

# Oklahoma Office of Child Abuse Prevention

## Evaluation Forms Manual



Oklahoma State Department of Health  
Family Health Services

Revised November 2008

Office of Child Abuse Prevention  
Family Support and Prevention Service  
Family Health Services  
Oklahoma State Department of Health  
1000 Northeast 10<sup>th</sup> Street  
Oklahoma City, OK 73117-1299

# **Program and Support Staff**

## **Oklahoma State Department of Health**

James M. Crutcher, MD, MPH  
Secretary of Health, Commissioner of Health

## **Family Health Services**

Edd E. Rhoades, MD, MPH  
Deputy Commissioner, Family Health Services

## **Family Support and Prevention Services**

Annette Jacobi, JD  
Chief

## **Office of Child Abuse Prevention**

Chris Fiesel, MA  
Programs Manager

Kathie Burnett, MS  
Program Consultant

Suzy Gibson, MS  
Program Consultant

Amber A. Sheikh, BDS, MPH  
Program Evaluator

Sherie Trice, MS  
CBCAP Consultant

Lisa Williams  
Administrative Programs Officer

Lori Owen  
Administrative Programs Officer

Sue Vaughn Settles, LCSW  
CATC Program Coordinator

Sandie Sherrill  
Programs Manager

Lisa Slater  
Administrative Assistant

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## Office of Child Abuse Prevention Program Staff

Amber Sheikh	Program Evaluator
Chris Fiesel	Programs Manager
Kathie Burnett	Program Consultant
Suzy Gibson	Program Consultant
Lori Owen	Administrative Programs Officer
Malinda Reddish-Douglas	Previous Epidemiologist

## Family Support and Prevention Service

Annette Jacobi	Chief
Mary Beth Cox	Program Evaluator, Children First

## Information Technology Services

Keith Lindsey  
Jeff Cosby  
Nancy Ivins  
Chad Magers

## Records Evaluation and Support

Mike Ewald

## Collaborators

Healthy Families Arizona  
Healthy Families Florida  
Healthy Families New York  
OCAP contractors

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# Office of Child Abuse Prevention Evaluation Manual

## Introduction

### The Act

In 1984, Oklahoma Legislators enacted the Oklahoma Child Abuse Prevention (CAP) Act (Oklahoma Statutes, Title 63, Section 1-227) and created the Office of Child Abuse Prevention (OCAP). The Office of Child Abuse Prevention is charged with the administrative responsibility of planning and implementing statewide community-based services to prevent child abuse and neglect and training of professionals who have responsibilities for children and families. Section 1-227.2 of Title 63 authorizes and directs the Office of Child Abuse Prevention to "...monitor, evaluate, and review the development and quality of services and programs for the prevention of child abuse and neglect..."

### The Charge

The charge of the Office of Child Abuse Prevention is to promote the health and safety of Oklahoma's children and families. Three primary methods employed to accomplish this mission are: 1) reducing violence and child maltreatment through education; 2) conducting multidisciplinary training of professionals; and 3) funding child abuse prevention programs. The Office works with the State Interagency Child Abuse Prevention Task Force, District Child Abuse Prevention Task Forces, Child Abuse Training and Coordination Council, and Multidisciplinary Child Abuse and Neglect Teams across Oklahoma.

### The Monitoring and Review

The OCAP Consultants, Programs Manager, Programs Administrator, and Evaluator monitor and review child abuse prevention program contracts administered from the Child Abuse Prevention Fund. The OCAP Consultants, Programs Manager, and/or Evaluator:

- Review the required Quarterly and Annual Program Performance Reports as submitted by the contractors;
- Conduct on-site visits to assess contractors' compliance with the approved contract or memorandum of understanding, the essential features of the specified OCAP program, including the Healthy Families Critical Elements and Parents As Teachers curricula; and
- Provide technical assistance, consultation, and training to the contractors' staff.

Detailed information on the monitoring and review of the OCAP programs is contained in the Office of Child Abuse Prevention ***Procedures Manual***.

### The Evaluation

The purpose of evaluation is to gain insight, improve program implementation, determine the effects of the program, and determine the effect on those who are participating in the program. The evaluation of OCAP programs envelops quality assurance, program model fidelity, goal achievement, and program outcome.

## Logic Model

A logic model provides a frame of reference for the process and evaluation of a program. The Office of Child Abuse Prevention (OCAP) has developed a logic model that defines an OCAP program; its structure can be seen on Page 6. The OCAP logic model defines some **assumptions** about child abuse prevention, the **inputs** necessary to conduct business, and the **activities, objectives, and goals** of the program. The model shows the sequence of these elements and shows how they work together to bring about change (i.e., prevention). The components of the program evaluation were designed using the logic model.

The impact of the program will be assessed using several outcome measures, including: increased immunization rates, earlier identification of developmental delays, reduced maternal smoking, increased time between pregnancies, increased knowledge of child development, and increased utilization of community resources.

### Assumptions & Inputs

A program must operate on certain assumptions. The OCAP programs operate on the following assumptions, which are key elements in determining the direction of the logic model and, thus, the program.

1. Program services are guided by literature on primary prevention programs and risk and protective factors of child abuse and neglect that show positive results such as:

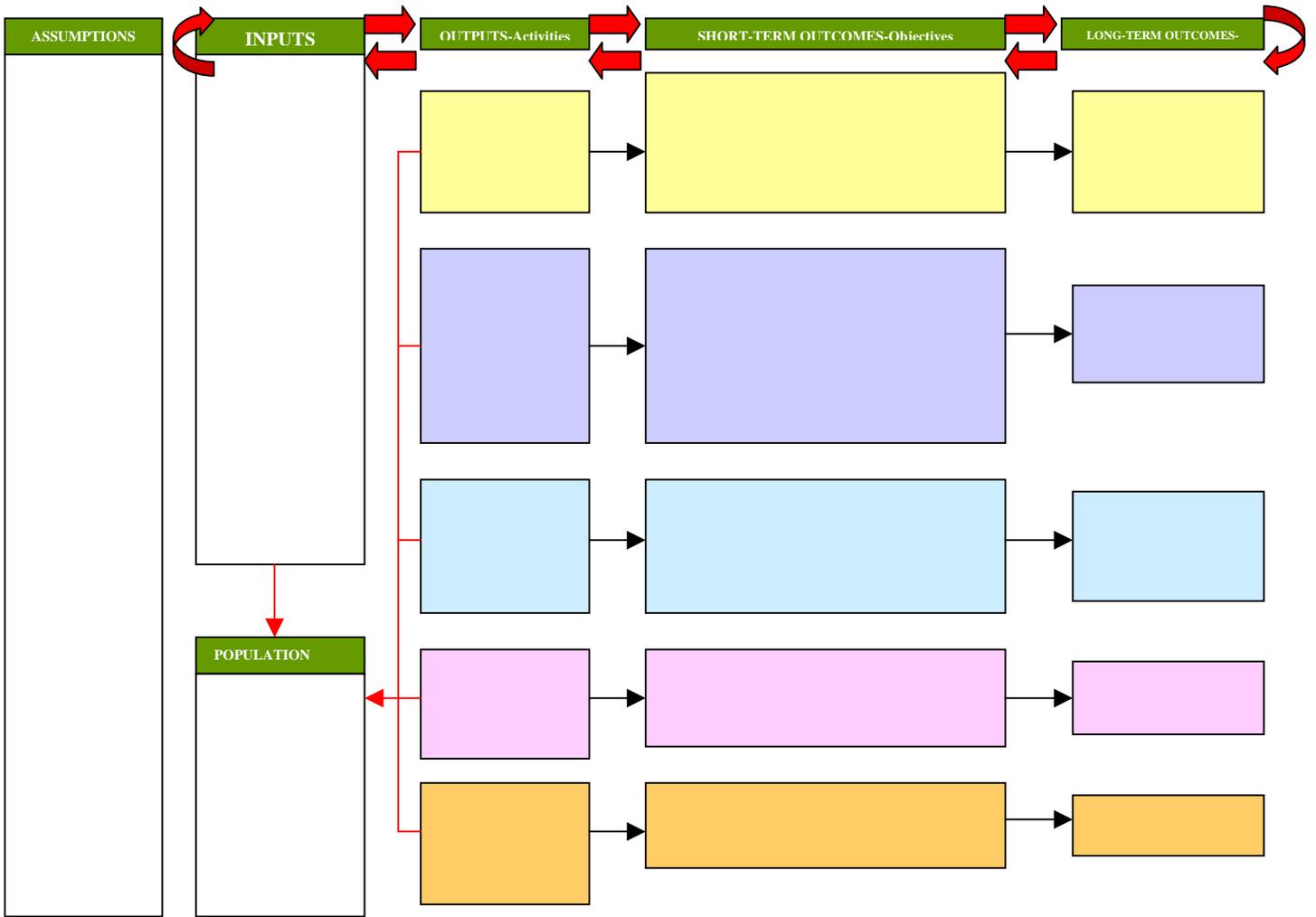
- ❖ Prevention programs are most effective when they are tailored to the specific needs of the identified population.
- ❖ The timing of the prevention and intervention matters.
- ❖ Intensity and duration of the prevention and intervention matters.
- ❖ Programs using modeling, and role-playing are nearly twice as effective as programs using non-directive strategies such as counseling and group discussions.
- ❖ Enhancement of protective factors and minimization of risk factors reduces the occurrence of child abuse and neglect amongst children and families.

2. The OCAP Home Visitation Program will utilize the Healthy Families America (HFA) model and Parents as Teachers (PAT) curriculum to deliver services.

