AT TIME OF SCREEN MOTHER IS:	☐ Pre-Natal	☐ Post-Natal	
Frederick County resident?	☐ Y	☐ N	☐ U
First Time Mom or Dad	☐ Y	☐ N	☐ U
Baby less than 3 months old	☐ Y	☐ N	
Includes parents who had a child that died or was removed from home.			
IF ALL ANSWERS ARE YES, PLEASE PROCEED WITH SCREEN			

Healthy Families Frederick County™

REFERRING AGENCY: _____

FOR HFF STAFF ONLY
HFF ID#
FRS/FSS ID#

Primary language spoken: ☐ English ☐ Spanish ☐ Other : _____

SCREEN DATE (REQUIRED): _____

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

ADDRESS: _____ **MOB DATE OF BIRTH:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

IS HOME LOCATED IN FREDERICK CITY ☐ **YES** ☐ **NO**

EMAIL ADDRESS (optional): _____ **BEST PHONE NUMBER:** _____

ESTIMATE DUE DATE: _____ **OR BABY'S DATE OF BIRTH:** _____

FAMILY STRESS/RESOURCES NEEDED: **(T / F / U** **T** = True **F** = False **U** = Unknown/Unable to Obtain Information)

_____ **PARENT IS SINGLE, SEPARATED, DIVORCED or WIDOWED**
_____ **PARTNER UNEMPLOYED**
_____ **FINANCIAL NEEDS**
_____ **UNSTABLE HOUSING**
_____ **NO PHONE**
_____ **EDUCATION LEVEL UNDER 12 YEARS**
_____ **LIMITED SUPPORT SYSTEM**
_____ **SUBSTANCE ABUSE (Past or Current)**
_____ **LATE, LIMITED or NO PRENATAL CARE**
_____ **HISTORY OF ABORTIONS**
_____ **MENTAL ILLNESS (Past or Current)**
_____ **CONSIDERED or CONSIDERING ABORTION (for this pregnancy)**
_____ **CONSIDERED or CONSIDERING ADOPTION (for this pregnancy)**
_____ **RELATIONSHIP or FAMILY CONFLICT**
_____ **DEPRESSION (Past or Current)**

REFERRED TO HEALTHY FAMILIES FREDERICK PROGRAM? ☐ YES ☐ NO

REASON NOT REFERRED:

☐ Not interested
☐ Participating in another program
☐ No time available to participate
☐ Missed at hospital
☐ Moving/moved
☐ Miscarriage
☐ Abortion
☐ Adoption
☐ Deceased target child
☐ Child Protective Services (CPS) status
☐ Language barrier, no interpreter
☐ Other (specify): _____

Date of data entry: _____ *Data entered by (Initials):* _____

PLEASE FAX BACK TO: 301-695-4826

06-01-2020