

**Family and Child Needs Assessment**

Date: \_\_\_\_\_ Case Manager: \_\_\_\_\_ Family I.D.: \_\_\_\_\_

Parent (s): \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Child: _____	Birthdate: _____	Child Care? [ ] yes [ ] no
Child: _____	Birthdate: _____	Child Care? [ ] yes [ ] no
Child: _____	Birthdate: _____	Child Care? [ ] yes [ ] no
Child: _____	Birthdate: _____	Child Care? [ ] yes [ ] no

- Adults living in the home:  
Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
\_\_\_\_\_
- Primary language: English \_\_\_\_\_ Other \_\_\_\_\_
- Do you have shared custody or visitation agreements? \_\_\_\_\_ If so, briefly explain:  
\_\_\_\_\_  
\_\_\_\_\_
- Is this the first daycare experience for your child? \_\_\_\_\_ Name of previous day care facility or provider: \_\_\_\_\_ How did previous settings work out? \_\_\_\_\_
- Is your child or family working with other agencies or support services that we need to be aware of (CPS, AID, NBRC, Teen Parent Connection, SAY, etc.)  
\_\_\_\_\_
- Do you have any concerns about your child in any of the following areas?  
Child \_\_\_\_\_ Age: \_\_\_\_\_ [ ] Male [ ] Female  

YES	NO		YES	NO	
[ ]	[ ]	Hearing	[ ]	[ ]	Learning/Cognitive Development
[ ]	[ ]	Vision	[ ]	[ ]	Behavior/Emotional Development
[ ]	[ ]	Speech	[ ]	[ ]	Social Development
[ ]	[ ]	Motor Skills	[ ]	[ ]	Physical Development

If yes, have you contacted a physician or clinic? \_\_\_\_\_  
Do you have medical insurance for your child (ren)? \_\_\_\_\_  
Have you contacted the public school district in regards to any of these concerns?  
\_\_\_\_\_

If yes, are you receiving services? \_\_\_\_\_

Description of Concerns:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Would you like information or referrals for yourself, your family, or your child(ren)?  
Please indicate who the resources are for: \_\_\_\_\_

- | YES                      | NO                       |                      | YES                      | NO                       |                          |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Financial Assistance | <input type="checkbox"/> | <input type="checkbox"/> | Legal Services           |
| <input type="checkbox"/> | <input type="checkbox"/> | Food Assistance      | <input type="checkbox"/> | <input type="checkbox"/> | Counseling Services      |
| <input type="checkbox"/> | <input type="checkbox"/> | Housing Services     | <input type="checkbox"/> | <input type="checkbox"/> | Parenting Support        |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutrition            | <input type="checkbox"/> | <input type="checkbox"/> | Activities               |
| <input type="checkbox"/> | <input type="checkbox"/> | Health Services      | <input type="checkbox"/> | <input type="checkbox"/> | Employment and Education |
| <input type="checkbox"/> | <input type="checkbox"/> | Special Needs        | <input type="checkbox"/> | <input type="checkbox"/> | Teens                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Safety               | <input type="checkbox"/> | <input type="checkbox"/> | Crisis Hotline           |

Please note specific needs for legal resources ( divorce, special education, etc);  
counseling needed (for family, child, behavior, abuse, etc.), and for specific parenting  
information (classes, child development etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any other concerns or resource needs?

Best time to reach you by phone: Home \_\_\_\_\_ Home Work \_\_\_\_\_

Other comments:

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