Appendix B

FIRST 5 SANTA CLARA COUNTY

FIRST 5 Santa Clara County is developing programs and services for families like yours with a child 0-5 years old. We need your help to define what kind of services would be helpful to you and your family during this time of change. We want to commend you in getting this far and asking for help. It indicates your strength as a parent and love for your child(ren).

Please give some thought to the questions and give your honest answer to each question.

1. What is your relationship to the child(ren)? } Mother } Father } Other _____

   Are you the primary caretaker of your children? _____

2. How many children do you have in your household? _____

3. What are their ages? (*Please put the number of children in the box*)

   ☐ 0-2 ☐ 3-5 ☐ 6-9 ☐ 10-13 ☐ 14-18

4. Please check if any of the following issues is present in your case?
   ☐ Family violence ☐ Alcohol or drug abuse ☐ Child endangerment
   ☐ Not Applicable

5. What is the greatest strength of your family? _____
_____

6. Do you have family or good friends living near-by who can offer you support or help?
   ☐ Yes ☐ No

7. Have you gone to a parent support group or class before? (This can be either with a community group, within your church, court ordered etc)
   ☐ Yes ☐ No
   If yes, where did you go? _____

   If yes, was this class or group helpful to you? ☐ Yes ☐ Somewhat ☐ Not really

8. What is the highest grade of school you have finished? _____

Please check the response that indicates your family's need for the following services. Check all that apply.

	You need:			Your child needs:		
Services	Yes	No	Maybe	Yes	No	Maybe
9.Health services						
10.Counseling services						
11.Dental services						
12.Health insurance						
13.Supervised Visitation services						
Classes						
14.Parenting classes						
15.Adult Education (ESL, GED, etc)						
16.Anger management						
17.Children of divorce support group						
18.Substance abuse treatment programs						

19. What other kinds of services do you think would be helpful to you and your family?

_____

_____

20. Please circle any of the responses that reflect some of the reasons that you felt you could not get the services you thought you needed. (*Please check all that apply*)

☐ Can't afford the services
☐ Don't have transportation
☐ Don't know where the services are
☐ I work during the day
☐ I do not speak English
☐ I don't have childcare available
☐ I don't have the time to go
☐ There is a waiting list
☐ Other 1 _____
☐ Other 2 _____

20. Your home Zip Code: _____

21. Your Ethnicity: (*You may check more than one)*

☐ Caucasian
☐ Latino/Hispanic
☐ *Mexican* ☐ *Other Hispanic*
☐ African American
☐ Asian/PI
☐ *Vietnamese* ☐ *Cambodian*
☐ *Chinese* ☐ *Korean* ☐ *Other*

☐ Other ethnicity not listed Please specify _____

22. What is the primary language used in your home? _____