Kinship Profile Questionnaire

**Purpose:** Use this form to collect background information regarding potential caregivers and all household members to initiate the home assessment process.

**Directions:** To complete this form, the caseworker or contractor provides this questionnaire to the potential caregiver to complete. The potential caregiver should contact the caseworker for assistance. If a question does not apply, write NA (Non-Applicable). After completing this form, the caregiver gives it to the home assessor.

|  |
| --- |
| CAREGIVER #1 INFORMATION |
| The primary caregiver is caregiver #1. |
| Full Legal Name (First, Middle, Last):      | Any other names you have used:       |
| Birthdate:       | Birthplace (city, state, country):      | Phone Number:      |
| Height:      | Weight:      | Hair Color:      | Eye Color:      | Race and Ethnicity:      |
| Military Record |
| Branch of Service:       | Dates of Service:       |
| Highest Rank Obtained:       | Type of Discharge:       |
| Work Performed in Service:       |
| Criminal Record |
| Have you ever been convicted?    Yes    NoIf yes, give the nature and disposition of the charges:       |
| Education |
| Highest school grade completed:       | When completed?       |
| Where completed:       |
| Number of college years completed:       | Degree Received:       |
| List any special training you have received and where it was received:       |
| Employment |
| Current Employer's Name:       | Position:       | Your Work Number:       |
| Address:       | Start Date:       |
| Type of Work Performed:       |
| Previous employment for last 5 years if different from present employment **(If needed,** **use back of page.)**Employer's Name:       | Position:       | Phone Number:       |
| Address:       | Start Date:       | End Date:       |
| Reason For Leaving:       |
| Hobbies:       |
| Marriage History |
| **How many times have you been married? (If never, enter never):**       |
| **Full Name of Spouse:** | **Date of Marriage:** | **Place of Marriage:** | **Number of Children:** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Date of Divorce or Death of Spouse:** | **Divorce Decree Number (if available) or County Where Divorced:** |
|       |       |
|       |       |
|       |       |
|       |       |
| Child Support |
| **Names of Children:** | **Amount of Child Support Payment:** | **Automatic Deduction by Employer:** | **Is Payment Current?** |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
| **Do you visit your children?**    Yes    No If **Yes**, how often?       If **No**, why?       |
| Medical History |
| Have you had a history of or treatment for any of the following? |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Tuberculosis |    |    | Depression |    |    | Alcoholism |    |    |
| Cancer |    |    | Seizures |    |    | Asthma |    |    |
| Severe Arthritis |    |    | Heart Condition |    |    | Chronic Headaches |    |    |
| Chronic Kidney Condition |    |    | Mental or Emotional Problems |    |    | Chronic Fatigue |    |    |
| Colitis |    |    | Ulcers |    |    | Insomnia |    |    |
| Eczema |    |    | Hemophilia |    |    | Allergies |    |    |
| Hay Fever |    |    | Diabetes |    |    | Other: |    |    |
| Have you ever received treatment for mental illness?    Yes    NoIf yes, when and who gave treatment?       |
| Have you ever taken medication for mental or emotional problems?    Yes    NoWhen:      Drugs Prescribed:       |
| Have you ever intentionally hurt yourself or attempted to commit suicide?    Yes    NoIf yes, when and why? |
| Have you ever gone to counseling for emotional or family problems?    Yes    NoIf yes, when?       Who was the counselor?       |
| Have you ever had a psychological examination or battery of psychological tests?    Yes    NoIf yes, when did you receive the psychological exam, and what was your diagnosis?       |
| If you are an adult, are you physically able to have children?    Yes    NoIf no, why not?       |
| **List all admissions to the hospital:** |
| **Date:** | **Place:** | **Reason for Admission:** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **List all prescription medications being taken on a regular basis:** |
| **Medication:** | **Reason for Medication:** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| Date of last visit to doctor and reason:       |
| List all illnesses you have had in the past year:       |
| Do you have a physical disability?    Yes    NoIf yes, please explain:       |
| Have you ever been treated for drug usage?    Yes    NoIf yes, when and where?       |
| **A statement may be needed from a physician, psychologist, or counselor concerning you and/or your child's past or** **current physical, mental, or emotional condition. Are you willing to give permission for release of such information, if necessary?**    Yes    No |

