



# Family Needs Assessment

# Family Needs Assessment

## Supporting Your Family

Families caring for a child with medical complexity carry an extraordinary weight—emotionally, physically and mentally. Understanding your family’s needs, and naming what helps and what doesn’t, allows you to create conditions where everyone can thrive. What restores one may overwhelm another and recognizing those differences helps friends and loved ones offer meaningful, practical support.

*It's important to remember that having needs doesn't mean you're weak; it means you're human.*

*Giving voice to your needs is an act of strength and love, because when families are supported, the entire ring of care becomes stronger.*

## Purpose

This assessment helps identify strengths, challenges and support needs within the family— including siblings, daily life, finances and caregiver wellness. The goal is to create a holistic picture of what can make life more manageable and sustainable for your family.



# Family Needs Assessment

## SECTION 1: SIBLING NEEDS

### EMOTIONAL & SOCIAL WELLBEING



**How are your children coping with their sibling's medical needs?**

- Doing well overall
- Occasionally struggling
- Often sad, anxious, or withdrawn
- Unsure



**Do your children have opportunities for:**

- One-on-one time with a parent or caregiver?  
 Yes  No
- Social activities or time with friends?  
 Yes  No
- Counseling or emotional support?  
 Yes  No



**Do you feel your children understand their sibling's medical condition and needs?**

- Yes, age-appropriately
- Somewhat
- No, they seem confused, scared and/or worried



**What additional support might help your children?**

- Peer support groups
- Family therapy or sibling counseling
- Respite activities for siblings (periodic trips to zoo, museum, festivals, seasonal activities, etc).
- Education/resources about their sibling's condition
- Other: \_\_\_\_\_

Use this page to learn more about siblings so your Support Team can make them feel extra special!

## FUN FACTS ABOUT

insert sibling name here

My favorite food is:

My favorite restaurant is:

My favorite toys right now are:

When upset, my comfort item is:

My favorite outing is:

My favorite books right now are:

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# FAMILY NEEDS ASSESSMENT

## SECTION 2: DAILY HOUSEHOLD RESPONSIBILITIES



**HOW WELL ARE HOUSEHOLD RESPONSIBILITIES GOING (MEALS, CLEANING, ERRANDS, ETC.)?**

- Well
- Manageable but tiring
- Overwhelming most days
- Unable to keep up



**WHICH AREAS FEEL MOST CHALLENGING? (CHECK ALL THAT APPLY)**

- Meal planning/preparation
- Cleaning/laundry
- Transportation
- Scheduling/appointments
- Night time routines
- Other: \_\_\_\_\_

**WHO HELPS WITH DAILY HOUSEHOLD TASKS?**

- Partner/spouse
- Extended family/friends
- Paid caregiver/household help
- No regular help available

**WHAT SUPPORTS WOULD MAKE DAILY LIFE MORE MANAGEABLE?**

- Home health aide
- Volunteer assistance
- Meal train or grocery delivery
- Organizational/planning support
- Other: \_\_\_\_\_



# FAMILY NEEDS ASSESSMENT

## SECTION 3: FINANCES

### How would you describe your current financial situation?

- Stable and manageable
- Some strain
- Significant difficulty meeting needs

01



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### Do you currently receive any financial support related to your child's medical condition?

- Medicaid or waiver program
- SSI or disability benefits
- Charitable or foundation support
- None

### Are there unexpected expenses that create ongoing stress?

- Transportation (gas, parking, etc.)
- Medications/supplies not covered by insurance
- Lost work income
- Childcare for siblings
- Other: \_\_\_\_\_

03



04

### What financial resources would be most helpful?

- Assistance navigating benefits
- Grants or emergency funds
- Budgeting or financial coaching
- Gift card drive or cash fundraiser
- Connection to community aid programs
- Other: \_\_\_\_\_

