MIECHV Family Demographic Form
Home Visitor: _____
☐ Intake ☐ Annual Update

Home Visitation PROGRAM
Supporting Families. Strengthening Communities.
West Virginia Department of Health and Human Resources

Date Completed: _____

Completed with Primary Caregiver at Intake and updated annually

Parent or Caregiver #1 (Primary Caregiver)

First Name: _____ **Middle Initial**:___ **Last Name**:_____
Date of Birth:_____ **Gender**: ☐ Female ☐ Male
Relationship to Index Child: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐Other:_____
Prenatal: ☐ Yes ☐ No **Expected Due Date** (mm/dd/yyyy):_____
Address:_____ **Phone**: _____
Total number of household members: _____

Race:
☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ More than 1 Race ☐ White
Ethnicity (*check only one*): ☐Hispanic/Latino ☐ Not Hispanic/Latino
Language used most often in the home: _____

Marital Status (*check only one*):
☐ Never Married (single) ☐ Married ☐Living with Partner (not married)
☐ Divorced ☐ Separated ☐ Widowed

Highest Level of Education completed (*check only one*):
☐ Less than HS diploma ☐ GED ☐ High School Diploma ☐ Some College
☐ Technical Training ☐ Associate Degree ☐ Bachelor Degree or higher ☐ Other: _____
If less than HS Degree or GED is participant enrolled in HS or GED program? ☐ Yes ☐ No
HS/GED Completion date (if completed after enrollment in HV)? _____
Enrolled in Education or workforce training program: ☐ Yes ☐ No

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed
Annual Household Income: $_____ ☐ prefer not to answer
Health Insurance Coverage: ☐ No Insurance ☐ Medicaid ☐ Tri-Care ☐ Private

Current living situation:

☐ Not Homeless
◊ Owns Home/Apartment
◊ Rents Home/Apartment
◊ Lives in Public Housing
◊ Lives with Parents/Other Family members

☐ Homeless
◊ Sharing Housing (not family)
◊ Lives in emergency/transition shelter
◊ Other living arrangement:
_____

Family Characteristics (*check all that apply*):
☐ Low Income Household
☐ Household contains an enrollee who is pregnant and under age 21
☐ Household has a history of child abuse or neglect or has had interactions with child welfare services
☐ Household has a history of substance abuse or needs substance abuse treatment
☐ Someone in the household uses tobacco products in the home
☐ Someone in the household has attained low student achievement or has a child with low student achievement
☐ Household has a child with developmental delays or disabilities
☐ Household includes individuals who are serving or formerly served in the US Armed Forces

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Parent or Caregiver #2
First Name: _____ **Middle Initial**:___ **Last Name**:_____ **Date of Birth**:_____ **Gender**: ☐ Female ☐ Male **Relationship to Index Child**: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐Other:_____
Race: ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ More than 1 Race ☐ White **Ethnicity** (*check only one*): ☐Hispanic/Latino ☐Not Hispanic/Latino
Marital Status (*check only one*): ☐ Never Married (single) ☐ Married ☐Living with Partner (not married) ☐ Divorced ☐ Separated ☐ Widowed
Highest Level of Education completed (*check only one*): ☐ Less than HS diploma ☐ GED ☐High School Diploma ☐ Some College ☐ Technical Training ☐ Associate Degree ☐ Bachelor Degree or higher ☐ Other: _____ **Enrolled in Education or workforce training program**: ☐ Yes ☐ No
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed **Health Insurance Coverage**: ☐ No Insurance ☐ Medicaid ☐ Tri-Care ☐ Private

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CHILD # 1 **Index Child: ☐ Yes ☐ No**

First Name: _____ **Middle Initial**: ___ **Last Name**:_____
Date of Birth:_____ **Gender**: ☐ Female ☐ Male
Race:
☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ More than 1 Race ☐ White
Ethnicity (*check only one*): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Health Insurance Coverage: ☐ No Insurance ☐ Medicaid/CHIP ☐ Tri-Care ☐ Private
Usual Source of Medical Care:
☐ Doctor/Nurse Practitioner Office ☐ Rural Health Center/FQHC
☐ Hospital Emergency Room ☐ Urgent Care/ Walk-in Clinic
☐ Hospital Outpatient ☐ Other: _____
☐ None

Does Child have a usual source of Dental Care: ☐ Yes ☐ No

CHILD # 2 **Index Child: ☐ Yes ☐ No**

First Name: _____ **Middle Initial**: ___ **Last Name**:_____
Date of Birth:_____ **Gender**: ☐ Female ☐ Male
Race:
☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ More than 1 Race ☐ White
Ethnicity (*check only one*): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Health Insurance Coverage: ☐ No Insurance ☐ Medicaid/CHIP ☐ Tri-Care ☐ Private

Usual Source of Medical Care:
☐ Doctor/Nurse Practitioner Office ☐ Rural Health Center/FQHC
☐ Hospital Emergency Room ☐ Urgent Care/ Walk-in Clinic
☐ Hospital Outpatient ☐ Other: _____
☐ None

Does Child have a usual source of Dental Care: ☐ Yes ☐ No

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CHILD # 3 **Index Child: ☐ Yes ☐ No**

First Name: _____ **Middle Initial**: ___ **Last Name**:_____
Date of Birth:_____ **Gender**: ☐ Female ☐ Male
Race:
☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ More than 1 Race ☐ White
Ethnicity (*check only one*): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Health Insurance Coverage: ☐ No Insurance ☐ Medicaid/CHIP ☐ Tri-Care ☐ Private

Usual Source of Medical Care:
☐ Doctor/Nurse Practitioner Office ☐ Rural Health Center/FQHC
☐ Hospital Emergency Room ☐ Urgent Care/ Walk-in Clinic
☐ Hospital Outpatient ☐ Other: _____
☐ None

Does Child have a usual source of Dental Care: ☐ Yes ☐ No

CHILD # 4 **Index Child: ☐ Yes ☐ No**

First Name: _____ **Middle Initial**: ___ **Last Name**:_____
Date of Birth:_____ **Gender**: ☐ Female ☐ Male
Race:
☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ More than 1 Race ☐ White
Ethnicity (*check only one*): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Health Insurance Coverage: ☐ No Insurance ☐ Medicaid/CHIP ☐ Tri-Care ☐ Private
Usual Source of Medical Care:
☐ Doctor/Nurse Practitioner Office ☐ Rural Health Center/FQHC
☐ Hospital Emergency Room ☐ Urgent Care/Walk-in Clinic
☐ Hospital Outpatient ☐ Other: _____
☐ None

Does Child have a usual source of Dental Care: ☐ Yes ☐ No

Next Form Due: _____