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| CAREGIVER #2 INFORMATION |
| Full Legal Name (First, Middle, Last):      | Any other names you have used:       |
| Birthdate:       | Birthplace (city, state, country):      | Phone Number:      |
| Height:      | Weight:      | Hair Color:      | Eye Color:      | Race and Ethnicity:      |
| Military Record |
| Branch of Service:       | Dates of Service:       |
| Highest Rank Obtained:       | Type of Discharge:       |
| Work Performed in Service:       |
| Criminal Record |
| Have you ever been convicted?    Yes    NoIf yes, give the nature and disposition of the charges:       |
| Education |
| Highest school grade completed:       | When completed?       |
| Where completed:       |
| Number of college years completed:       | Degree Received:       |
| List any special training you have received and where it was received:       |
| Employment |
| Current Employer's Name:       | Position:       | Your Work Number:       |
| Address:       | Start Date:       |
| Type of Work Performed:       |
| Previous employment for last 5 years if different from present employment **(If needed,** **use back of page.)**Employer's Name:       | Position:       | Phone Number:       |
| Address:       | Start Date:       | End Date:       |
| Reason For Leaving:       |
| Hobbies:       |
| Marriage History |
| **How many times have you been married? (If never, enter never):**       |
| **Full Name of Spouse:** | **Date of Marriage:** | **Place of Marriage:** | **Number of Children:** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Date of Divorce or Death of Spouse:** | **Divorce Decree Number (if available) or County Where Divorced:** |
|       |       |
|       |       |
|       |       |
|       |       |
| Child Support |
| **Names of Children:** | **Amount of Child Support Payment:** | **Automatic Deduction by Employer:** | **Is Payment Current?** |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
| **Do you visit your children?**    Yes    No If **Yes**, how often?       If **No**, why?       |
| Medical History |
| Have you had a history of or treatment for any of the following? |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Tuberculosis |    |    | Depression |    |    | Alcoholism |    |    |
| Cancer |    |    | Seizures |    |    | Asthma |    |    |
| Severe Arthritis |    |    | Heart Condition |    |    | Chronic Headaches |    |    |
| Chronic Kidney Condition |    |    | Mental or Emotional Problems |    |    | Chronic Fatigue |    |    |
| Colitis |    |    | Ulcers |    |    | Insomnia |    |    |
| Eczema |    |    | Hemophilia |    |    | Allergies |    |    |
| Hay Fever |    |    | Diabetes |    |    | Other: |    |    |
| Have you ever received treatment for mental illness?    Yes    NoIf yes, when and who gave treatment?       |
| Have you ever taken medication for mental or emotional problems?    Yes    NoWhen:      Drugs Prescribed:       |
| Have you ever intentionally hurt yourself or attempted to commit suicide?    Yes    NoIf yes, when and why? |
| Have you ever gone to counseling for emotional or family problems?    Yes    NoIf yes, when?       Who was the counselor?       |
| Have you ever had a psychological examination or battery of psychological tests?    Yes    NoIf yes, when did you receive the psychological exam, and what was your diagnosis?       |
| If you are an adult, are you physically able to have children?    Yes    NoIf no, why not?       |
| **List all admissions to the hospital:** |
| **Date:** | **Place:** | **Reason for Admission:** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **List all prescription medications being taken on a regular basis:** |
| **Medication:** | **Reason for Medication:** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| Date of last visit to doctor and reason:       |
| List all illnesses you have had in the past year:       |
| Do you have a physical disability?    Yes    NoIf yes, please explain:       |
| Have you ever been treated for drug usage?    Yes    NoIf yes, when and where?       |
| **A statement may be needed from a physician, psychologist, or counselor concerning you and/or your child's past or** **current physical, mental, or emotional condition. Are you willing to give permission for release of such information, if necessary?**    Yes    No |

