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	
O Medi-Cal	O English	O Hispanic/Latino	O Black or African American
Other: ___________	O Spanish	O White, non-Hispanic	O Hawaiian/Pacific Islander
	Other: _______________	O Native American	O Asian
		O Decline to self-identify	O Multi-racial:______________

For help with this form or to learn more call (530) 902-4383 or Email: healthyfamilies@yolokids.org

Return completed form to Fax: (530) 753-7662 or by email