



Parent/Guardian: In our effort to better serve your child and family, please complete the following brief questionnaire regarding the current community resources and/or services received by your child/family. Simply check the box in the “Have” column for any resource/service already in place for your child/family.

Family Information									
Name of child:		Completion Date:		Number of people living in your home, Older than 18 years of age: <input type="text"/>		Number of people living in your home, Younger than 18 years of age: <input type="text"/>			
YEARLY Household Gross Income Estimate									
Less than \$26,000	\$26,000 - \$35,000	\$35,000 - \$45,000	\$45,000 - \$54,000	\$54,000 - \$63,000	\$63,000 - \$72,000	\$73,000 - \$82,000	\$82,000 or more		
What are your current concerns for your child and/or family?									
Of these concerns, what is most important to you (may list more than one priority)									
Have	Resources or Services			Have	Resources or Services				
<input type="checkbox"/>	Child/Children – Health Insurance or TEFRA			<input type="checkbox"/>	Adult Education/GED Program				
<input type="checkbox"/>	Child/Children – Primary Care Physician			<input type="checkbox"/>	Other Clothing/Food Assistance				
<input type="checkbox"/>	Child/Children – Well Child Care/Immunizations			<input type="checkbox"/>	TANF (Temporary Assistance for Needy Families)				
<input type="checkbox"/>	Child/Children – Prescriptions/Medical Supplies			<input type="checkbox"/>	LIHEAP (Low Income Home Energy Assistance)				
<input type="checkbox"/>	Child/Children – Dental Care			<input type="checkbox"/>	Other Diaper/Formula Assistance				
<input type="checkbox"/>	Child/Children – Vision Care			<input type="checkbox"/>	Parent Support Group(s)				
<input type="checkbox"/>	Self/Other Adults – Health Insurance			<input type="checkbox"/>	Counseling services for self/child/other adult(s)				
<input type="checkbox"/>	Self/Other Adults – Primary Care Physician			<input type="checkbox"/>	Reliable transportation				
<input type="checkbox"/>	Self/Other Adults – Dental Care			<input type="checkbox"/>	Valid driver’s license or state ID				
<input type="checkbox"/>	Self/Other Adults – Vision Care			<input type="checkbox"/>	Access to public transportation				
<input type="checkbox"/>	Self/Other Adults – Prescriptions/Medical Supplies			<input type="checkbox"/>	SoonerRide				
<input type="checkbox"/>	WIC (Women, Infants, and Children)			<input type="checkbox"/>	Housing				
<input type="checkbox"/>	Tribal Affiliation/Benefits/CDIB			<input type="checkbox"/>	Housing and/or Utility Assistance				
<input type="checkbox"/>	SNAP (Supplemental Nutrition Assistance)			<input type="checkbox"/>	Community Weatherization Assistance				
<input type="checkbox"/>	SSI/Social Security Income			<input type="checkbox"/>	Childcare				
<input type="checkbox"/>	SSI/DCP (Disabled Children Program)			<input type="checkbox"/>	DHS Childcare Assistance				
<input type="checkbox"/>	DDSD – Family Support Assistance Program			<input type="checkbox"/>	Early Head Start/Head Start				
<input type="checkbox"/>	DDSD – In-Home Supports Waiver			<input type="checkbox"/>	Private Therapy Services (PT, OT, Speech)				
<input type="checkbox"/>	Respite Care			<input type="checkbox"/>	Access to community library services/program				
Do you have any immediate resource needs regarding food, shelter, or safety for your child, self, or family?						Yes:	<input type="checkbox"/>	No:	<input type="checkbox"/>
ADDITIONAL COMMENTS?									