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| OTHER ADULT HOUSEHOLD MEMBER’S INFORMATION |
| Complete this section for each adult living in the home other than caregiver #1 and caregiver #2. If there are multiple other adults living in the home, make additional copies of this section for each adult as needed. |
| Full Legal Name (First, Middle, Last):      | Any other names you have used:       |
| Birthdate:       | Birthplace (city, state, country):      | Phone Number:      |
| Height:      | Weight:      | Hair Color:      | Eye Color:      | Race and Ethnicity:      |
| Military Record |
| Branch of Service:       | Dates of Service:       |
| Highest Rank Obtained:       | Type of Discharge:       |
| Work Performed in Service:       |
| Criminal Record |
| Have you ever been convicted?    Yes    NoIf yes, give the nature and disposition of the charges:       |
| Education |
| Highest school grade completed:       | When completed?       |
| Where completed:       |
| Number of college years completed:       | Degree Received:       |
| List any special training you have received and where it was received:       |
| Employment |
| Current Employer's Name:       | Position:       | Your Work Number:       |
| Address:       | Start Date:       |
| Type of Work Performed:       |
| Previous employment for last 5 years if different from present employment **(If needed,** **use back of page.)**Employer's Name:       | Position:       | Phone Number:       |
| Address:       | Start Date:       | End Date:       |
| Reason For Leaving:       |
| Hobbies:       |
| Marriage History |
| **How many times have you been married? (If never, enter never):**       |
| **Full Name of Spouse:** | **Date of Marriage:** | **Place of Marriage:** | **Number of Children:** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Date of Divorce or Death of Spouse:** | **Divorce Decree Number (if available) or County Where Divorced:** |
|       |       |
|       |       |
|       |       |
|       |       |
| Child Support |
| **Names of Children:** | **Amount of Child Support Payment:** | **Automatic Deduction by Employer:** | **Is Payment Current?** |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
|       |       |    Yes    No |    Yes    No |
| **Do you visit your children?**    Yes    No If **Yes**, how often?       If **No**, why?       |
| Medical History |
| Have you had a history of or treatment for any of the following? |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Tuberculosis |    |    | Depression |    |    | Alcoholism |    |    |
| Cancer |    |    | Seizures |    |    | Asthma |    |    |
| Severe Arthritis |    |    | Heart Condition |    |    | Chronic Headaches |    |    |
| Chronic Kidney Condition |    |    | Mental or Emotional Problems |    |    | Chronic Fatigue |    |    |
| Colitis |    |    | Ulcers |    |    | Insomnia |    |    |
| Eczema |    |    | Hemophilia |    |    | Allergies |    |    |
| Hay Fever |    |    | Diabetes |    |    | Other: |    |    |
| Have you ever received treatment for mental illness?    Yes    NoIf yes, when and who gave treatment?       |
| Have you ever taken medication for mental or emotional problems?    Yes    NoWhen:      Drugs Prescribed:       |
| Have you ever intentionally hurt yourself or attempted to commit suicide?    Yes    NoIf yes, when and why? |
| Have you ever gone to counseling for emotional or family problems?    Yes    NoIf yes, when?       Who was the counselor?       |
| Have you ever had a psychological examination or battery of psychological tests?    Yes    NoIf yes, when did you receive the psychological exam, and what was your diagnosis?       |
| If you are an adult, are you physically able to have children?    Yes    NoIf no, why not?       |
| **List all admissions to the hospital:** |
| **Date:** | **Place:** | **Reason for Admission:** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **List all prescription medications being taken on a regular basis:** |
| **Medication:** | **Reason for Medication:** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| Date of last visit to doctor and reason:       |
| List all illnesses you have had in the past year:       |
| Do you have a physical disability?    Yes    NoIf yes, please explain:       |
| Have you ever been treated for drug usage?    Yes    NoIf yes, when and where?       |
| **A statement may be needed from a physician, psychologist, or counselor concerning you and/or your child's past or** **current physical, mental, or emotional condition. Are you willing to give permission for release of such information, if necessary?**    Yes    No |

