



Healthy Families Yolo County provides a range of services to help you raise a healthy and happy baby including visits at your home or a location of your choice, child development education, parenting support, help connecting with community resources, and much more!

Parent self-referral form

By initialing below, I agree that this information will be shared with Healthy Families Yolo County who will call and/or meet with me to offer connection to support services & resources that may be helpful to me and my family.

Services are voluntary, confidential, and free. **INITIAL HERE:** _____ **DATE:** _____

Name _____ D.O.B. _____
 Address _____ City _____ Zip Code _____
 Phone # _____ Email address: _____
 Partner's Name _____ D.O.B. _____ Phone# _____
 Clinic/Hospital _____ Medical Provider _____
 EDD (Expected due date) or D.O.B. _____ Baby's name _____
 Do you have other children? Yes No If yes, how many? _____ Ages? _____

Please circle your answer to the questions below. Your answers are kept confidential.

- 1. Marital status (*circle one*) : Single Separated Divorced Married
- YES NO 2. Is your partner unemployed?
- YES NO 3. Do you worry about how to buy food and other basic needs for your family?
- YES NO 4. Do you have a stable, safe home?
- YES NO 5. Do you have a phone?
- YES NO 6. Have you received your high school diploma or GED?
- YES NO 7. Do you have family members you can call in case of emergency?
- YES NO 8. Have you ever had a problem with alcohol or drugs?
- 9. When did you start prenatal care for this pregnancy? (*circle one*) 1st trimester 2nd trimester 3rd trimester
- YES NO 10. Have you ever chosen to end a pregnancy?
- YES NO 11. Have you ever received treatment for a mental health disorder?
- YES NO 12. Did you consider abortion for this pregnancy?
- YES NO 13. Did you consider adoption for this pregnancy?
- YES NO 14. Are you feeling stress about your relationship with your partner or other family members?
- YES NO 15. Do you have a history of depression or are you currently experiencing feelings of depression?

| Health Insurance | Primary Language Spoken | Race/Ethnicity Categories | |
|--------------------------------|-------------------------------|--|---|
| <input type="radio"/> Medi-Cal | <input type="radio"/> English | <input type="radio"/> Hispanic/Latino | <input type="radio"/> Black or African American |
| Other: _____ | <input type="radio"/> Spanish | <input type="radio"/> White, non-Hispanic | <input type="radio"/> Hawaiian/Pacific Islander |
| | Other: _____ | <input type="radio"/> Native American | <input type="radio"/> Asian |
| | | <input type="radio"/> Decline to self-identify | <input type="radio"/> Multi-racial: _____ |

**Return completed form to Marisol Andrade or you may call to complete with her by phone (530) 902-5983
 Fax: (530) 753-7662 Email: MARISOL.ANDRADE@YOLOCOUNTY.ORG**