|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-00989A (02/2017) | | | | | | | **STATE OF WISCONSIN** | | | | |
| **CHILD AND FAMILY INFORMATION** | | | | | | | | | | | |
| Child’s Name | | | | | | | Date of Report | | | | |
| Enter date | | | | | | | Enter date | | | | |
| Parent / Legal Guardian Name | | | | | | | Parent / Legal Guardian Name | | | | |
| Enter date | | | | | | | Enter date | | | | |
| Relationship to Child | | | | | | | Relationship to Child | | | | |
| Enter date | | | | | | | Enter date | | | | |
| Street | City | | | | State | Zip Code | Street | | City | State | Zip Code |
| enter date | enter date | | | | WI | enter date | enter date | | enter date | WI | enter date |
| Phone Number | | | | | | | Phone Number | | | | |
| Enter date | | | | | | | Enter date | | | | |
| Alternate Phone Number | | | | | | | Alternate Phone Number | | | | |
| Enter date | | | | | | | Enter date | | | | |
| Email Address | | | | | | | Email Address | | | | |
| Enter date | | | | | | | Enter date | | | | |
| Other Caregiver Name | | | Other Caregiver Phone Number | | | | Street | | City | State | Zip Code |
| Enter date | | | Enter date | | | | enter date | | enter date | WI | enter date |
| Primary Language of Parent / Legal Guardian | | | | | | | Primary Language of Child | | | | |
| Enter date | | | | | | | Enter date | | | | |
| Child’s Race | | | | | | | Child’s Ethnicity: Hispanic | | | | |
| Enter date | | | | | | | Yes  No | | | | |
| Spends Day With Name | | Relationship | | | | | | | | | |
| Enter date | | Mom  Dad  Childcare Provider (Name) Enter date  Other (specify) Enter date | | | | | | | | | |
| List Others in the Child’s Home (Include Pets) | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | |
| List Other Important People in the Child’s Life | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | |
| Referral Source Name / Title / Contact Information | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | |
| Primary Medical Care Provider Name / Medical Home | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | |
| Community Supports (Select Services and Programs Child / Family Use) | | | | | | | | | | | |
| BadgerCare Plus | | | | Health Department | | | | SSI | | | |
| CYSHCN | | | | Healthy Start | | | | W2 | | | |
| Department of Human Services | | | | Katie Beckett | | | | WIC | | | |
| Family Resource Center | | | | Library | | | | YMCA/YWCA | | | |
| Family Support | | | | Medicaid/MA | | | | Support Groups Enter date | | | |
| Head Start | | | | FACETS | | | | Other Enter date | | | |