- ❖ The program will follow the critical elements of the HFA model i.e. service initiation, service content, and staff characteristics to ensure model fidelity. (See Page 7.)
- ❖ Program benefits from the research-based PAT curriculum will depend on the core values and assumptions of the PAT model. In addition, a program must have certain elements available and operable in order for it to function properly. These are called “inputs” for the purpose of a logic model. The OCAP programs must have the following inputs for the program to function:

- ❖ OCAP contracting agencies.
- ❖ HFA & PAT trained agency staff including program supervisors, Family Assessment Workers, Family Support Workers and data entry support.
- ❖ Transportation for conducting home visits.
- ❖ Social services / resources.
- ❖ Partnerships to provide referrals.
- ❖ Stable OCAP funding.
- ❖ OCAP central office staff.
- ❖ Program Evaluation.
- ❖ Program monitoring and contract compliance to ensure program fidelity.

Office of Child Abuse Prevention Home Visitation Program – Logic Model



**The Healthy Families America (an initiative of Prevent Child Abuse America) 12 critical elements are used to assure the quality of program services. The 12 critical elements are measured using both the site visits (described in more detail in the OCAP Procedures Manual) and the data collection forms.**

## **Healthy Families America: 12 Critical Elements**

1. Initiate services prenatally or at birth of the child (at least before the child reaches one year of age).

2. Use a standardized assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse, and parental history of abuse in childhood).

3. Offer services voluntarily and use positive, persistent, outreach efforts to build family trust.

4. Offer services intensively with well-defined criteria for increasing or decreasing intensity of service over the long-term (i.e., 3 to 5 years).

5. Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; materials used should reflect the cultural, linguistic, and racial and ethnic diversity of the population served.

6. Services should focus on supporting the parent(s) as well as supporting parent-child interaction and child development.

7. At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.). Depending on the family's needs, the family may also be linked to additional services such as financial, food and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelter.

8. Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet each family's varying needs and to plan for future activities (i.e., for many communities no more than 15 families per home visitor on the most intense service level, and, for some communities the number may need to be significantly lower, e.g., less than 12).

9. Service providers should be selected because of their personal characteristics (i.e., nonjudgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

10. Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers should receive basic training in areas such as: cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.

11. Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation.

12. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference, in order to avoid stress-related burnout.

## Activities, Objectives and Goals

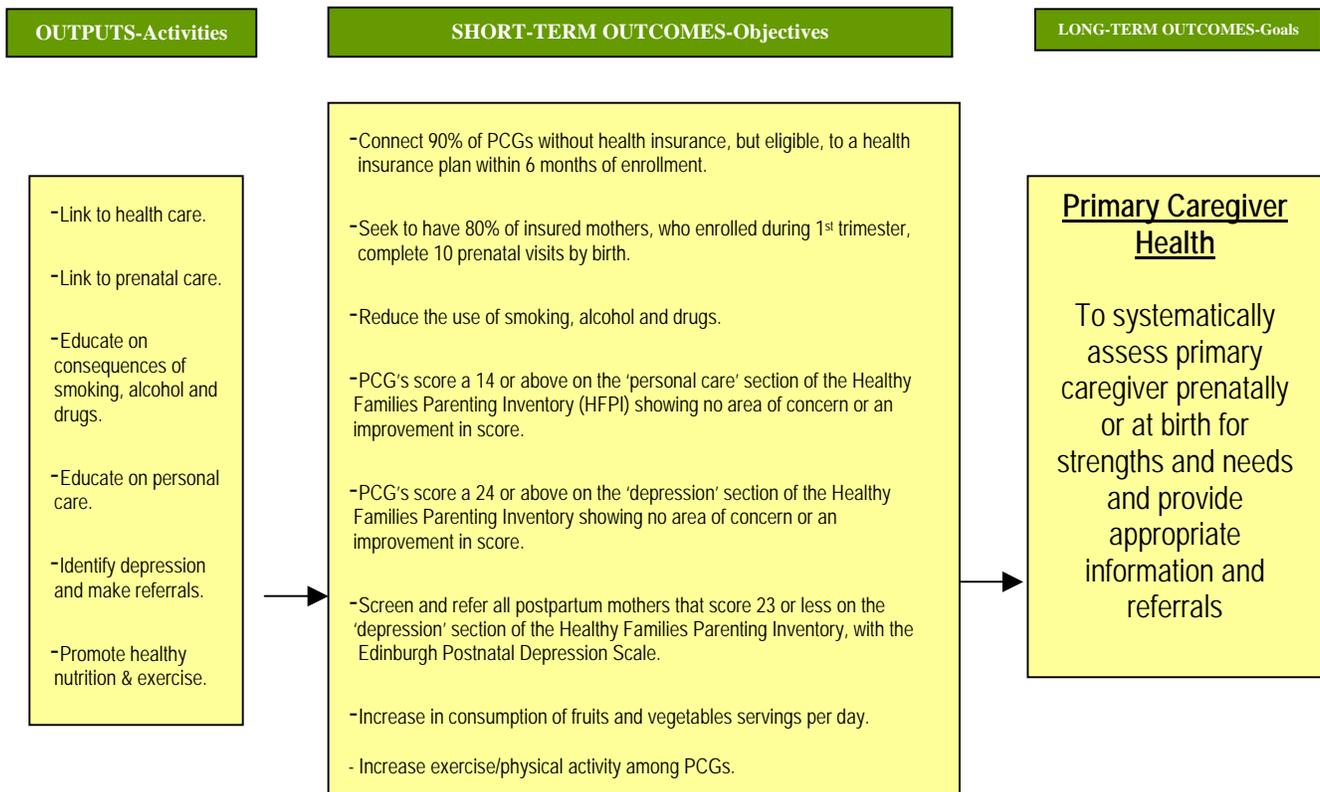
In a program or logic model, an objective is a measurable statement reflecting the changes you wish to see in your population served as a result of the program activities. A program can have short-term, intermediate and/or long-term objectives.

Ultimately, the goal(s) should be a statement of impact of the program. It does not have to be measurable nor time-limited, but should reflect the impact the program has on the people it serves or society at large.

