Early Childhood Home Visiting | Ohio Department of Health

Help Me Grow Home Visiting
Family Demographic Information

Instructions: Complete upon enrollment and whenever information needs updated.

Child Information (must be completed for all children that meet the age requirements of the program)

First Name:	Middle name:		Last Name:
Date of Birth:	Due Date:	City of Birth:	Index child: ☐ Yes ☐ No
Start date for index child:		End date for index child (if applicable):	
Was child premature: ☐ Yes ☐ No		Gender: ☐ Male ☐ Female	Language:
Developmental Screening Exempt: ☐		If so, Child in the Early Intervention Program: ☐ Yes ☐ No	
Race: ☐ American Indian/Alaskan Native ☐Hawaiian/Pacific ☐ Black/African American ☐ Asian ☐ White ☐ Declined to answer		Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Declined to answer ☐Unknown	
Has health insurance: ☐ Yes ☐ No		In Medical Home: ☐ Yes ☐ No	
Health Insurance: ☐ Buckeye Health Plan ☐ CareSource ☐ Molina ☐ Paramount Advantage ☐ United Health Community ☐ Private ☐ Tricare ☐ Uninsured If Medicaid, ID #: _____			

Caregiver Information (must be completed for primary caregiver and other caregivers who will participate in ongoing services, optional for any other caregivers)

First Name:	Last Name:		Relationship to Child:
Gender: ☐ Male ☐ Female	Primary caregiver: ☐ Yes ☐ No		Residential: ☐ Yes ☐ No
Street Address:		City:	Zip:
Date of Birth:		Email address:	
Phone #:		Permission to text: ☐ Yes ☐No	
Housing Status: ☐ Owns or shares own home, apartment of condominium ☐ Rents or shares own home or apartment ☐ Live with parents or family members ☐ Lives in public housing ☐ Not homeless other ☐ Homeless and sharing housing ☐ Homeless and in transitional housing/emergency shelter ☐ Homeless other			
Race: ☐ American Indian/Alaskan Native ☐Hawaiian/Pacific ☐ Black/African American ☐ Asian ☐ White ☐ Declined to answer		Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined to Answer	
Primary Language: _____ Is an interpreter needed with this family? ☐ Yes ☐ No		What is your highest level of completed education?	
Report Marital Status: ☐ Married ☐ Never Married ☐Divorced/Separated ☐ Not married but living with partner		Student Status: ☐ Student Full-Time ☐ Student Part-Time ☐ Not a Student ☐ Unknown	
Health Insurance: ☐ Yes ☐ No If Yes, which insurance provider: ☐ Buckeye Health Plan ☐ CareSource ☐ Molina ☐ Paramount Advantage ☐ United Health Community ☐ Private ☐Tricare Provider #:_____		Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Not employed ☐Unknown/Did Not Report	
		In Medical Home: ☐ Yes ☐ No	
Receive: ☐ WIC ☐ TANF ☐ SSI/SSDI ☐ Food Stamps ☐ Emergency Food Assistance ☐ Other ☐ None If WIC, WIC ID #: _____		Eligible but do not receive: ☐ WIC ☐ TANF ☐ SSI/SSDI ☐ Food Stamps ☐ Emergency Food Assistance ☐ Other ☐ None	