ADDITIONAL SERVICES REQUESTED FOR FAMILY SUPPORT SERVICES (PIH)
PARTNERS IN HEALTH QUESTIONNAIRE

Applicant Name: _____ **Record #** _____ **Site** _____

Sibling Enrolled? ☐ **Yes** ☐ **No** **Sibling Name:** _____ **Record #** _____

Birth Mothers Maiden Name: _____ **Birth Hospital:** _____

Impact of the chronic health condition

Is the chronic health condition expected to last one year or longer? ☐ Yes ☐ No ☐ Don't Know

Do you believe this condition impacts the applicant's daily functioning/activities? ☐ Yes ☐ No ☐ Don't Know

	Weekly	Bi-Weekly	Monthly	Every Few Months	Yearly
How often does the applicant see visit a PCP for their chronic health condition?	☐	☐	☐	☐	☐
How often does the applicant see a Specialist for their chronic health condition?	☐	☐	☐	☐	☐

Household Expenses

Type of Residence/Housing ☐ Own ☐ Rent ☐ Section 8/Assistance ☐ Shared with Family ☐ Other/ Shelter

Type of Utilities used ☐ Phone ☐ Electric ☐ Electric Heat ☐ Oil ☐ Gas/Propane ☐ Wood ☐ Water/Sewer ☐ Other

Transportation Used Regularly ☐ Own Car #of _____ ☐ Bus ☐ Taxi ☐ Friends/Family ☐ Other

Natural Supports & Family Strengths:
What/who helps you and your family dealing with this health condition? Greatest strength?

FAMILY NEEDS: What are your needs related to this condition, family, or household?	Begin Date	How long to complete	Who

FAMILY GOALS : What are your goals related to this condition, family, or household?	Begin Date	How long to complete	Who

For Office Use Only

☐ New ☐ Update ☐ Re- Application (discharged 1+) Region: _____ Site Name: _____

FSC Signature: _____ Record ID _____ SMS Case # _____