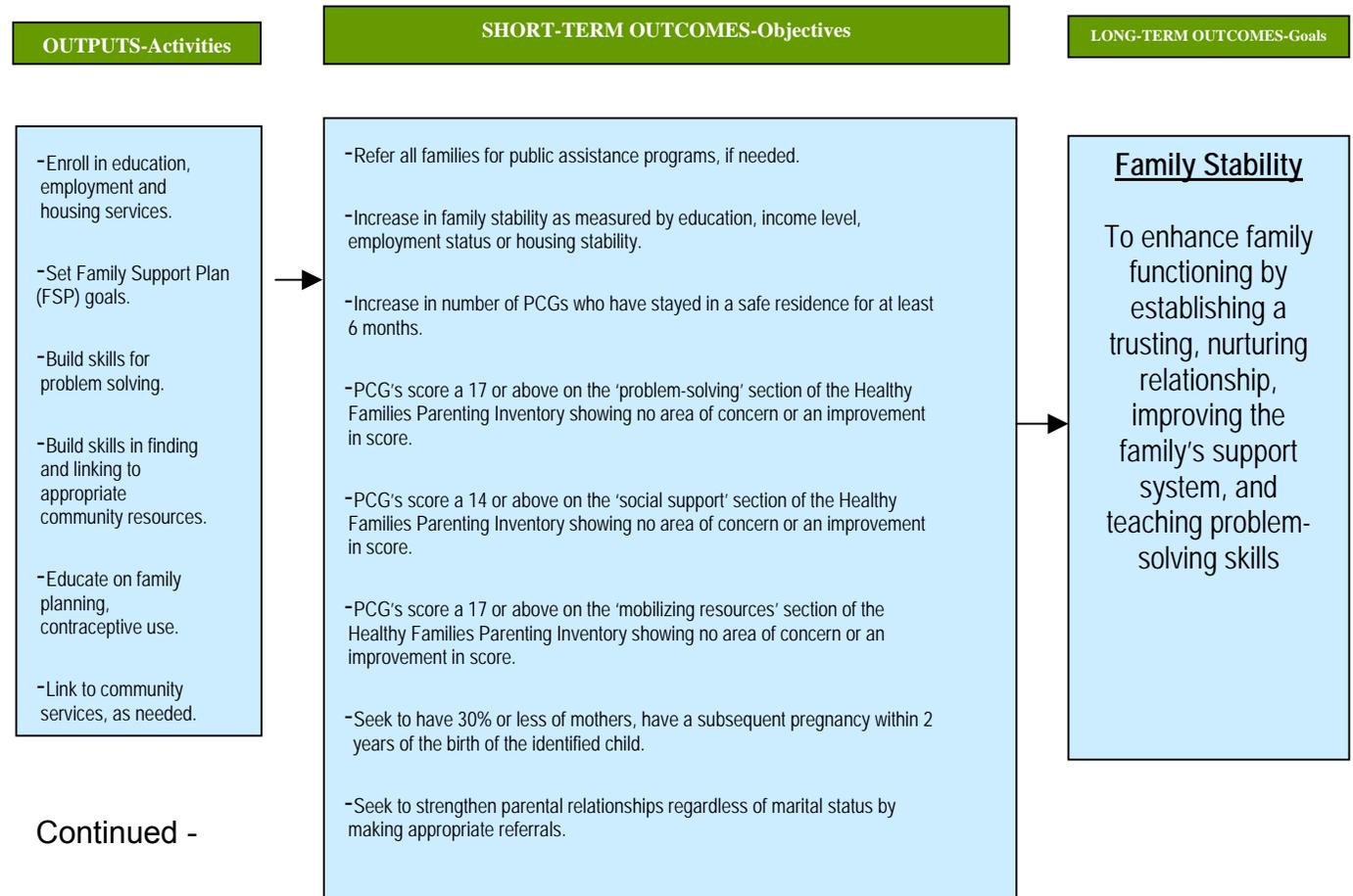
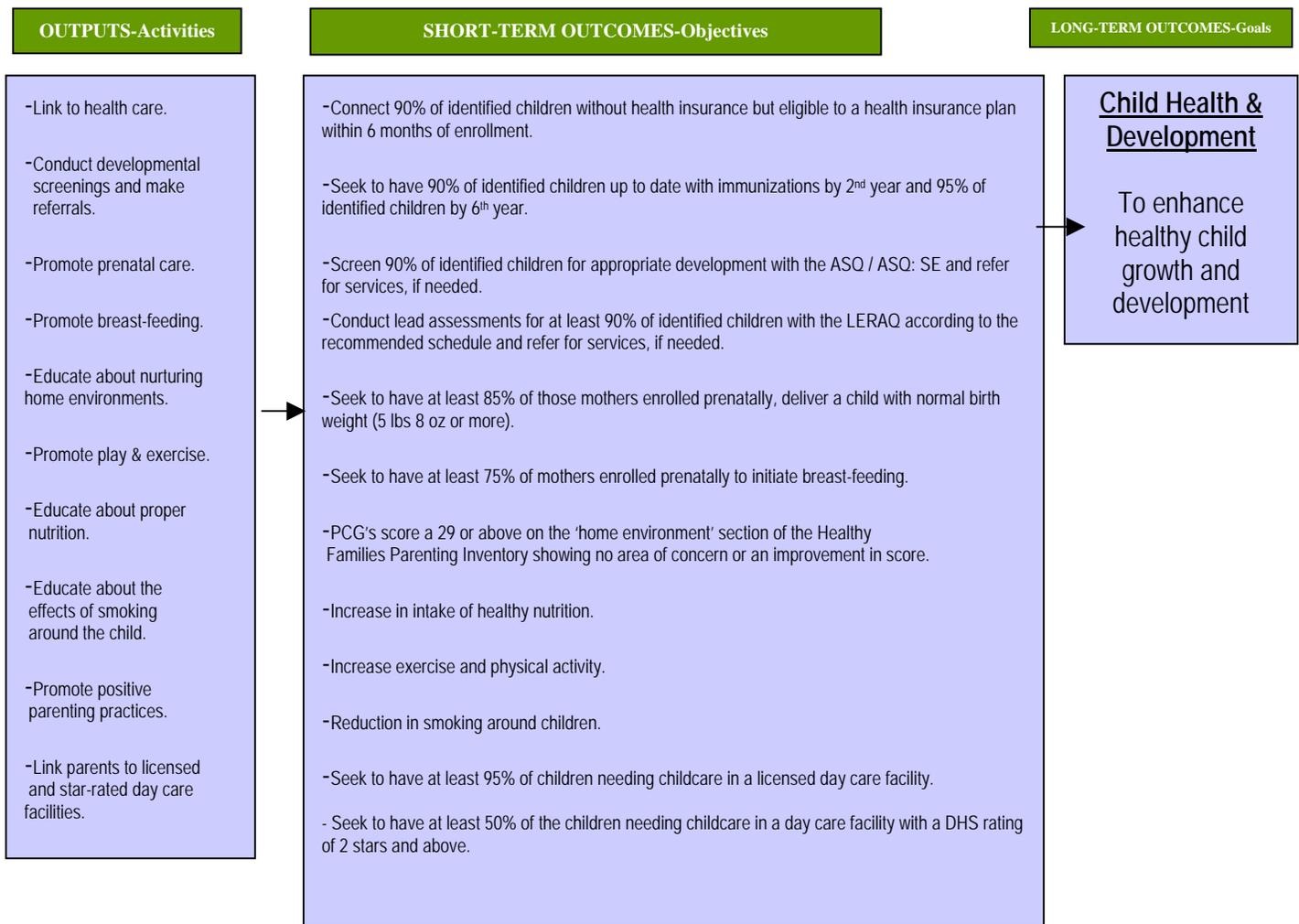
The activities, objectives and goals of the OCAP programs, as stated in the logic model, fall into the following domains:

- ❖ **Primary Caregiver health**
- ❖ **Child health and development**
- ❖ **Family stability**
- ❖ **Positive parenting and parent-child interaction**
- ❖ **Family safety**

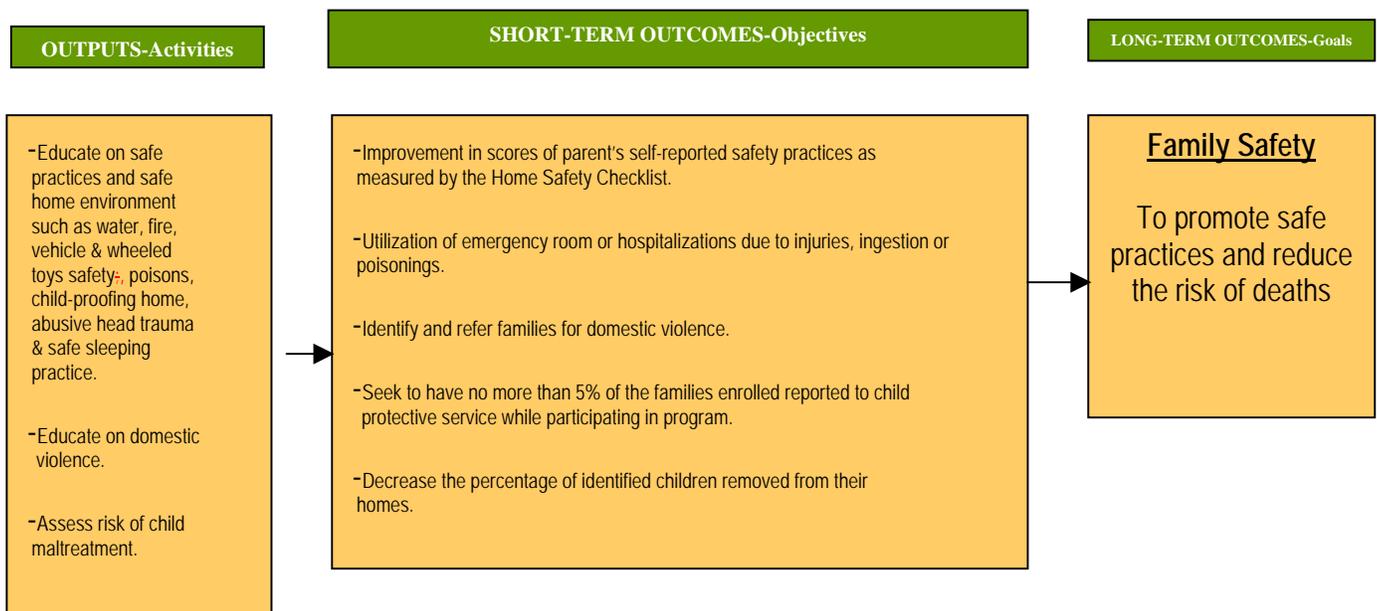
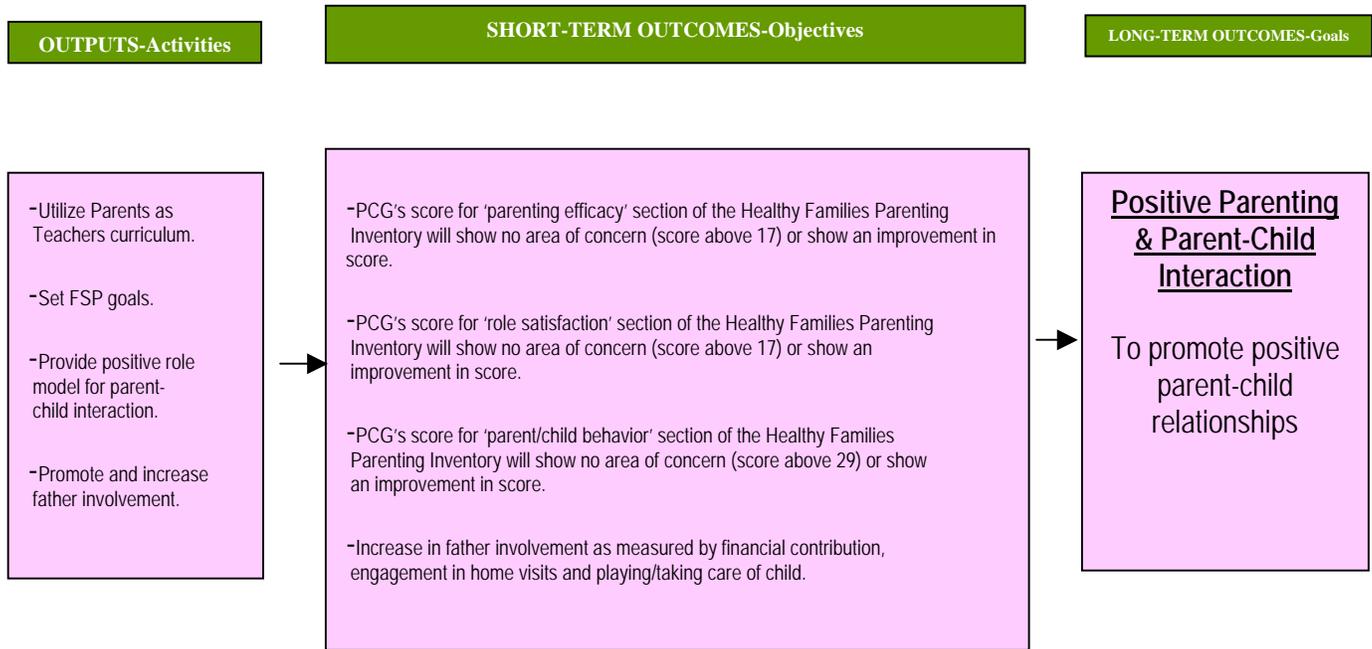
The activities, objectives and ultimate goal associated with each of these domains for OCAP programs are depicted on the following pages.



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## Measures

There are many types of measures and evaluations used in our design. These types are:

Quantitative measures	Measurements in numbers, such as the number of families served
Qualitative measures	Measures involve word descriptions like focus groups interviews or anecdotal stories
Process evaluation	Also called formative, looks at how well a program is doing and how it can improve
Outcome evaluation	Sometimes called impact evaluation, determines program effectiveness in producing results or what is done to achieve stated goals

The logic model determines specific evaluation components. Each piece of the logic model must have a measurement that indicates whether the activity, objective, or goal is being achieved and to what level. The measures and evaluations for a program and logic model are represented in the data collection forms, which are described in the next section. To see which items on the forms correspond to which elements in the logic model, see Appendix 1.

While the items on the forms are very important to program evaluation, there are several additional components that are important for the overall evaluation and monitoring of the OCAP programs: the site visit, data collection forms, outcome measurement tools, quarterly and annual reports, and the statewide database (OCAPPA). The logic model was utilized to design all of these components, which are inter-linking, complimentary, and necessary.

Continued -

# Office of Child Abuse Prevention Evaluation Forms

## Purpose and Structure

### The Purpose

The program evaluation forms are designed to assist with the documentation of the OCAP program services as well as to provide a foundation for systematic evaluation. **The Program Supervisors hold the responsibility of appropriate form use. The family-related forms should be routinely maintained in the family folders in a locked filing cabinet in a secured room at the facility. Program and staff-related forms should be kept in a centralized, secured filing system. Screening and assessment forms of families who do not receive services, should be kept in a centralized, secured filing system.**

### Multiple Objectives

The program evaluation forms serve several objectives. The usefulness of the data collected by the program evaluation forms is highly dependent on the consistent use and timely administration of the forms.

◆ Provide documentation of services delivered
◆ Serve to identify special needs of the family members
◆ Provide a framework for the program
◆ Assist Family Support Workers track families' progress
◆ Assist high-risk families to enter the program based on need
◆ Enable the production of statistical, quarterly, and annual reports
◆ Provide standard definitions and sequence of services for all OCAP programs
◆ Help the supervisor identify areas of guidance for FSW's, and FAW's
◆ Allow for systematic, statewide evaluation

NOTE: The evaluation forms are only one part of the evaluation process. The evaluation forms are not used to collect data on all aspects of the program. The evaluation forms only report the minimum amount of data needed to assess the essential parts of the program.

In addition to the evaluation forms, other documentation and forms will be necessary to conduct the program. Examples of additional forms include: consent for services form specific to each contracting agency, family folder documentation of home visits, center-based education session documentation, and other forms or documentation specific to each contracting agency.

Continued -

## The Structure

An instruction sheet precedes each program evaluation form in this manual. Each instruction sheet will contain the following:

- ❖ The form's purpose
- ❖ General instructions, including whose form it is, what it is for, when it is administered, and where it is filed
- ❖ Instructions for completing each item on the form

The forms are to be administered following a certain schedule (see below). In the event that a form cannot be completed at the appropriate time, the supervisor should be informed and decide the appropriate action to take, consulting central office staff when necessary.

## Home Visitation Services Form Schedule

Family referred to program		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Participant Activity Form (Initial)	Completed to activate participants in the database and each time there is a change of status for a specific PCG or child.	Candidate (possible PCG) form
Screening Form	Completed to assess enrollment eligibility for every referral into program.	Candidate (possible PCG) form
Family Assessment Form	Completed once for every positive screening and before home visitation services can begin. (Families can attend Center-based services without an assessment)	Candidate (possible PCG) form
Family enrollment/intake		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Primary Caregiver Intake Form	Completed once for entry into program.	PCG form
Primary Caregiver Health Form	Completed at 2 <sup>nd</sup> home visit.	PCG form
EPDS	Completed for prenatal and postpartum mothers if they score 23 or less on the HFPI depression scale.	Mother form
Relationship Assessment Form	Filled out at 3 <sup>rd</sup> home visit.	PCG form
Child enrollment/birth		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Pregnancy & Birth Form	1 <sup>st</sup> home visit	Child form (BOTH TWINS)
Child Health Form	Completed within 2 months of enrollment or birth of child	Child form (BOTH TWINS)
Home Safety Form	Completed within 2 months of enrollment or birth of child	Child form (PICK A TWIN)

Healthy Families Parenting Inventory (HFPI)	<b>Prenatal family:</b> Completed by 2nd home visit <b>Family enrolled with child:</b> Completed within 2 months of enrollment	PCG form (but on Child Form schedule) (PICK A TWIN)
Immunization <b>Log</b>	Completed according to immunization schedule	Child form (BOTH TWINS)
Child Development Screening Log	Completed when child is 4 months	Child form (BOTH TWINS)
Lead Assessment Log/ LERAQ	Completed at 6 months	Child form (BOTH TWINS)
<b>Family follow-up forms</b> (Forms can be administered 2 weeks before and 2 week after the 6 <sup>th</sup> month mark)		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Primary Caregiver Update Form	Completed six months from enrollment and again every six months.	PCG form
Primary Caregiver Health Form	Completed at 6 months from enrollment and again every six months.	PCG form
Healthy Families Parenting Inventory (HFPI)	<b>Prenatal family:</b> Follow up at child's birth then every 6 months according to child's age. <b>Family enrolled with child:</b> Follow up every 6 months according to child's age.	PCG form (but on Child Forms schedule) (PICK A TWIN)
EPDS	Completed for <b>prenatal</b> and postpartum mothers if they score 23 or less on the HFPI depression scale	Mother form
Relationship Assessment Form	Completed six months from enrollment and again every six months	PCG form
<b>Child follow-up forms</b>		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Child Health Form	6 monthly follow-up according to the child age	Child form (BOTH TWINS)
Home Safety Form	6 monthly follow-up according to the child age	Child form (PICK A TWIN)
Immunization <b>Log</b>	Filled according to immunization schedule	Child form (BOTH TWINS)
Child Development Screening Log	Completed according to the ASQ/SE schedule	Child form (BOTH TWINS)
Lead Assessment Log/ LERAQ	Completed every year till child is 6 years of age.	Child form (BOTH TWINS)
<b>Forms completed on an ongoing basis</b>		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Home Visitation <b>Log</b>	Completed every time a home visit is attempted or completed	PCG form
Family Support Plan Log	Completed within 45 days from intake (enrollment date) and every 6 <b>months</b> from 1 <sup>st</sup> FSP date	PCG form
Service Utilization Form	Completed at each home visit.	PCG/Child form
Participant Activity Form	Completed to activate participants in the database and each time there is a change of status for a specific PCG or child.	PCG/Child form

Center-Based Services Forms		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Center-Based services intake Form	Completed the first time a participant attends. Recollected every fiscal year.	Participant form
Center-Based Activity Log	Completed every time a center-based activity is held	Program site form
Program and Staff Forms		
<u>Form</u>	<u>When to administer</u>	<u>Whose form</u>
Program Information Form	Completed at the beginning of the contract year	Program site form
Staff/volunteer Form	Completed once on every program staff or volunteer	Staff form

## The Administration

### Important Points:

- ◆ Primary Caregiver is the person that gives most of the care to the baby and is the legal guardian. In general, the mother is the primary caregiver. If another person, such as a father or grandparent, has custody of the baby and is raising the baby, then that person would be the primary caregiver.
- ◆ Other Caregiver is any one in the home (other than the primary caregiver) who is actively participating in the care of the child and is actively participating in home visitation. This means that the other caregiver has been assessed and has consented for services. The other caregiver can be the father of the baby, the partner of the mother, the grandparent of the baby, or any other relative or friend.
- ◆ Child is the identified child, or the child for whom the family originally enrolled in the program. If the primary caregiver or other caregiver has other children and they are living in the home, no forms are required for these children.

## The Entry of Collected Data

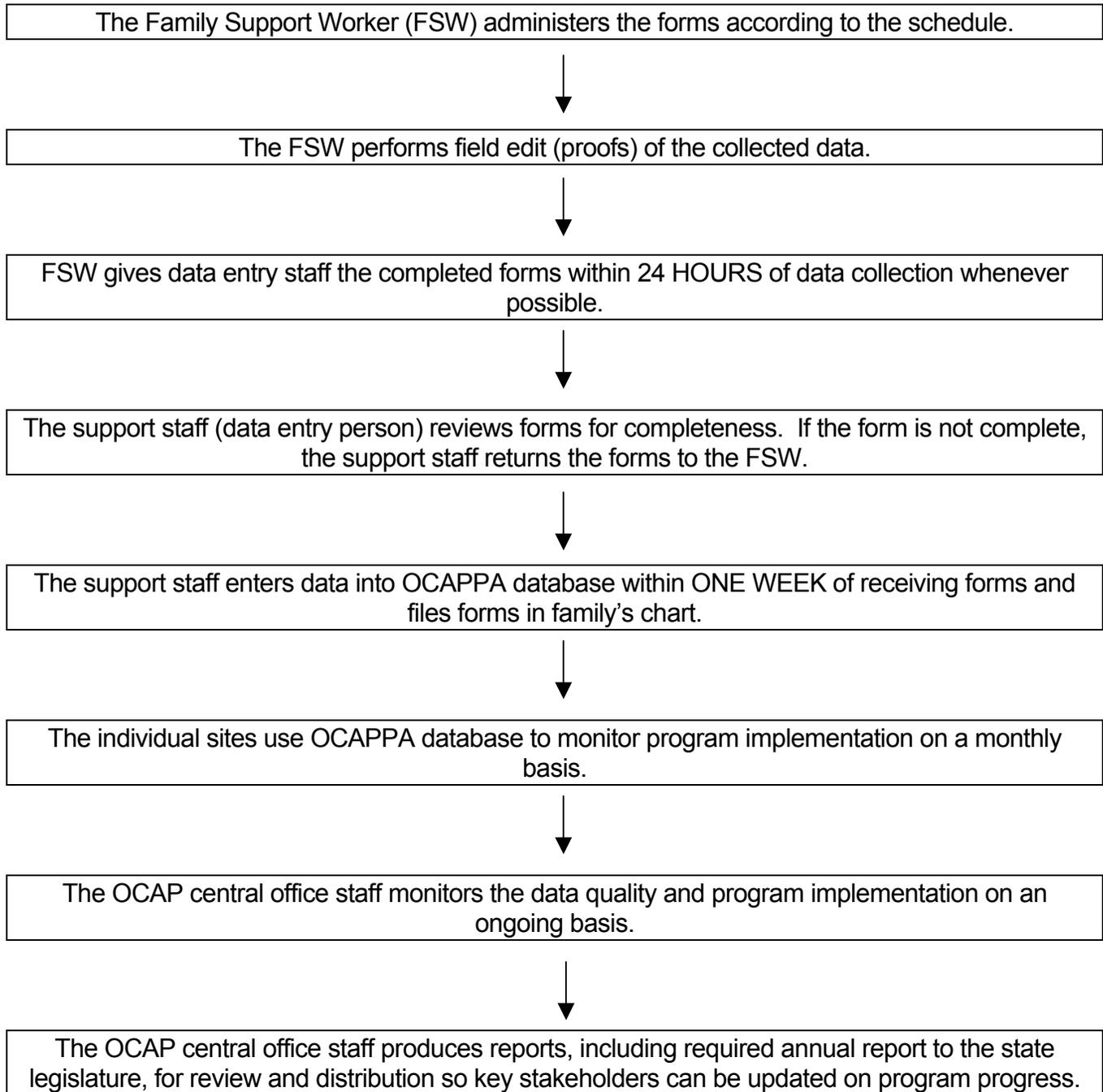
The use of the evaluation forms begins the first day of contract initiation. Entry of evaluation forms begins immediately after evaluation and database training and establishment of database access to individual contractors. Each contractor must complete a Program Information form and a Staff/Volunteer form by the site administrator or designee and return to the Program Evaluator in the Office of Child Abuse Prevention who will initiate access to the database. Contractor performance and numeric reports are based upon data in the database system.

Once data forms are completed, they must be entered into the OCAPPA database within ONE WEEK. (See Forms Flow Chart, Page 16).

## Description of the Flow of Data

1. Family Support Workers are responsible for complete data collection for clients and children.
2. The FSW will follow the data collection schedule in order to avoid overloading the client with multiple forms on the same visit.
3. The FSW will perform a thorough review of all forms to ensure that they are filled out completely and accurately. This step is very important for maintaining data quality and minimizing the amount of time spent resolving potential data questions and mistakes later. To ensure data quality is maintained, follow these steps:
  - ❖ Make sure the PCG and child's names are accurately and consistently recorded.
  - ❖ Clarify all unclear responses. Make sure it is clear on the form which response category is checked/chosen.
  - ❖ Make sure all numerical responses are legible.
  - ❖ All questions that are skipped as part of an established "skip pattern" should be left blank (no option is checked or slashed).
  - ❖ There should be NO MISSING DATA unless noted that the client refused to answer the question.
  - ❖ If a question was omitted, call the client to obtain the information or plan to get it on the next home visit.
4. The home visitor has 24 HOURS to give the completed forms to the data entry staff.
5. The data entry staff person should review the forms for completeness and check the data collection schedule to determine if forms are missing. The data entry staff person is NOT to fill in missing data. Instead, he/she should return the incomplete form to the FSW or the program supervisor.
6. Data should be entered into OCAPPA database within ONE WEEK of the form being completed. (For data entry instructions, see the OCAPPA Data Entry Manual.)
7. The data entry staff person files the form in the family's chart or central file. See the filing instructions for information on which folder the form is filed.
8. Sites are expected to use the OCAPPA report menu to monitor their own program implementation on a monthly basis using the canned reports
9. The OCAP central office monitors the quality of data and program implementation on an ongoing basis.

## Recommended Data Management Flow Chart



## Basic Interviewing and Data Collection Techniques

### **Role of the Family Support Worker**

The FSW has a vital role in assuring the goals of the evaluation are attained. In addition to maintaining records of the services provided, the FSW collects information about the program participants' risk factors and progress toward the individual's program goals.

### **Remain Objective!**

It is of utmost importance that program participants' responses are their own. FSWs must be careful to avoid behavior (conscious or unconscious, spoken or unspoken), which could affect the way a client answers a question.

### **Attitude**

Approach the program participant with a positive, self-assured (but matter-of-fact) manner when asking questions. Friendliness – not familiarity – is an asset.

### **Read questions slowly**

This may be the client's first exposure to the question. If she doesn't understand, simply read the question again. Don't try to explain in your own words.

### **Ask questions in a neutral, conversational tone**

Only those words underlined should be emphasized. Do not use intonation that may change the meaning of the question or bias the response.

Tailor the question to the program participant. For example, use the child's name in the following question: Has (child's name) had a blood test for lead poisoning?

### **Maintain Consistency**

The FSW must read the questions to the client exactly as they are written on the forms. Only when the questions are asked in the same way can the data be combined to give a true picture of the responders' thoughts. At times a program participant with limited education may need help in understanding a question. Try re-reading the question slower. If the FSW must rephrase or paraphrase a question to ensure understanding, be sure to keep the intent of the original question.

### **Ask questions exactly as they are written**

Much time and thought has gone into the creation of the data collection forms to make sure that the questions collect the information they are intended to collect.

### **Ask questions in the order indicated**

Questions are ordered in a certain way to prevent the answers to some questions from influencing the answers to others. If the program participant begins to talk about events related to questions that occur later in the questionnaire, do not skip ahead. Say "We will be getting to that in a few minutes." Skipping ahead may cause you to omit some questions.

### **Be sure the program participant hears the entire question before answering**

If a client interrupts to answer, politely ask her to wait until she has heard the entire question. At times, you may need to reread the question if the client was talking as you were reading.

**Do not explain words in a question unless you feel the program participant cannot grasp the intent of the question.**

The program participant may ask you to explain the words in a question or part of a question. As a general rule, you should not try to offer your own explanation because it could bias a client's response. Some clients may ask for an explanation in order to figure out the "socially desirable" response. Simply repeat the question slowly and encourage the client to answer according to her own thoughts or situation. If you feel that a client cannot grasp the intent of the question, you may try paraphrasing using simpler words, but be sure you reflect the original intent of the question.

### **Follow Designated Skip Patterns**

There are many skip instructions throughout the questionnaires. The skip pattern directs you to omit a question or sequence of questions, depending on the client's response to a question. CAREFULLY FOLLOW ALL SKIP PATTERNS to avoid asking questions which are not relevant for to that program participant. Failure to follow skip patterns results in confounding of the data.

### **Assure Confidentiality of the Data**

Persons working collecting data in this manner on the personal thoughts, feelings and experiences of families have a moral duty to those people to keep the information they provide confidential. FSWs often ask some questions that they would not think of asking even a close friend, questions that may be perceived of as "too personal." You will find that clients are willing to answer these questions, and even to offer you information that she would not tell a close friend or relative. It is important for clients to speak honestly. FSW's and FAW's must assure program participants that all information they provide will be treated confidentially (with the only exception being the mandated reporting of current possible child maltreatment).

#### **THIS MEANS:**

No names are used during data analysis. Numbers, not names, identify data.

Data are published in the form of summary statistics only.

FSW's and FAW's do not discuss data or personal observations about program participants with anyone not associated with the project, or in the presence of persons not associated with the project (without permission of the program participant).

Program participant information is maintained in a locked file when not in use.

### **Using Probes**

A probe is a technique used for obtaining more complete information when a program participant does not thoroughly understand a question. A probe should always be neutral, and should not suggest answers. There are several neutral probes that appear as part of normal conversation that can be used to stimulate a fuller, clearer response.

#### **An expression of interest and understanding**

By saying things such as "uh-huh" or "yes," the FSW indicates that the response has been heard, that it is interesting and that more is expected.

#### **An expectant pause**

The simplest way to convey to a program participant that you know she has begun to answer the question, but has more to say, is to be silent. The pause allows the program participant to gather her thoughts.

### **Examples of probe phrases**

To clarify: "What do you mean exactly?" "What do you mean by..." "Could you explain that a little please? I don't think I understand."

To specify: "When in particular do you have in mind?" "Could you be more specific about that?" "Tell me about that..." (who, what, where, when, why)

To seek relevance: “I see. Well, let me ask you again.” (Repeat question.) “Would you tell me how you mean that?”

### **To avoid biasing the program participant's answers...**

#### **Don't ask whether a person means this or that**

This suggests only one possible answer, even though there may be many possibilities the program participant is thinking about.

#### **Don't try to sum it up in your own words.**

Avoid summing up what the client has said in your own words. This may suggest to the program participant that your idea of her feelings is not the “right answer.”

#### **Don't ask whether the program participant meant something specific by a certain word.**

This suggests one answer, when she might have another in mind.

### **Handling the “I Don't Know” response**

When a program participant says, “I don't know,” they may be conveying a number of different things.

She may not understand the question and wants to avoid saying she doesn't understand

She may be saying “I don't know” to fill in the silence while she thinks about it

She may be trying to avoid the question because she feels uninformed, afraid of giving a wrong answer, or because the question is too personal

Or she may really not know or have an opinion

Try to decide which of the above explanations may be the case. Don't be in a rush to settle for an “I don't know” reply. If you sit quietly, the program participant will usually think of what to say. Silence and waiting are the best response for a “don't know” answer. If you feel your program participant has answered “I don't know” out of fear of admitting ignorance, you may want to reassure her by saying “There's really no correct answer.”

Many of the questions ask about recall of events over time. The “I don't know” response may mean, “I don't remember” in these questions. You may try to assist with recall by conceptualizing the time frame. For example, when asking a program participant how many months she has received food stamps since the birth of her infant (who is now 6 months old), you might note that the number of months would be 6 or less.

Always try at least once to obtain a reply to an “I don't know” response, before accepting it as the final offer. Be careful, though, not to antagonize program participants or force an answer if they state again that they don't know.

### **Recording Program Participants' Responses**

Many of the questions provide you with response categories. Check the one that applies in a clear, legible fashion. Some answers require multiple responses depending on what is checked.

For some questions, response categories will need to be read to a program participant. For example:

“How often do you usually see or talk to the baby's father?”

❖ Not at all / Less than once a week / At least once a week but not daily / Daily

Yes/No questions do not need the response categories read.

When questions elicit numerical responses, be sure to write the number legibly on the form. Dates are to be recorded according to month, day and year like this: mm/dd/yyyy. Use numbers for the month, not alphabetical abbreviations.

Also, write down single numbers, not number ranges. For example, if a program participant says she has smoked 6 or 7 cigarettes in the past 14 days, do not write "6-7." Help the program participant give her best estimate of whether it is 6 or if it's 7.

Should a program participant refuse to answer a question, there is a question at the end of most forms for the home visitor to record the refusal. Make a note on the form so that it is clear why there is no response so that the clerk or data entry person does not give it back to you due to missing information.

### **Closing the Interview**

Thank the program participant for her participation in providing the requested information. Make every attempt to close on a pleasant note and make the program participant feel that the interview has been valuable. After data collection is completed, the FSW may need to seek clarification and document.

# Instructions for Screening Form

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## Purpose

The Screening Form gathers initial information on potential OCAP program participants. The screening is a fast, inexpensive method to group those who probably are at risk from those who probably are not at risk. This form collects preliminary information on the candidate's enrollment eligibility, contact information, interest in enrollment and demographics. Characteristics of those who enroll in the program are compared to those who do not enroll to help modify the evaluation, education and promotion of the program.

**More than one screening per candidate is allowed by site only if there is a change in the candidate's situation over time that warrants a new screening.** For e.g. a candidate that screened negative initially may have a change in the risk factors that would result positive if screened again. A referral from a source such as a hospital or Children First does not constitute a screening. A screening is to be counted only when the OCAP screening form is filled out completely and entered in to the OCAPPA database.

## General Instructions

- ❖ **Whose form:** Candidates who have been referred to the OCAP program, both those that enroll and those that do not enroll.
- ❖ **When:** Complete when the first contact or referral is made to the OCAP program.
- ❖ **What:** Gather as much information as possible on the individual when the referral is being made.
- ❖ **File:** The screening form is filed at the OCAP program site that is providing screening service. If the candidate enrolls in the program, the screening form is filed in the family folder.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure the information pertaining to the candidate (potential primary caregiver-PCG) is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, misspells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**Today's Date:** The date on which the screening was conducted. Use mm/dd/yyyy format.

**First Name / Last Name / DOB:** The candidate's first and last names and date of birth (potential PCG).

**Gender:** Check the appropriate box indicating the candidate's gender.

**SSN:** Record the candidate's social security number if available.

### **Item Instructions**

S1: Check the appropriate box indicating the type of disability the candidate currently experiences. Note that "None" is a possible choice.

S2: Check the appropriate box indicating the language the candidate currently speaks or uses.

S3: Check the appropriate box, indicating race of the candidate. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the candidate.

S4: Check the appropriate box indicating whether the candidate is Hispanic or Latino.

S5: Check the appropriate box indicating the marital status of the candidate.

S6: Check the appropriate box indicating whether the candidate is enrolled in school. Do not include short courses for job skills or job training.

    "Yes" box checked: record the last grade the candidate completed.

    "No" box checked: record the last grade the candidate completed.

        - If the candidate has graduated from high school or has obtained a GED, enter "12" as the last grade completed.

        - If the candidate has completed more than high school, add the number of years additional education completed to 12, and record that total.

S7: Record the street address of the candidate. Include the apartment number if applicable.

S8: Record the city in which the candidate resides.

S9: Record the county in which the candidate resides.

S10: Record the state in which the candidate resides.

S11: Record the candidate's zip code.

S12: Record the telephone number, including area code, of the primary phone where the candidate can be reached. Check the appropriate box indicating the type of telephone for this number.

S13: Record the telephone number, including area code, of the secondary phone where the candidate can be reached. Check the appropriate box indicating the type of telephone for this number.

S14: Check the appropriate box indicating the type of agency, program or person who initiated the referral.

- Select self-referral if the candidate saw the promotional material and called the program on his/her own accord.

- If the candidate was given the promotional materials by a particular service such as WIC, then that service would be the referral source.
- If the agency or program that made the referral is not represented in the list, check the “Other” box and record the specific referral source.

S15: Check the appropriate box indicating whether the candidate is or will become a first-time parent. If the “No” box is checked, record the number of children the candidate currently has.

S16: Check the appropriate box indicating whether the candidate is currently pregnant. If the “Yes” box is checked, record the expected due date. If the “No” box is checked, record the date of the most recent infant’s birth. Use mm/dd/yyyy format for recording dates.

S17: Determine whether the candidate is pregnant (29 weeks or fewer) with her first child.

- a) If yes, check the appropriate box indicating whether the candidate was referred to Children First.
- b) If yes, check the appropriate box indicating whether services were available from Children First.

S18: Check the appropriate box indicating whether the candidate’s child has any birth defect or if there are developmental concerns.

- a) If the “Yes” box is checked for S18, check the appropriate box indicating whether the candidate was referred to SoonerStart.
- b) If the “Yes” box is checked for S18a, check the appropriate box indicating whether services were available from SoonerStart.

### **Risk Factor Screening Record**

For items S19 through S33, circle the appropriate response indicating whether each item is true, false or unknown for the candidate.

S19: If the candidate is a teen or marital status is single, separated, divorced, or widowed, then mark “True”.

S20: If the candidate’s prenatal care did not begin within the first 12 weeks of pregnancy, then mark “True”. If the candidate has not received any prenatal care, then mark “True”. If the candidate has missed prenatal appointments or if medical advice has not been followed, then mark “True”.

S21: If candidate considered having an abortion for this pregnancy, then mark “True”.

S22: If the candidate’s partner (husband, live-in boyfriend, or domestic partner) is unemployed, then mark “True”.

S23: If the candidate receives public aid such as Medicaid, food stamps, or TANF, is employed but does not have medical insurance, or expresses concern about finances, then mark “True”.

S24: If the candidate does not list a home address, is uncertain of having a home, or lists an address of a homeless shelter (or equivalent), then mark “True”.

S25: If the candidate does not have a home phone or a cell phone, then mark “True”.

S26: If the candidate did not complete 12 years of education, then mark “True”.

S27: If the candidate does not list any immediate family emergency contacts (must include names, relationship, and telephone number), then mark “True”.

S28: If the candidate excessively uses or used alcohol or drugs, then mark “True”.

S29: If the candidate has had two or more total induced terminations of pregnancy, or one induced termination of pregnancy within the previous 12 months of the current pregnancy, then mark “True”.

S30: If the candidate considered adoption for this pregnancy, then mark “True”.

S31: If there is any indication of discord among family members of the candidate, then mark “True”.

S32: If the candidate reports depression or if program worker conducting the screening indicates it is warranted, then mark “True”.

S33: If the candidate has had or is currently receiving psychiatric care, then mark “True”.

The screening is considered positive if two or more factors are true for the parent. Additionally, the screen is positive if S19, S20, or S21 are true or if there are seven or more unknowns.

### **Screening Outcome**

S34: Check the appropriate box indicating whether the screening is positive.

S35: Check the appropriate box indicating whether a referral was made for assessment. If the “No” box is checked, record the appropriate reason code from the list on the Screening Form. If reasons 5 or 19 are recorded, provide details for the situation. If the “Other” reason is chosen, record the specific reason that a referral was not made for assessment.

