

Tribal Needs Assessment

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Primary Caregiver	Name:				DOB:	
Second Caregiver	Name:				DOB:	
	Physical address:	Street Address/Apt #	City	State	Zip Code	
	Mailing address:	Street Address/Apt #/ PO Box #	City	State	Zip Code	
Contact	Email:					
Contact	Phone:					
Number of people (adults) in your household:						
How did you hear about the program?						

Income Assistance

<p>1. Please select any of the following sources of income or income assistance that your household is currently receiving to assist support the kin child(ren): <i>(Check all that apply)</i></p> <p>NOTE: <i>This information is being collected to assist your navigator in understanding what income sources you may be eligible for that you may not be currently receiving.</i></p>	
<input type="checkbox"/> Pension <input type="checkbox"/> Child support <input type="checkbox"/> TANF child only <input type="checkbox"/> Social Security Benefits (SSD) <input type="checkbox"/> Veteran benefits <input type="checkbox"/> Salary/Wages	<input type="checkbox"/> Unemployment income <input type="checkbox"/> Survivor benefits for the child <input type="checkbox"/> Monthly maintenance payment <input type="checkbox"/> Monthly adoption support subsidy <input type="checkbox"/> Monthly relative guardianship assistance program (RGAP) subsidy <input type="checkbox"/> Per Capita/Treaty Income <input type="checkbox"/> Other, please explain: _____

This section is asking about your kinship child.

Please complete questions 1-25 of this section for ONE kinship child in your care/home. If you have more than one (1) kinship child in your care, please complete additional 'kinship child form' for EACH.

Please provide additional information on the kinship child(ren) (under 18) currently living in your home		
1. Kinship child's name: first/middle/last _____ (Add kinship child)		
2. Gender	3. Birthdate	4. Race/Ethnicity (<i>Check all that apply</i>)
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Two Spirit <input type="checkbox"/> Transgender <input type="checkbox"/> Non-binary	____/____/____ (MM/DD/YYYY)	<input type="checkbox"/> American Indian/ Alaskan Native; Tribal affiliation: _____ <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino/Latinx <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Other: _____
5. Time kinship child has been in your care:	Year(s)	Month(s)
	_____	_____
6. Have you been the primary caregiver for your kinship child continuously?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Intermittent (on and off)		

7. What is your relationship to the kinship child? (Select all that apply)	
<input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Foster parent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Non-relative <input type="checkbox"/> Other, please explain: _____	
8. Date kinship child left the home (if more than one child left the home, please complete questions using separate forms).	Date child left home: _____
9. Where did the child move to?	<input type="checkbox"/> returned to birth parent <input type="checkbox"/> entered foster care <input type="checkbox"/> moved to another kin caregiver <input type="checkbox"/> aged out <input type="checkbox"/> Other: _____
10. Date of first Kinship Needs Assessment (if this is not the first time you completed this form with this family):	_____/_____/_____ (MM/DD/YYYY)
Kinship Child Health	
11. In general, how would you rate your kinship child's <u>physical health</u>?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Very Good <input type="checkbox"/> Fair
12. In general, how would you rate your kinship child's <u>behavioral health</u>?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Very Good <input type="checkbox"/> Fair
13. Does your kinship child have access to primary care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are your kinship child's physical health needs being met?	<input type="checkbox"/> Yes <input type="checkbox"/> Not applicable <input type="checkbox"/> No <input type="checkbox"/> I don't know

15. Are your kinship child's behavioral health needs being met?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not applicable <input type="checkbox"/> I don't know		
16. Behavioral health/ counseling for kinship child(ren) (Select all that apply)	Used in past 12 months	Currently use	Don't currently use, but need	Don't need at this time
Culturally relevant/holistic healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapy/counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use/recovery support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kinship Child Education				
17. Does your kinship child attend school (includes pre-school if applicable)?	<input type="checkbox"/> Yes → <input type="checkbox"/> No (skip to next)	If yes, what is your kinship child's grade? _____ Grade		
18. Does your kinship child receive or need any special education services or other support programs?	<input type="checkbox"/> Yes → <input type="checkbox"/> No (skip to next) <input type="checkbox"/> I don't know	Does your kinship child have a current IEP or 504 plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	
19. Is your kinship child receiving all of the services outlined in the IEP or 504 Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not applicable <input type="checkbox"/> I don't know		
20. Do you need assistance addressing your kinship child's social or behavioral needs at school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Please explain what you need help with.				
21. Do you need assistance requesting academic support for your kinship child?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO		
Please explain what you need help with.				

Caregiver Health (SF-12)**These questions ask your views about your own health.**

22. In general, would you say your overall health is: (Select one)	<i>Primary</i>	<i>Secondary</i>
	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very Good <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very Good <input type="checkbox"/> <input type="checkbox"/> Good <input type="checkbox"/> Poor
23. Do you have any unmet healthcare needs?	<i>Primary</i>	<i>Secondary</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify: _____

