healthy families
of Delaware Opportunities

Community Survey Form

Name:_____ Partner's Name: _____

Your date of birth: _____ Partner's Phone: _____

Mailing Address:_____ Address: ☐ Same as Mine

_____ _____

County: _____ _____

Phone: _____ Email : _____

May Delaware Opportunities staff contact you with program information?

☐Yes ☐ No

I received this survey from: _____

My due date is: _____

Did you first see a healthcare provider for your pregnancy?

☐1 to 3 months ☐3 to 6 months ☐6 to 9 months ☐Not at all

I am ☐Single ☐ Married ☐Separated ☐ Divorced ☐ In a Significant Relationship

Please check all that apply:

☐I am currently receiving Public Assistance ☐I am currently employed without health insurance

☐I am currently receiving Medicaid ☐I currently have financial concern