

**EMAA HEAD START**  
**PIR TRACKING**

Child's Name \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_ Family Advocate's Name \_\_\_\_\_

*Directions: Begin filling out at Final Enrollment. Update as needed in a different colored ink. Family Advocate is responsible. Area Support Assistant will initial & date as updated information is entered.*

**FAMILY NEEDS ASSESSMENT/PARTNERSHIP AGREEMENT**

Completed? Yes No Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Has this **family** experienced homelessness **during the enrollment year**? (Definition of "homeless" per the McKinney-Vento Homeless Assistance Act) Yes No

If so, did **family** acquire housing **during the enrollment year**? Yes No

Did this **family** receive services under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) **during the enrollment year**? Yes No

**PIR HEALTH** (for **enrolled child**)

**At Enrollment**

**At End of Enrollment**

Medicaid Eligibility (**circle what applies**)

Yes No Potential

Yes No Potential

Primary Health Coverage (**circle what applies**)

None Med/CHIP CHIP Med Other Private

None Med/CHIP CHIP Med Other Private

Other Health Coverage (**circle what applies**)

None Med/CHIP CHIP Med Other Private

None Med/CHIP CHIP Med Other Private

Does **enrolled child** have:

**At Enrollment**

**At End of Enrollment**

An ongoing source of continuous & accessible routine, preventive & acute **medical** care?

Yes No

Yes No

An ongoing source of continuous & accessible routine, preventive, & acute **dental** care?

Yes No

Yes No

Did **enrolled child** receive preventive dental care (fluoride app, cleaning, sealants) **during this enrollment year**? Yes No

Place a "Y" on the line if this child **received ongoing medical treatment for the following chronic health conditions, (health conditions that continue over a long period of time) since last year's PIR was reported:**

\_\_\_\_ Anemia      \_\_\_\_ Asthma      \_\_\_\_ High Lead Level      \_\_\_\_ Hearing Difficulties  
\_\_\_\_ Overweight      \_\_\_\_ Vision Problems      \_\_\_\_ Diabetes

**PIR MENTAL HEALTH** (To be **completed by Teaching Staff AND Family Advocate together**. Do not include routine communication with staff or parents or routine child screenings & assessments)

Did a Mental Health Professional:

- Consult with program staff about the child's behavior/mental health? Yes No
- Provide 3 or more consultations with staff **since last year's PIR was reported**? Yes No
- Consult with parent/guardian about the child's behavior/mental health? Yes No
- Provide 3 or more consultants with parent/guardian **since last year's PIR was reported**? Yes No
- Provide an individual mental health assessment? Yes No
- Facilitate a referral for mental health services? Yes No

Mental Health Referrals:

Was the child referred by the program for mental health services outside of Head Start **since last year's PIR was reported**? Yes No

If so, did the child receive mental health services **since last year's PIR was reported**? Yes No