Around the Korner Center for School Age Enrichment

Child and Family Needs Assessment

Dear Parent/Guardian,

As a way to ensure your needs are being met within our program and outside our program, we want to ensure we are able to connect you to community services or organizations at no cost or at a reduced cost. Please feel free to add if services are not listed.

Child	Name:	DOB:
Parent/Guardian A	Name:	DOB:
Parent/Guardian B	Name:	DOB:

Please indicate below if there are any services or information about certain services which you feel would be helpful to you or your family:

- ☐ Emergency Assistance
- ☐ WIC/Nutrition/Food
- ☐ Housing Assistance
- ☐ Dental/Medical Health Services
- ☐ Clothing Referral
- ☐ Transportation
- ☐ Child Support
- ☐ Legal Services/Custody
- ☐ Education/Careers
- ☐ Special Abilities-Needs
- ☐ Child Development
- ☐ School Districts
- ☐ CPR/Frist Aid
- ☐ Parent Support Groups
- ☐ Parenting Classes
- ☐ Counseling
- ☐ Immigration Services
- ☐ Alcohol/Drug Abuse Prevention, Education and Treatment
- ☐ Other: _____

Please Indicate your most needed resources:

1. _____
2. _____
3. _____

☐ **No Services Needed at this Time.**

Parent/ Guardian Signature: _____ Date: _____