CS1 2.2a Date_____

OVEC Head Start
Family Needs Assessment

Child's Name: _____

Name of Parent(s)/Legal Guardian(s) completing assessment _____

_____

I. Family Strengths:

What is special or unique about your family? Tell us what your family enjoys.

_____

_____

_____

II. Current Family Situation:

1. **Do ALL people living in the household have health coverage?** Yes No List additional comments below.

_____

2. **Describe your family's current <u>housing and transportation</u>:**
   a. Does the current housing meet the family's needs? Yes No
   b. How long has the family lived in current housing? _____
   c. Does the family have a reliable means of transportation? Yes No

III. Family Support System:

Who would you consider to be part of your family's support system and/or are people you can turn to when you need help, advice, or are in a crisis, or just to listen? (Check all that apply).

____ Parents	____ Spouse/Partner	____ Head Start	_____ School
____ Friends	____ Family Members	____ Other Agencies	_____ Neighbors
____ Grandparents	____ Church	____ Counselor	_____ No One

Other: _____

IV. Vision Statement: Where would you like to be in 2-3 years?

_____

_____

_____

V. Family Interest Survey

Throughout the year, the Head Start & Early Head Start programs offer a variety of Educational Opportunities and/or information for families to learn and participate. Our goal is to help you get the information you want or put you in touch with the resources that may have the information. Please check those that interest you.

✓ if interested	Topic	✓ if interested	Topic
	Child Development		Family Planning / Pregnancy
	Home as a learning tool		Breast Feeding Support
	Disabilities/IEP/IFSP		Prenatal / Post-Partum Care / Depression
	Parenting Skills		Safe Sleep
	Fatherhood Activities		Toilet Training
	Preventive Medical and Oral Health, immunizations		Foster, Guardian, Grandparents as Caregivers
	Importance of Healthy Eating / Physical Activity		Blended Families
	Negative consequences of sweetened beverages		Diversity
	Meal Plan / Nutrition / Food Budget		Divorce
	Poison Prevention / Carbon Monoxide		Domestic Violence
	Lead Exposure/home/water		Community Events
	Consequences of tobacco use		Childcare
	Counseling		Heating Assistance Program
	Emergency First Aid / CPR		Legal Aid Society
	Discipline		Budgeting/Financial Planning
	Finding a Job / Job Training		Buying a Home
	G.E.D.		Couponing
	Driver's License		Clothes Bank
	Depression / Fatigue/ Mental Health		Local Food Bank/Food Pantry
	Substance Abuse Information		Child Support
	Anger / Hostility / Stress		Making a Will
	Child Abuse & Neglect		
	Single Parenting		

I am not interested in receiving any information at this time. Date _____ Initials _____

Parent/Guardian Signature _____

Staff Signature _____