



Child Advocacy Center OF AIKEN COUNTY

4231 Trolley Line Road • Aiken, SC 29802 • (803) 644-5100 • cacofaiken.org

Child's Name: _____

Date of Birth: _____

CONSENT FOR FORENSIC INTERVIEW:

As the parent or legal guardian of the above-named child, I give my consent to the Child Advocacy Center of Aiken County to conduct a Forensic Interview with my child. My child will be interviewed in an open-ended, child-friendly manner regarding allegations or suspicions of maltreatment. I understand that the purpose of this interview is to gather information to facilitate an on-going investigation. This information may be used as evidence in a court of law. I have been given an opportunity to ask questions regarding the forensic interview. I am aware that portions of the Forensic Interview may be used by CAC of Aiken County staff for training purposes only, and I am aware that any identifying information of my child and/or family will be protected. I understand and give permission for my child to participate in the Forensic Interview.

CONSENT TO AUDIO/VIDEO RECORD FORENSIC INTERVIEW:

I understand that my child's Forensic Interview will be audio/visually recorded to accurately document my child's statements. This audio/visual recording will be shared with members of the investigation team to facilitate the ongoing investigations. Child Advocacy Center of Aiken County staff may also review this recording for quality assurance. I give consent for my child to be audio/visually recorded during the forensic interview.

Signature of Legal Guardian on behalf of child

Date

CONSENT OF RELEASE OF INFORMATION:

I understand that according to SC Code 63-11-310, Child Advocacy centers are required to release all information that they gather pursuant to an investigation of child abuse or neglect to county DSS office, law enforcement and to the circuit solicitor.

I authorize the Child Advocacy Center of Aiken County to release and/or receive information from:

Mental Health Professional/Therapist: _____

Medical Provider/Pediatrician: _____

Other: _____

Signature of Legal Guardian

Date

South Carolina Attorney General's Office
South Carolina Crime Victim Services Division
Department of Crime Victim Compensation (DCVC)



Forensic Interview Release Form

In the matter of:

Victim's Legal Name (Required)

Name of Forensic Interviewer (Required)

Address (Required)

Address (Required)

City State Zip (Required)

City State Zip (Required)

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina Department of Crime Victim Compensation and its authorized agents to receive my interview records and to pay directly such expenses allowed by law to the Children's Advocacy Center for the forensic interview conducted for evidentiary purposes as prescribed by South Carolina Department of Crime Victim Compensation.

Dated this _____ day of _____, 20____, at _____

Signature of Patient/Guardian (Required)

Forensic Interviewer's Signature (Required)

Name of Law Enforcement Officer requesting the Interview - Date of the Request - Contact #

Name of Law Enforcement Agency (Required)

The Children's Advocacy Center must attach a copy of the Forensic Interview Billing Claim Form and a law enforcement incident/supplemental report to this Forensic Interview Release Form for payment and forward to:

Department of Crime Victim Compensation (DCVC)
Edgar A. Brown Building, 1205 Pendleton Street, Room 401, Columbia, SC 29201

Telephone 803-734-1900 • Facsimile 803-734-2261

***DCVC will not cover the cost of the interview if such is not requested by a law enforcement officer.
*If a child is in the legal custody of another government agency, the cost of the exam will not be covered by DCVC.**



Child Advocacy Center OF AIKEN COUNTY

INTAKE INFORMATION SHEET

Today's Date: _____

Child's Name: _____ DOB: _____ Race: _____

Child's School: _____

Child's Medical Insurance Provider: Medicaid Other: _____ No Insurance

Parent/Guardian Name: _____

Parent/Guardian Place of Employment: _____ Not Employed/Retired

Home Address: _____

Cell Phone #: _____ Home Phone #: _____ Alt. Phone #: _____

Please provide us with information about who lives in the home with the child:

1. Name: _____ Nickname: _____

Age: _____ Race: _____ Gender: _____ Relationship to child: _____

2. Name: _____ Nickname: _____

Age: _____ Race: _____ Gender: _____ Relationship to child: _____

3. Name: _____ Nickname: _____

Age: _____ Race: _____ Gender: _____ Relationship to child: _____

4. Name: _____ Nickname: _____

Age: _____ Race: _____ Gender: _____ Relationship to child: _____

5. Name: _____ Nickname: _____

Age: _____ Race: _____ Gender: _____ Relationship to child: _____

6. Name: _____ Nickname: _____

Age: _____ Race: _____ Gender: _____ Relationship to child: _____

Continued on next page



Please check all that apply to your child:

- Has a medical or mental health condition or a special need that may affect the interview.

Please explain: _____

- Takes medication on a regular basis.

List medications: _____

- Has difficulty with speaking, hearing, vision, physical mobility, or another need.

Please explain: _____

- Has a school individual education plan (IEP), receives special education services or other special assistance at school.

Please explain: _____

- Needs special accommodation's for today's interview.

Please explain: _____

- Has been interviewed here or at another center/location before.

Please explain: _____

- Previous child maltreatment investigations in the family.

Please explain: _____

- Child has experienced traumatic events, recently, or in the past.

Please explain: _____

Please list anything about your cultural or religious beliefs that we need to know that would help us better serve your child:

Please list any family history of psychiatric problems, substance, domestic violence, legal problems, divorce, etc.

What else would you like us to know?



Child Advocacy Center

OF AIKEN COUNTY

Needs Assessment

Caregiver's Name: _____ Relationship: _____

Child/Children's Name: _____

County of Residence: _____

Phone Number: _____ Alt. Phone Number: _____

Email Address: _____

Please answer the following:

1. Is your child currently in counseling? No Yes

If yes, where? _____

2. Are you interested in counseling for your child? No Yes Maybe

3. Are you interested in counseling for yourself? No Yes Maybe

4. Would you be interested in a parent/caregiver support group? No Yes Maybe

5. Does your household need assistance? (Check all that apply.)

Housing Utilities Food Clothing

Childcare Healthcare Pregnancy Skills Training

Other: _____

STAFF USE ONLY

Advocate: _____ Service/Fl Date: _____

Disclosure: No Yes Abuse Type: SA PA Neglect Other: _____

Alleged Offender: _____

Interviewer Comments:

