



## Community Survey Form

Name: \_\_\_\_\_

Your date of birth: \_\_\_\_\_

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

County: \_\_\_\_\_

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

May we contact you?  Yes  No

Alternate Phone: \_\_\_\_\_

I received this survey from: \_\_\_\_\_

My due date is: \_\_\_\_\_

When 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 receiving Medicaid
- I am currently employed without health insurance
- I currently have financial concerns

For more information on Healthy Families of Delaware Opportunities please contact us at  
(607) 746-1730 or [healthyfamilies @delawareopportunities.org](mailto:healthyfamilies@delawareopportunities.org)

**Thank you for your time in completing our survey**