Program Worker who conducted the screening: Record the name of the program worker who conducted the screening.

## SCREENING FORM

Today's Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Gender:  Female  Male

S0. What is your social security number (SSN)? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

S1. Disability:  Blind  Deaf  Wheelchair  Other  None

S2. Language:  English  Spanish  American Sign Language  Other

S3. Race:  American Indian/Alaskan Native  Native Hawaiian/Pacific Islander  
Please check all that apply.  Asian  White  
 Black/African American  Other, specify: \_\_\_\_\_

S4. Are you Hispanic or Latino:  Yes  No

S5. Are you currently married:  Yes  No

S6. Are you currently enrolled in school:  Yes, Please indicate last grade completed \_\_\_\_\_  
 No, Please indicate last grade completed or GED \_\_\_\_\_

S7. Street Address: \_\_\_\_\_ S8. City: \_\_\_\_\_

S9. County: \_\_\_\_\_ S10. State: \_\_\_\_\_ S11. Zip Code: \_\_\_\_\_

S12. Phone 1: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Home  Cell  Message  Pager  Work

S13. Phone 2: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Home  Cell  Message  Pager  Work

### *Referral Information*

S14. Referral Source:

<input type="checkbox"/> Department of Human Service	<input type="checkbox"/> WIC	<input type="checkbox"/> School
<input type="checkbox"/> Hospital	<input type="checkbox"/> Head Start	<input type="checkbox"/> Faith-Based Organization
<input type="checkbox"/> Indian Health Service	<input type="checkbox"/> Babyline	<input type="checkbox"/> Child care provider
<input type="checkbox"/> Children First	<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Doctor's office
	<input type="checkbox"/> Friend	<input type="checkbox"/> Other, specify _____

### *Screening Information*

S15. Are you or will you be a first-time parent?  Yes  No If no, how many children do you have? \_\_\_\_\_

S16. Are you pregnant?  Yes, What is your due date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 No, What is the date of your baby's birth (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

S17. If you are pregnant (before 29 weeks) with your first child, you may be eligible for the Children First Program.

- a. Were you referred to Children First?  Yes  No  Unknown or N/A  
 b. If yes, were services available from Children First?  Yes  No  Unknown or N/A

S18. If your baby is already born, does the baby have any birth defect or developmental concerns (ex: prematurity)?  Yes  No

- a. If yes, were you referred to SoonerStart?  Yes  No  Unknown or N/A  
 b. If yes, were services available from SoonerStart?  Yes  No  Unknown or N/A

*Risk Factor Screening Record*

	(+)	(-)	( )
S19. Teen, Single, Separated, Divorced, or Widowed*	True	False	Unknown
S20. Late or no pre-natal care, poor compliance*	True	False	Unknown
S21. Abortion unsuccessfully sought or attempted*	True	False	Unknown
S22. Partner unemployed	True	False	Unknown
S23. Inadequate income	True	False	Unknown
S24. Unstable housing	True	False	Unknown
S25. No phone	True	False	Unknown
S26. Education under 12 years	True	False	Unknown
S27. Inadequate emergency contacts	True	False	Unknown
S28. History of substance abuse	True	False	Unknown
S29. History of abortions	True	False	Unknown
S30. Relinquishment for adoption sought or attempted	True	False	Unknown
S31. Marital or family problems	True	False	Unknown
S32. History of or current depression	True	False	Unknown
S33. History of psychiatric care	True	False	Unknown

*The screening is considered positive if two or more factors are true for the parent. Additionally, the screen is positive if any of the asterisked (\*) factors are true or if there are seven or more unknowns.*

*Screening Outcome*

S34. Was the screening positive?  Yes  No

S35. Was a referral made for assessment?  Yes  No, Reason code: \_\_\_\_\_  
**(If 9 or 10) Details:** \_\_\_\_\_

Reason Coding:

- |   |   |
|---|---|
| 1. Person not interested  | 11. The pregnancy ended in a miscarriage                            |
| 2. Person does not feel need for the program  | 12. The pregnancy ended in an adoption                              |
| 3. Person did not return phone calls  | 13. The pregnancy ended in an abortion                              |
| 4. Program was unable to contact family for assessment                                | 14. Schedule conflict (too busy, work conflict, etc.)               |
| 5. Person moved/plans to move out of the state  | 15. Referred to Children First                                      |
| 6. Person could not be located (wrong address, etc.)                                  | 16. Referred to SoonerStart   |
| 7. Person requested additional time and never followed up                             | 17. Program has full caseload                                       |
| 8. Person lives outside of program service area                                       | 18. Person did not provide specific reasons                         |
| 9. Person currently participating in another program<br><b>(Give name as details)</b> | 19. Child Protective Services is currently involved with the family |
| 10. Other, <b>give details</b> _____  |   |

Program Worker who conducted the screening: \_\_\_\_\_

# Instructions for Family Assessment Form

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## Purpose

The Family Assessment Form gathers in-depth information on candidates who have positive screenings. Receiving assessment service from an OCAP program makes the candidate an OCAP program participant for that site if the candidate assesses positive. Assessments systematically identify families who would most benefit from intensive home visitation services. The form is a summary page for the results of the family assessment.

**More than one assessment per candidate is allowed by site only if there is a change in the candidate's situation over time that warrants a new assessment.** For example: first assessment completed but person does not enroll for home visitation. Person comes to the program again after several months to start home visits. Assess again to see if situation has changed (e.g. divorce, job change, domestic violence, etc). This can be done only before the identified child reaches 12 months of age.

Person is said to be an OCAP participant once an assessment is completed. If home visits do not begin the case remains open in the OCAPPA database as an inactive family till the child ages out at 6 years i.e. the family can come back for HV at anytime during this period.

## General Instructions

- ❖ **Whose form:** Family Assessment Worker or persons who are authorized to initially assess and are under interagency agreement.
- ❖ **When:** The assessment is completed on every positive screening and before services can begin.
- ❖ **What:** The form systematically collects information about the strengths and needs of the family for the purpose of developing a family support services plan. If the assessment is positive, the family can accept services.
- ❖ **File:** The Family Assessment Form is filed at the OCAP program site providing assessment service. If the candidate enrolls in the program the Family Assessment Form is filed in the family folder.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure the information pertaining to the candidate (potential primary caregiver-PCG) is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, misspells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**First Name / Last Name / DOB:** The candidate's first and last names and date of birth (potential PCG).

**Today's Date:** The date on which the assessment was conducted. Use mm/dd/yyyy format.

**Family Assessment Worker Name:** The first and last name of the FAW who conducted this interview.

## **Item Instructions**

### **Family Stress Checklist**

Provide score for mother, father on the following index of Stresses using the 0 - 10 scale, where a score of 0= normal; 5=mild; 10=severe; and unk=unknown.

FA1. Childhood History - Person being assessed was beaten or deprived as a child.

FA2. Troubled History – Person being assessed has a criminal, mental illness, or substance abuse history.

FA3. Child Protective Service Involvement – Person being assessed has been suspected of abusing in the past.

FA4. Coping Skills – Person being assessed displays low self-esteem, social isolation, or depression.

FA5. Stressors/Concerns – Person being assessed experiences multiple crises or stresses.

FA6. Potential for Violence – Person being assessed displays violent outbursts.

FA7. Expectations of Infant – Person being assessed has rigid and unrealistic expectations of child's behavior.

FA8. Discipline of Infant – Person being assessed uses harsh punishment towards the child.

FA9. Perception of New Infant – Person being assessed perceives baby/child as difficult and/or provocative.

FA10. Bonding/Attachment Issues – Person being assessed has the potential for a parent/child relationship at risk for bonding.

**Total Score:** Record the assessment score for mother, father and other. A score of 25 or higher is positive.

**Total Unknowns:** Record the number of unknowns for mother, father.

FA11. Outcome and Disposition: The family assessment is positive if any of the individual's assessments was positive. Record if the family assessment was positive, if services were offered, and if services were accepted.

FA12. Record the specific referral that was made for other or center-based services.

FA13. Check the appropriate box indicating if an assessment was positive and services were not initiated. If the "Other" reason is chosen, specify other.

## FAMILY ASSESSMENT FORM

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Assessment Worker Name: \_\_\_\_\_

### Family Stress Checklist

Scoring: 0 - normal; 5 - mild; 10 - severe; unk - unknown

Index of Stresses	Mother				Father				Other			
FA1. Childhood history	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA2. Troubled history	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA3. CPS involvement	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA4. Coping skills	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA5. Stressors/concerns	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA6. Potential for violence	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA7. Expectations of infant	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA8. Discipline of infant	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA9. Perception of new infant	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA10. Bonding/attachment issues	0	5	10	unk	0	5	10	unk	0	5	10	unk
TOTAL SCORE												
TOTAL UNKNOWNNS												

A score of 25 or higher qualifies as a positive assessment.

