

Additional File Information

Primary Caregiver (Circle one answer or write in answer)

Name: _____

Gender: Male Female

Language: English Spanish Other

Food Stamp/SNAP: Yes No

Race: _____

Township: _____

County: _____

Marital Status: Married Single Divorced Widowed Separated Other

Disabled: Yes No

Current Housing: Homeless Own Rent Other

Current Housing Date: (Day you moved in) _____

Has Family Moved in 24 Months: Yes No

Member of US Military on Active Duty: Yes No

Secondary Caregiver (Circle one answer or write in answer)

Name: _____

Gender: Male Female

Language: English Spanish Other

Race: _____

Marital Status: Married Single Divorced Widowed Separated Other

Disabled: Yes No

Member of US Military on Active Duty: Yes No

Child Information (Circle one answer or write in answer)

Name: _____

Primary Language: English Spanish Other

Speak English at Home: Yes No

English Skills: Very Well Well Not Well Not at All

US Citizenship: Yes No

Parental Status: Two Parents Single Parent

Medical Insurance: Yes No

Specify Medical Insurance (if applicable): _____

Current School District: (Where resides 50% of time) _____

Child's Medical & Dental Home

Child receives medical services through

_____ Ongoing source of continuous accessible medical care (Medical Home)

_____ Indian Health Services

_____ Migrant Community Health Center

Program verification date (child up to date status) _____

Primary reason for NOT receiving treatment _____

Child receives an ongoing source of Continuous Dental Care (Dental Home) _____

Is the child up to date on a schedule of age appropriate Preventive and Primary Health Care including all appropriate tests and physical exams? _____

Up to date at enrollment (based on EPSDT schedule) _____

Health Care Prof. Verification Date (Child up to date status) _____