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**Extreme Hardship Waiver (I601 / I601A) Evaluation Intake Form**

**\*This Form is Confidential\***

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_**

**Basic Information**

**Full Name (including any other names used):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Sex:** \_\_\_\_\_\_\_\_ **Race/Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place of Birth (Country, State, City):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immigration Information**

**What is your current immigration status in the U.S?**

☐ Citizen at birth

☐ Naturalized citizen

☐ Permanent resident

**Date/age of entry to the U.S. (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date you obtained your citizenship or residency (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reasons for relocating to the U.S. (if applicable):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please state how the immigration process is affecting you (unable to fall asleep, difficulty concentrating, appetite changes, ruminating thoughts, etc.):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information about Relative (Beneficiary)**

**Full Name (including any other names used):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Sex:** \_\_\_\_\_\_\_\_ **Race/Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place of Birth (Country, State, City):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date/age of entry to the U.S.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the Beneficiary’s relationship to you?**

☐ Spouse

☐ Parent

☐ Child

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the Beneficiary’s immigration status in the U.S?**

☐ No legal status

☐ TPS

☐ DACA

☐ Nonimmigrant visa

☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current living situation with Beneficiary:**

☐ Living together

☐ Not living together

Where does beneficiary live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Beneficiary is a spouse, please answer the questions below:**

☐ N/A

**Date/year you began a committed relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marriage Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

**Do you have children?**

☐ Yes ☐ No

(If yes, please list children's dates of birth and names).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name** | **Date of Birth** | **Sex** | **¿U.S. Citizen or Resident?** | **Name of Biological Parent** |
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**How would you describe your relationship with your children?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your spouse have children from a previous relationship or marriage?**

☐ N/A

☐ No

☐ Yes,

# of children: \_\_\_\_\_\_\_\_\_

**Do you have any other dependents?**

☐ No

☐ Yes

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were your parents ever separated or divorced?**

☐ Yes ☐ No

**How would you describe your relationship with your mother?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you describe your relationship with your father?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have siblings?**

☐ No

☐ Yes

How many brothers? \_\_\_\_\_\_\_\_

How many sisters? \_\_\_\_\_\_\_\_

Which number are you in birth order? # \_\_\_\_\_\_\_\_

**How would you describe your relationship with your siblings?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please state any concerns you have over the health or development of any family members (children, spouse, parents):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical and Mental Health Information**

**Have you ever been hospitalized for any medical or mental health reasons? (**If yes, please complete the table below).

☐ Yes ☐ No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date/Year** | **Reason** | **Hospital** | **How long?** | **Treatment** |
|  |  |  |  |  |
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**Do you have any medical or mental health conditions? (**If yes, please complete the table below).

☐ Yes ☐ No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date/Year** | **Reason** | **Diagnosis/Condition** | **Provider** | **Clinic/Office** |
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**Are you able to obtain medical records or letters from doctors, therapists, or other healthcare providers that document your health conditions or treatment?**

☐ Yes ☐ No

**Have you ever talked to a psychiatrist, psychologist, or other mental health professional?**

☐ Yes ☐ No

**Have you ever experienced thoughts of suicide or hurting yourself?**

☐ Yes ☐ No

**Medications**

**Please fill out the table below if you take any medication.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dosage/Use** | **Reason/For** | **Provider** |
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**Substance Use**

**Do you drink alcohol?**

☐ No

☐ Yes

How much per day/week/month/year? \_\_\_\_\_\_\_\_\_\_\_

**Do you use any non-prescription drugs?**

☐ No

☐ Yes

What kind(s) and how often? \_\_\_\_\_\_\_\_\_\_\_

**Trauma/Hardship History Information**

**Please indicate any trauma or hardship you have experienced throughout your life. For each hardship, include date(s) or age(s) when it occurred and the location where it happened. Check all that apply:**

|  |  |  |
| --- | --- | --- |
| **Type of Hardship** | **Date(s)/Age(s)** | **Location** |
| ☐ Poverty or financial instability |  |  |
| ☐ Physical, emotional, and/or sexual abuse |  |  |
| ☐ Neglect |  |  |
| ☐ Domestic violence |  |  |
| ☐ Trauma (e.g., natural disasters, accidents, war) |  |  |
| ☐ Family separation or loss |  |  |
| ☐ Divorce or significant relationship loss |  |  |
| ☐ Discrimination/prejudice |  |  |
| ☐ Serious illness and/or disability |  |  |
| ☐ Death of close family member or friend |  |  |
| ☐ Mental health crisis |  |  |
| ☐ Victim of violence or crime |  |  |
| ☐ Educational disruption |  |  |
| ☐ Employment loss and/or unemployment |  |  |
| ☐ Housing Instability/Homelessness |  |  |
| ☐ Cultural Adjustment |  |  |
| ☐ Pregnancy loss/miscarriage |  |  |
| ☐ Other (please specify): |  |  |

**Beneficiary Spouse or Relative’s Country of Origin**

**Please state any concerns you about physical safety in Beneficiary’s country of origin:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please state any concerns you have regarding your or your spouse/relative’s ability to secure employment and overall financial situation in Beneficiary’s country of origin:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please state any concerns you have over about access to medical care in spouse or relative’s country of origin:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please state any additional concerns you about residing in Beneficiary’s country of origin that have not been mentioned above:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Information**