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| PRESENT HOUSEHOLD INFORMATION  |
| Address:       | Phone Number:       |
| How long have you lived at this address?       |
| Is this address a:    House    Mobile Home    Apartment  |
| How many rooms do you have?       | How many bedrooms?       | How many baths?       |
| All Household Members |
| **Name:** | **Date of Birth:** | **Relationship:** | **Grade/School:** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Child Care Arrangements** |
| When both parents are working or away from home, who cares for the children? List all individuals (babysitters, nannies, etc.) as well as any facilities (day cares etc.) who provide care. |
| **Name/Facility Name** | **Age of Caregiver (If not a Facility)** | **Phone Number** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **Children’s Immunizations** |
| Are the children current on their immunizations?    Yes    NoIf no, why?       |
| Firearms in the Home |
| Do you have firearms in the home?    Yes    NoIf yes, what type of gun(s) and where/how stored:       |
| Monthly Budget |
| **Income** | **Gross** | **Take Home** |
| Primary Caregiver’s Monthly Income | $      | $      |
| Partner’s Monthly Income | $      | $      |
| Other Monthly Income (Child Support, Rent, Etc.) | $      | $      |
| **TOTAL INCOME** | $      | $      |
| **MONTHLY EXPENSES** | **AMOUNT** |
| House Payment (Rent/Mortgage) | $      |
| Payments on Other Real Property | $      |
| Automobile Payment | $      |
| Automobile Expenses (Gas, Upkeep) | $      |
| Food | $      |
| Utilities (Electricity, Gas, Water, etc.) | $      |
| Telephone Expenses | $      |
| Revolving Charge Accounts (Visa, Mastercard, etc.) | $      |
| Insurance (Life, Health/Hospitalization, Auto, Property) | $      |
|  -Life | $      |
|  -Health/Hospitalization | $      |
|  -Auto | $      |
|  -Property | $      |
| Medical/Dental Expenses | $      |
| Clothing | $      |
| Furniture | $      |
| Church Contributions | $      |
| Entertainment | $      |
| Support of Relatives | $      |
| Miscellaneous (Specify) | $      |
| **TOTAL MONTHLY EXPENSES** | $      |
| REFERENCES (people whom we can talk to that know you well) |
| 1. Name:
 |
| Relationship: | Address: |
| Day Phone Number:  | Night Phone Number: |
| 1. Name:
 |
| Relationship: | Address: |
| Day Phone Number:  | Night Phone Number: |
| 1. Name:
 |
| Relationship: | Address: |
| Day Phone Number:  | Night Phone Number: |
| 1. Name:
 |
| Relationship: | Address: |
| Day Phone Number:  | Night Phone Number: |
| 1. Name:
 |
| Relationship: | Address: |
| Day Phone Number:  | Night Phone Number: |
| 1. Name:
 |
| Relationship: | Address: |
| Day Phone Number:  | Night Phone Number: |

|  |
| --- |
| GENERAL COMMENTS |
| COMMENTS (Any additional information you feel will be helpful):       |
| SIGNATURES |
| **WE AFFIRM THAT THE ANSWERS WE HAVE PROVIDED ARE ACCURATE TO THE BEST OF OUR KNOWLEDGE.** |
| Caregiver #1 Print Name:**X**       | Caregiver #1 Signature:**X**       | Date Signed:      |
| Caregiver #2 Print Name:**X**       | Caregiver #2 Signature:**X**       | Date Signed:      |