

## **Family Needs Assessment**

Nam	e of Family member	needing care:
Sold	ier/Parent/Guardian	<u> </u>
Age (if under 18):Date of Birth:		
Today's Date:		Review Date (at least annually):
level in pla	s of support. It is criti anning, thereby allowi	nent (FNA) is a tool to obtain information for determining cal that Family choice, interests and strengths be considered ng an alignment of resources with needs. The more de, the better we can assist your Family member.
1.	Tell me about your E	FM.
2.		e resources your Family has used for respite care support? ny of them now? How have they helped?
3.		ment/assignment cycle affecting/impacting your Family? pportunities to relax?
Eami	ly Noods Assassment	(ENA)

a	What are some of the things your Family enjoys doing? What are some of the activities in which your Family participates? Do you have local and accessible support systems? Please provide some examples.
	What are some of your concerns regarding the care of your EFM? What skills are needed by those involved in providing respite care for your Family member?
	What activities does your EFM enjoy doing? What activities is he or she involved n? What are his or her strengths?
	What type of skills are you looking for in a respite care provider? Are there skills you could teach the potential EFMP respite care provider?
	How does your EFM communicate his or her likes and dislikes or needs and desires?
Family N	Needs Assessment (FNA)

9.	Are there behavioral concerns the EFM respite care provider needs to know about and for which training is necessary? Please describe in detail.
10.	Do you have other Family members enrolled in the EFMP? If yes, please provide detailed information.
11.	Do you have a preferred EFM respite care provider(s)? If yes, please list.
12.	Agencies you are currently receiving services from:  TRICARE ECHO Vocational Rehabilitation
	Mental Health The ARC Easter Seals Other (Please List)
13.	Additional comments/information:
<b>Family</b>	Needs Assessment (FNA)