISED EXCHANGES?			
DO YOU HAVE ANY ADDITIONAL INFORMATION YOU	WOULD LIKE US TO KNOW?			
EMERGENCY CONTACT:				
NAME:	RELATIONSHIP:			
TELEPHONE NUMBER:	□ HOME □ CELL			
ALTERNATE TELEPHONE NUMBER:	□ HOME □ CELL			
PLEASE SIGN AND DATE THIS APPLICATION:				
SIGNATURE	 Date			

## PLEASE PROVIDE THE FOLLOWING INFORMATION:

DO YOU HAVE AN ATTORNEY REPRESENTING YOU?	ES DNO
Name:	TELEPHONE NUMBER:
Address:	
DOES YOUR CHILD(REN) HAVE A CASA OR GUARDIAN AD	LITEM? ☐ YES ☐ NO
Name:	TELEPHONE NUMBER:
Address:	
Do you have a Children's Services Caseworker?	□YES □No
Name:	TELEPHONE NUMBER:
Address:	
DO YOU HAVE AN UPCOMING HEARING?	lo
Date:	
Court, Judge or Magistrate:	