SECTION II: PART 2 Kinship Caregiver Needs Assessment

Client identification number:				
1. Date survey completed:	____/____/____ (MM / DD / YYYY)			
Please check which services you have received in the <u>last 12 months</u> , services you <u>currently receive</u> , and services you <u>need</u> for yourself and/or your kinship child.				
Services	Used in past 12 months	Currently use	Don't currently use, but need	Don't need at this time
1. Current housing needs (Select all that apply)				
Section 8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tribal housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shelter and transitional housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subsidies, vouchers, affordable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eviction prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing with services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shared housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing repair/maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Searching for housing (i.e. additional space, lower cost)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Support obtaining concrete goods (i.e. bedding, furniture, clothing, cultural activities) (Select all that apply)				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Help getting additional food for your family (Select all that apply)				
Food Bank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School lunch program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Stamps, EBT, SNAP, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: Tribally run food program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Services	Used in past 12 months	Currently use	Don't currently use, but need	Don't need at this time
4. Help accessing public assistance (Select all that apply)				
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security (SSI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TANF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aged, Blind or Disabled (ABD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Help with transportation (Select all that apply)				
Bus/taxi pass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rides to/from appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Help with School related supports (Select all that apply)				
Preschool enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K-12 enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Special education services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IEP/504 plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational advocate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Equipment (i.e. internet, computers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School transportations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-secondary supports (i.e. scholarships, college applications, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Services	Used in past 12 months	Currently use	Don't currently use, but need	Don't need at this time
7. Help accessing primary care, other medical care, or resources (Select all that apply)				
For self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For kinship child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For other children/adults in the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Child care support (i.e. Working Connections, after school care, informal child care etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Respite: temporary, time-limited break for caregivers (Select all that apply)				
Respite for caregivers (DCYF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite programs (DD Administration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other respite vouchers programs (e.g. Lifespan Respite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Camp/retreats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child/youth activities (e.g. extra-curricular activities, scouts, sports)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family recreation activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tribal-specific Respite Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Services	Used in past 12 months	Currently use	Don't currently use, but need	Don't need at this time
10. Behavioral health/counseling for family members (Select all that apply)				
Culturally relevant/holistic healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapy/counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use/recovery support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Kinship care support groups/networking (Select all that apply)				
For self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For kinship child(ren)/youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Services	Used in past 12 months	Currently use	Don't currently use, but need	Don't need at this time
12. Training for kinship caregivers (such as parenting classes and trainings) (Select all that apply)				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Language services				
Traditional Language classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Access to legal services and advice (i.e. legal representation, custody, estate planning/end of life, child support, etc.) (Select all that apply)				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. In-home family services (Select all that apply)				
Home-visiting programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family preservation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-home services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth to 3/early intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The table below lists all services from the Kinship Needs Assessment. Please rank your top three to five needs from the options below. (1 = the most important need)

<p><input type="checkbox"/> Financial support for necessities</p> <p><input type="checkbox"/> Financial education support</p> <p><input type="checkbox"/> Help finding/maintaining housing</p> <p><input type="checkbox"/> Support obtaining durable goods</p> <p><input type="checkbox"/> Help getting enough food daily for your family</p> <p><input type="checkbox"/> Getting and keeping public assistance</p> <p><input type="checkbox"/> School related supports</p>	<p><input type="checkbox"/> Respite</p> <p><input type="checkbox"/> Help with transportation</p> <p><input type="checkbox"/> Help accessing primary care, other medical care or resources</p> <p><input type="checkbox"/> Help accessing dental care services</p> <p><input type="checkbox"/> Personal and emotional support about your circumstance, someone to talk to</p> <p><input type="checkbox"/> Someone to talk to regarding your kinship child(ren)</p> <p><input type="checkbox"/> Child-care support</p> <p><input type="checkbox"/> Referral to aging and disability resource center</p>	<p><input type="checkbox"/> Behavioral health / counseling</p> <p><input type="checkbox"/> Kinship Care Support groups / networking</p> <p><input type="checkbox"/> Training for kinship caregivers</p> <p><input type="checkbox"/> Language services</p> <p><input type="checkbox"/> Access to legal services and advice</p> <p><input type="checkbox"/> In-home family services</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Other: _____</p>
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GOAL SETTING

Please enter the date goal set for each goal. Identify the category of each goal using the table above. The Essential Tasks section is available to give more detailed description of the goal. When a goal is completed, be sure to check the box in the goal status field and enter the date completed.

Date Goal 1 Set: ____/____/____		Category:								
Task 1:										
Describe Essential Tasks:										
What you'll do:										
What others will do:										
How important is it for you to work on the goal you identified above?										
Not Important	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Very Important
How confident are you that you will be successful in reaching the goal you identified above?										
Not Important	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Very Important
Next Steps/Follow up										
Date Goal Completed		____/____/____								
Goal Status:		<input type="checkbox"/> Goal completed <input type="checkbox"/> Goal no longer relevant <input type="checkbox"/> Caretaker no longer has children				<input type="checkbox"/> Caretaker no longer wants services <input type="checkbox"/> Lost contact with caregiver <input type="checkbox"/> End of service period				

Date Goal 2 Set: ____/____/____		Category:									
Task 1:											
Describe Essential Tasks:											
What you'll do:											
What others will do:											
How important is it for you to work on the goal you identified above?											
Not Important	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	Very Important
How confident are you that you will be successful in reaching the goal you identified above?											
Not Important	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	Very Important
Next Steps/Follow up											
Date Goal Completed		____/____/____									
Goal Status:		<input type="checkbox"/> Goal completed <input type="checkbox"/> Goal no longer relevant <input type="checkbox"/> Caretaker no longer has children					<input type="checkbox"/> Caretaker no longer wants services <input type="checkbox"/> Lost contact with caregiver <input type="checkbox"/> End of service period				

Date Goal 3 Set: ____/____/____		Category:								
Task 1:										
Describe Essential Tasks:										
What you'll do:										
What others will do:										
How important is it for you to work on the goal you identified above?										
Not Important	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Very Important
How confident are you that you will be successful in reaching the goal you identified above?										
Not Important	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Very Important
Next Steps/Follow up										
Date Goal Completed		____/____/____								
Goal Status:		<input type="checkbox"/> Goal completed <input type="checkbox"/> Goal no longer relevant <input type="checkbox"/> Caretaker no longer has children				<input type="checkbox"/> Caretaker no longer wants services <input type="checkbox"/> Lost contact with caregiver <input type="checkbox"/> End of service period				