**FAMILY ASSESSMENT**

Child’s Name

Date of Birth\_ / \_/

\*\*\* to be completed by the evaluator

|  |
| --- |
| 1. Do you have a family support system or are you currently using any supports/resources in the community? |
| 2. What activities in the community would you and your family like to become involved in but you have found them to be challenging? |
| 3. Do you think you need more information about your child’s development or disability? |
| 4. Do you need help in accessing child care or day care for your child?  \_\_\_\_\_YES \_\_\_\_\_\_NO |
| 5. Do you need help in accessing health care?  \_\_\_\_\_YES \_\_\_\_\_\_NO |
| 6. Would you like resources regarding parenting?  \_\_\_\_YES \_\_\_\_\_NO |

Completed by Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Evaluator’s signature and title)

BP interagency 7/15