

Healthy Families New York/Home Visiting Program Kempe Assessment Form

This form has two pages

1. Primary Caretaker 1's Identifier:			2. Date of Kempe Assessment:			3-4. Family Assessment Worker Name:			
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<div style="display: flex; justify-content: space-between;"> First Last </div>			
5. Primary Caretaker 1's Name:				6. Primary Caretaker 1's Phone:					
<div style="display: flex; justify-content: space-between;"> First Last </div>				<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
7. Primary Caretaker 1's Address:									
Apt			Street			City		Zip Code	
8. Was Assessment Prenatal/Postnatal?					9. Who was present during the Assessment? (check only one)				
<input type="checkbox"/> Prenatal (<i>enter due date</i>) <input type="checkbox"/> Postnatal (<i>enter Target Child DOB</i>)					<input type="checkbox"/> 3. MOB <input type="checkbox"/> 5. FOB <input type="checkbox"/> 4. Both Parents <input type="checkbox"/> 6. Parent and Current Partner				
<div style="display: flex; justify-content: center; align-items: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div style="display: flex; justify-content: center; align-items: center; margin-top: 5px;"> Month Day Year </div>					9a. Observation by Supervisor <input type="checkbox"/> Yes <input type="checkbox"/> No				
Mother		Father		Mother		Father			
0-5-10-U		0-5-10-U		0-5-10-U		0-5-10-U			
10-11. Childhood History				20-21. Potential for Violence					
12-13. Substance Abuse, Mental Illness or Criminal History				22-23. Expectations of Infant's Milestones/Behavior					
14-15. Previous or Current CPS Involvement				24-25. Discipline of Infant/Toddler Child					
16-17. Self Esteem, Available Lifelines (Possible Depression), Coping Skills				26-27. Perception of New Infant					
18-19. Stressors/Concerns				28-29. Bonding/Attachment of New Infant					
30. Total Score Mother					31. Total Score Father				
<input type="text"/> <input type="text"/> <input type="text"/>					<input type="text"/> <input type="text"/> <input type="text"/>				
32. Assessment Result					33. If Item 32 is "Assessed Negative", were referrals made for new parent or family?				
<input type="checkbox"/> 1. Assessed Positive (<i>Skip Item 33</i>) <input type="checkbox"/> 2. Assessed Negative					<input type="checkbox"/> Yes <input type="checkbox"/> No				

Complete page 2

Date Form Submitted	Reviewer's Initials	Date of Data Entry	Initials of Data Entry Operator

Healthy Families New York/Home Visiting Program Kempe Assessment Form (Second Page)

Primary Caretaker 1's Identifier: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small; margin-top: 5px;"> Last Name (3 let) FI Birth Date (Month/Day/Yr) </div>	Date of Kempe Assessment: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 2px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small; margin-top: 5px;"> Month Day Year </div>
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Questions 34 through 37 apply to Primary Caretaker 1

34. Marital Status <input type="checkbox"/> 1. Married <input type="checkbox"/> 2. Not Married	35. Race/Ethnicity <input type="checkbox"/> 1. White, non-Hispanic <input type="checkbox"/> 2. Black, non-Hispanic <input type="checkbox"/> 3. Hispanic/Latina/Latino <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native American <input type="checkbox"/> 6. Other (<i>Specify</i> _____)	36. Education <input type="checkbox"/> 1. Less than 12 years <input type="checkbox"/> 2. High School/GED <input type="checkbox"/> 3. More than 12 years	37. Employed <input type="checkbox"/> Yes (<i>If Yes, ↓</i>) Number of Hours per week <div style="display: flex; justify-content: center; align-items: center; margin-left: 40px;"> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <input type="checkbox"/> No	38. Biological Father Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No
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Check either Y for Yes, N for No or UK for Unknown in Questions 39, 40, and 41

39. Primary Caretaker 1 History	40. Primary Caretaker 1 Parenting Attitudes	41. Primary Caretaker 1 Current Issues																																																																																																																																																				
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