# FAMILY NEEDS ASSESSMENT

## Section 4: RESPITE & PERSONAL WELLNESS

### HOW OFTEN DO YOU GET PERSONAL TIME TO REST OR RECHARGE?

- Daily or almost daily
- Once or twice a week
- Rarely
- Never

### DO YOU HAVE ACCESS TO RESPITE CARE (SOMEONE QUALIFIED TO CARE FOR YOUR CHILD SO YOU CAN REST)?

- Yes
- Occasionally
- No



### WHAT ACTIVITIES HELP YOU FEEL RESTORED OR SUPPORTED?

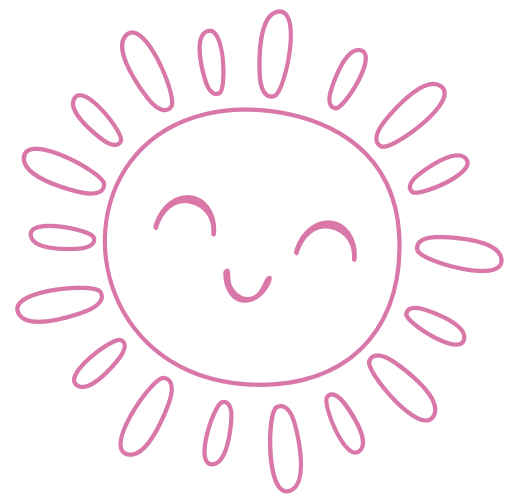
- Exercise or outdoor time
- Faith or spiritual practice
- Quality time with friends/family
- Counseling or therapy
- Quiet/alone/rest time
- Other:

### WHAT PREVENTS YOU FROM TAKING TIME FOR YOURSELF?

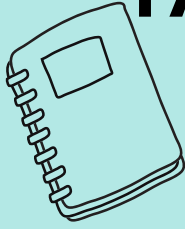
- Lack of respite care
- Guilt or worry about leaving
- Financial cost
- No time in schedule
- Other:

### WHAT WOULD HELP YOU CARE FOR YOURSELF MORE CONSISTENTLY?

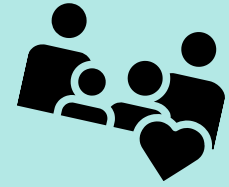
- Access to trained respite providers
- Counseling/peer support
- Support group or caregiver community
- Flexible work or childcare options
- Other:



# FAMILY NEEDS ASSESSMENT



## SECTION 5: STRENGTHS & PRIORITIES



~~~~~  
What are your family's  
greatest strengths?



~~~~~  
What areas feel most  
urgent to address right  
now?



~~~~~  
What would "feeling  
supported" look like for  
your family?



# GET TO KNOW YOUR FAMILY SURVEY

This section will help people get to know your family, your routines and what matters most to you. Every family caring for a child with medical complexity is unique. By sharing your story, we can better understand how to support your family's needs, strengths and goals.

## Section 1: Basic Family Information

Primary Caregiver(s) Name(s):

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Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Best way/time to reach you: \_\_\_\_\_

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Primary Language(s) spoken at home:

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Cultural or faith traditions important to your family:

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## Section 2: Child with Medical Complexity

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

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Other Medical Conditions:

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Current Care Team (doctors, therapists, specialists):

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Preferred Hospital/Clinic: \_\_\_\_\_

Current Medications/Equipment:

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Describe your child's personality, interests and what brings them joy:

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# GET TO KNOW YOUR FAMILY SURVEY

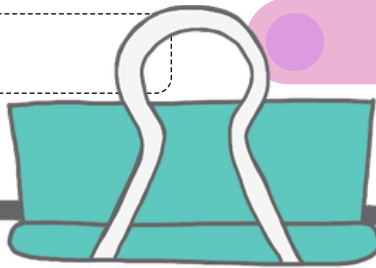
## Section 3: Family Members and Supporters

Please list all members of your household :

- ★
- ★
- ★
- ★
- ★

Other important people who help care for your child (family, friends, aides):

- 
- 
- 
- 
- 



Do you have pets?

**Yes No**

If yes, please list and include any important information (temperament, feed schedule/location, care needs, health issues, vet contact information):

# GET TO KNOW YOUR FAMILY SURVEY

## Section 5: Strengths, Values, and Goals

What does a typical day look like for your family?

What are the most challenging parts of your day?

What helps your family feel most supported or at ease?

What does a 'good day' look like for your child?

What are your family's greatest strengths?

Three horizontal purple boxes for writing answers to the question: "What are your family's greatest strengths?"

What priorities guide your family's decisions?

Three horizontal purple boxes for writing answers to the question: "What priorities guide your family's decisions?"

## Section 5 Continued

**What goals or hopes do you have for your child and your family this year?**

1

2

3

**Is there a spiritual practice that is encouraging to you and your family?**

**Is it helpful to you if people keep you and your family in thoughts or prayers?**

**Use the space below if you feel comfortable writing down your spiritual needs and preferences.**