**Who currently lives with you in your household?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please state which family members in your support system are U.S. citizens:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please state other sources of support in the US (friends, church, community groups, etc.):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please state whether you or Beneficiary have family to support or assist you in Beneficiary’s country of origin:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education/Military Information**

**What is your highest level of education?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where did you attend school/college?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever served in the military?**

☐ No

☐ Sí

Please provide details of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment/Financial Information**

**Current Employment Status:**

☐ Employed or self-employed

☐ Unemployed

☐ Other (e.g., internship, volunteering): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your occupation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How long have you had this occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Job Title (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer Name (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your spouse/relative (Beneficiary) work?**

☐ No

☐ Yes

Please state what Beneficiary’s job is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is the income earner in your household? If more than one provider, please state percentage of income each contributes [e.g., Jose (husband) 60%, Maria (wife) 40%]:**

**Earner 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ = \_\_\_\_\_% Earner 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ = \_\_\_\_\_%**

**Approximately, how much do you pay in household bills monthly?** $ \_\_\_\_\_\_\_\_\_\_\_\_

(This includes rent/mortgage, power, car insurance, phone, groceries, etc.)

**Please check any unpaid loans/debt and the amount still owed:**

☐ **None**

☐ **Auto: $ \_\_\_\_\_\_\_\_\_\_**

☐ **Mortgage: $ \_\_\_\_\_\_\_\_\_\_**

☐ **Business: $ \_\_\_\_\_\_\_\_\_\_**

☐ **Personal: $ \_\_\_\_\_\_\_\_\_\_**

☐ **Student: $ \_\_\_\_\_\_\_\_\_\_**

☐ **Credit card debt: $ \_\_\_\_\_\_\_\_\_\_**

☐ **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_**

**Do you have concerns about losing your home or business due to deportation?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Information**

**Have you ever been arrested?**

☐ No

☐ Yes

Please provide details of the arrest(s) including the date, location, and reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any past or current legal issues (besides your immigration case)?**

☐ No

☐ Yes

Please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any formal or informal custody arrangements for any minor children (if applicable):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK ALL THAT APPLY & ***HIGHLIGHT*** THE MAIN PROBLEM:

**DIFFICULTY WITH: NOW PAST DIFFICULTY WITH: NOW PAST DIFFICULTY WITH: NOW PAST**

Anxiety People in General Nausea

Depression Parents Abdominal Distress

Mood Changes Children Fainting

Anger or Temper Marriage/Partnership Dizziness

Panic Friend(s) Diarrhea

Fears Co-Worker(s) Shortness of Breath

Irritability Employer Chest Pain

Concentration Finances Lump in the Throat

Headaches Legal Problems Sweating

Loss of Memory Sexual Concerns Heart Palpitations

Excessive Worry History of Child Abuse Muscle Tension

Feeling Manic History of Sexual Abuse Pain in joints

Trusting Others Domestic Violence Allergies

Communicating Thoughts of Hurting Often Make Careless

with Others Someone Else Mistakes

Drugs Hurting Self Fidget Frequently

Alcohol Thoughts of Suicide Speak Without Thinking

Caffeine Sleeping Too Much Waiting Your Turn

Frequent Vomiting Sleeping Too Little Completing Tasks

Eating Problems Getting to Sleep Paying Attention

Severe Weight Gain Waking Too Early Easily Distracted by Noises

Severe Weight Loss Nightmares Hyperactivity

Blackouts Head Injury Chills or Hot Flashes

**FAMILY HISTORY OF (Check all that apply):**

Drug/Alcohol Problems Physical Abuse Depression

Legal Trouble Sexual Abuse Anxiety

Domestic Violence Hyperactivity Psychiatric Hospitalization

Suicide Learning Disabilities “Nervous Breakdown”

**Any additional information you would like to include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Additional Documents**

Throughout the evaluation process, we ask that you provide the following supporting documents so that the therapist can supplement the evaluation used for your immigration case. Please provide these to your therapist in a timely manner to avoid delays, preferably before your last meeting. You can talk to your attorney or paralegal and have them send it to your therapist directly if you prefer.

|  |  |
| --- | --- |
| If **you are petitioning for a** **Spouse:** | **If you are petitioning for** a **Parent (or Child):** |
| ☐ Form of government-issued photo ID (e.g., driver’s license, passport) for **both you and your spouse**  ☐ Marriage certificate  ☐ Certificate of naturalization or residency card (if you were born outside the U.S)  ☐ Affidavit/letter describing extreme physical, emotional, and/or financial hardship if your spouse were to leave the U.S.  ☐ Medical records or letters from healthcare providers documenting any physical or mental health conditions or hospitalizations you’ve had in the last 10 years | ☐ Form of government-issued photo ID (e.g., driver’s license, passport) for **both you and your parent (or child)**  ☐ Certificate of naturalization or residency card (if you were born outside the U.S)  ☐ Affidavit/letter describing extreme physical, emotional, and/or financial hardship if your parent or child were to leave the U.S.  ☐ Medical records or letters from healthcare providers documenting any physical or mental health conditions or hospitalizations you’ve had in the last 10 years |

**Thank you for taking the time to complete this intake form. Your patience and attention are greatly appreciated and will significantly help us in preparing for your evaluation. This information will help ensure a smoother and more efficient process.**