

Parent Name: _____ SS# _____ DOB: _____ Today's Date: _____

Participant County of Residence _____

Basic Needs	M O B	S O	Infant and Maternal Health (continued)	M O B	S O
1) Inability to meet basic needs (no access to food, clothing, no access to any form of transportation)	4	4	21) No medical home for child or children	3	3
2) Inadequate income and/or housing	3	3	22) Child or other family members or caregivers in home with special needs (developmental/physical/medical disabilities or behavioral/learning disorder)	3	3
3) Social Isolation: (no one to call in an emergency and/or no plan in place, no involvement with social service agencies, no access to a phone, inability to communicate within the community)	4	4	23) Self-reported the use of drugs and/or alcohol during pregnancy prior to knowledge of pregnancy	3	na
History of Parent(s) (Childhood)			Relationships and Support (Current)		
4) Witness to domestic violence during childhood/adolescence	3	3	24) Currently (within last 12 months) victim of domestic violence or other abuse	5	5
5) Instability of care during childhood	3	3	25) Past abusive relationships (not related to childhood)	3	3
6) Raised by alcoholic, drug-addicted or mentally unstable caregiver	4	4	26) Limited contact with close friends and/or family	3	3
7) Verbalized experiencing abuse or neglect during childhood/adolescence	4	4	27) Expressed fear of violence in home	4	4
8) MOB and/or SO placed in protective care (i.e. with relative or state)	4	4	28) Current physical response to anger (throw things, hit, punch, slap, etc.)	5	5
History of Parent(s) (Adulthood)			29) Inappropriate coping mechanisms	4	4
9) Current mental illness requiring treatment or hospitalization	4	4	Parent/Child Interaction		
10) Active substance abuse in home environment by anyone other than MOB (within last 12 months or since becoming a parent)	4	4	30) Negative verbalization about the baby (expressed disapproval, anger, hostility)	5	5
11) Verbalized suicide ideation and/or attempted suicide (Within the last two years or since becoming a parent)	4	4	31) Verbalized unrealistic expectations about child developmental milestones, toilet training (before 18 mos or older than five yrs) and/or walking (before nine mos or older than 16 mos)	3	3
12) History of mental illness or substance abuse, requiring treatment or hospitalization	3	3	32) Limited awareness of discipline options or leaves a crying child unchecked for longer than ten minutes	3	3
13) History of alcohol/substance abuse that didn't result in treatment or hospitalization	2	2	33) Parent(s) verbalizes need to physically punish a child one year of age or younger	4	4
14) MOB and/or SO has committed violence against another person	3	3	34) Verbalized feelings of inadequacy about parenting or no positive statements	2	2
15) MOB and/or SO Repeated (three or more) victimless crimes (arrested &/or convicted for theft, possession, vandalism, etc.) OR any one of the following: DUI, drug dealing or prostitution charge or currently involved in the criminal justice system	3	3	35) CPS report on parent(s) made(prior or present)	4	4
Infant and Maternal Health			36) Parent's other children placed in protective care or termination of parental rights	5	5
16) Late prenatal care (12 weeks or later)	3	na	Maternal/Parental Life Course		
17) Little or no prenatal care (less than 5 visits) or poor compliance with treatment or medication	4	na	37) Less than high school and/or no GED	2	2
18) Upon knowledge of pregnancy, continued use of alcohol (drinking) or drugs and/or baby/mother has positive drug screen	5	na	38) Parent is less than 18 yrs old	2	2
19) Upon knowledge of pregnancy, continued smoking/use of tobacco	3	na	39) Not legally married or separated	1	1
20) Current maternal depression	4	na	40) Observed or parent verbalized a sense of hopelessness, victimization, being overwhelmed, etc.	3	3
7/23/02	Score			Score	

Parent Name: _____

DOB: _____

Scoring:	MOB	SO
Total Points from Concerns page/Final Score		

A score of 13 or greater from either the MOB or the SO qualifies the family as eligible for voluntary participation in the Healthy Families Florida program.

Family Strengths

This section is for Family Assessment Worker to identify a family's strengths. Please shade in the circle for any strengths MOB or SO have.

Strength	MOB	SO
Received individual or family counseling to resolve childhood issues (counseling can be from a licensed therapist, a clergyman, etc.).	<input type="radio"/>	<input type="radio"/>
Completed or is receiving treatment for drug and/or alcohol addiction and is abstaining from use.	<input type="radio"/>	<input type="radio"/>
Received counseling or treatment for depression or other issues.	<input type="radio"/>	<input type="radio"/>
MOB and/or SO received anger management counseling.	<input type="radio"/>	<input type="radio"/>
MOB received consistent prenatal care.	<input type="radio"/>	<input type="radio"/>
SO/MOB quit smoking, drinking alcohol or using drugs upon knowledge of and/or during pregnancy.	<input type="radio"/>	<input type="radio"/>
Target child was wanted.	<input type="radio"/>	<input type="radio"/>
Has a strong support system of friends and/or family.	<input type="radio"/>	<input type="radio"/>
Enrolled in high school/GED classes.	<input type="radio"/>	<input type="radio"/>
Consistently employed (holds a job for at least six months).	<input type="radio"/>	<input type="radio"/>
MOB and/or SO has received parenting skills/child development education (classes, books, videos, information).	<input type="radio"/>	<input type="radio"/>
Family receives services for special needs household member.	<input type="radio"/>	<input type="radio"/>

FAW: _____

DATE: _____