### Assessment Outcome

#### FA11. Outcome and Disposition

- |   |  |
|---|--|
| <input type="checkbox"/> Positive, offered home visitation* | <input type="checkbox"/> Negative or positive, referred to other services <b>(Complete FA12**)</b> |
| <input type="checkbox"/> Positive, refused services         | <input type="checkbox"/> Negative, referred to center-based activities <b>(Complete FA12**)</b>    |
| <input type="checkbox"/> Positive, caseload full            | <input type="checkbox"/> Negative, no services or referrals given                                  |

FA12. \*\*Specify referral: \_\_\_\_\_

### Assessment Follow-up

FA13. \*If assessment was positive and services were not initiated, check the reason for not initiating:

- |  |  |
|--|--|
| <input type="checkbox"/> Person did not feel need for the program          | <input type="checkbox"/> Person could not be located (wrong address, etc.)       |
| <input type="checkbox"/> Person did not return phone calls                 | <input type="checkbox"/> There was no HV available to provide services           |
| <input type="checkbox"/> Person moved/plans to move out of the state       | <input type="checkbox"/> All HV have full caseloads                              |
| <input type="checkbox"/> Schedule conflict (too busy, work conflict, etc.) | <input type="checkbox"/> Person did not keep the scheduled intake appointment(s) |
| <input type="checkbox"/> Referred on to another OCAP program site          | <input type="checkbox"/> Other: _____  |

# Instructions for Participant Activity Form

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## Purpose

The Participant Activity Form “begins and ends” an individual's participation in the OCAP Program. It indicates who is involved in the program and, if not involved, why. The form also records the participant’s enrollment status, change of participant, when a participant exits or completes the program, and when a participant completes the program. The form identifies significant changes that might impact outcomes, such as change of primary caregiver (PCG), report of possible child maltreatment, and change of Family Support Worker (FSW).

## General Instructions

- ❖ **Whose form:** A person who is referred to or becomes an OCAP program participant.
- ❖ **When:** Complete each time there is a change of status for a specific PCG or child. Check only ONE status change option for a specific date.
- ❖ **What:** The form records changes in enrollment status and changes in active involvement of the PCG/child in the program.
- ❖ **File:** The Participant Activity Form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first “Participant Activity Form”. Similarly the information submitted for the child should be consistent with the “Pregnancy and Birth Form”. Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

- **First name / Last name / DOB:** The PCG’s / child’s first and last names and date of birth.
- **Date:** The date that the indicated activity change occurred. Record the date in mm/dd/yyyy format.
- **FSW name:** The first and last name of the FSW assigned to this family.

## Item Instructions

Note: You must complete services and enter all other forms related to the family before entering a Participant Activity Form that withdraws a family from the OCAP program.

- To attain program goals, it is important to retain families until their goals are attained. As a guideline, 12 weeks of consistent effort may be needed to establish a working relationship and engage families in the program prior to changing the Participant Activity Form from active to inactive or withdraw status.

- Each time that a participant undergoes any activity change that is listed on this form, complete the form, putting the date that the activity change occurred.
- If an activity status option (P1, P2, etc.) has multiple parts, be sure to put a response for each part. (Ex: P2a and P2b)

Item	Description	Activity Status
P1	Enrollment Status	
P1a	Referred for screening or Center-Based	Inactive
P1b	Screening not completed	Inactive
P1c	Screening negative	Inactive
P1d	Screening positive, not referred for assessment	Inactive
P1e	Screening positive, referred for assessment	Inactive
P1f	Assessment negative or too high risk	Inactive
P1g	Assessment positive, not enrolled	Inactive
P1h	Assessment positive, enrolled	Active
P1i	Assessment not completed	Inactive
P2	Change of adult participating	Change PCG/Active
P3	No further participation by PCG	
P3a	Client declined further participation	Inactive
P3b	Moved out of area, no further participation	Inactive
P3c	Unable to locate	Inactive
P3d	Excessive cancellations/no show appointments	Inactive
P3e	Child no longer in PCG's home (Formal arrangement)	Withdraw/case closed
P3f	Child no longer in PCG's home (Informal arrangement)	Withdraw/case closed
P3g	PCG/Child death, no further participation	Withdraw/case closed
P3h	Child adopted, no further participation	Withdraw/case closed
P4	Child reached 6 <sup>th</sup> birthday	Withdraw/case closed
P5	Miscarriage/Fetal/Infant/Child Death	Active
P6	Client temporarily suspends participation	Inactive
P7	Returned to program / service area	Active
P8	Transfer to new service area	Transfer/Active
P9	DHS notified of potential abuse or neglect	Active
P10	Program unable to provide services	Inactive
P11	New Family Support Worker	Active
P12	Child begins program, choose born or enrolled	Active

## PARTICIPANT ACTIVITY FORM

First name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ FSW Name: \_\_\_\_\_

*Please choose only one option*

<p><input type="checkbox"/> <b>P1. Enrollment status</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Referred for screening or Center-Based</li><li><input type="checkbox"/> b. Screening not completed</li><li><input type="checkbox"/> c. Screening negative</li> <li><input type="checkbox"/> d. Screening positive, not referred for assessment</li><li><input type="checkbox"/> e. Screening positive, referred for assessment</li><li><input type="checkbox"/> f. Assessment negative or too high risk</li><li><input type="checkbox"/> g. Assessment positive, not enrolled</li><li><input type="checkbox"/> h. Assessment positive, enrolled</li><li><input type="checkbox"/> i. Assessment not completed</li></ul> <p><input type="checkbox"/> <b>P2. Change of adult participating in program</b></p> <p>a. Please indicate reason:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Child not living with PCG</li><li><input type="checkbox"/> b. PCG Death</li><li><input type="checkbox"/> c. PCG lost legal custody</li><li><input type="checkbox"/> d. Military deployment</li><li><input type="checkbox"/> e. Other: _____</li></ul> <p>b. Relationship of new PCG to child:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Father</li><li><input type="checkbox"/> b. Grandmother</li><li><input type="checkbox"/> c. Foster parents</li><li><input type="checkbox"/> d. Other: _____</li></ul> <p><input type="checkbox"/> <b>P3. No further participation by the PCG</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Client declined further participation (Choose one)<ul style="list-style-type: none"><li><input type="checkbox"/> i. Returned to work or school</li><li><input type="checkbox"/> ii. Receiving services from other program</li><li><input type="checkbox"/> iii. Pressure from family members</li><li><input type="checkbox"/> iv. Refused new home visitor</li><li><input type="checkbox"/> v. Incarcerated</li><li><input type="checkbox"/> vi. Other: _____</li></ul></li> <li><input type="checkbox"/> b. Moved out of area, no further participation</li><li><input type="checkbox"/> c. Unable to locate</li><li><input type="checkbox"/> d. Excessive cancellations/no show appointments</li><li><input type="checkbox"/> e. Child no longer in PCG's home (Formal arrangement)</li><li><input type="checkbox"/> f. Child no longer in PCG's home (Informal arrangement)</li><li><input type="checkbox"/> g. PCG / Child death, no further participation</li><li><input type="checkbox"/> h. Child adopted, no further participation</li></ul>	<p><input type="checkbox"/> <b>P4. Child reached 6<sup>th</sup> birthday</b></p> <p><input type="checkbox"/> <b>P5. Miscarriage/Fetal/Infant/Child death</b></p> <p>a. Date of Death (mm/dd/yyyy): _____/_____/_____</p> <p>b. Specify primary cause of death:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Abortion</li><li><input type="checkbox"/> b. Miscarriage</li><li><input type="checkbox"/> c. Fetal/Stillbirth</li><li><input type="checkbox"/> d. Neonatal</li><li><input type="checkbox"/> e. Infant</li><li><input type="checkbox"/> f. Child</li></ul> <p><input type="checkbox"/> <b>P6. Client temporarily suspends participation</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Out of town</li><li><input type="checkbox"/> b. Baby or PCG hospitalized</li><li><input type="checkbox"/> c. Schedule conflict</li><li><input type="checkbox"/> d. Other: _____</li></ul> <p><input type="checkbox"/> <b>P7. Returned to program / service area</b></p> <p><input type="checkbox"/> <b>P8. Transfer to new service area</b></p> <p>Previous OCAP program: _____ Current OCAP Program: _____</p> <p><input type="checkbox"/> <b>P9. DHS notified of potential abuse or neglect</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Reported by FSW</li><li><input type="checkbox"/> b. Reported by Other: _____</li></ul> <p><input type="checkbox"/> <b>P10. Program unable to provide services (specify)</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. FSW is not available</li><li><input type="checkbox"/> b. Unable to accommodate schedule</li><li><input type="checkbox"/> c. Other: _____</li></ul> <p><input type="checkbox"/> <b>P11. New family support worker</b></p> <p>Previous FSW name: _____ New FSW name: _____</p> <p><input type="checkbox"/> <b>P12. Child begins program; choose one:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> a. Infant born</li><li><input type="checkbox"/> b. Child enrolled</li></ul>
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# Instructions for OCAP Family Support Plan Log

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## Purpose

The purpose of the Family Support Plan Log is to monitor when the Family Support Plan is initiated and when it is updated.

## General Instructions

- ❖ **Whose** form: This is a PCG form.
- ❖ **When:** Complete this form each time the Family Support Plan is initiated or updated with a participating family.
- ❖ **What:** The form allows the program to monitor frequency of initiation or renewal of the Family Support Plan.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first “Participant Activity Form”. Avoid alternate names, misspells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**PCG First Name / Last Name / DOB:** The PCG’s first and last names and date of birth.

**PCG Intake Date:** The date on which the candidate was enrolled in the program i.e completed the Primary Caregiver Intake Form. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

## Item Instructions

- When you initiate a Family Support Plan with a newly enrolled family complete the first date in the table – “**Date FSP due**” – which will be 45 days from the enrollment date (See Example).
- When you complete the initial Family Support Plan, fill out the date it was completed (“Date FSP Completed”), whether it was completed on time (Yes or No) and the Type of FSP it was. Also, record the date the next FSP is due on the appropriate line on the form, which will be 6 months after the initial FSP date.

- Maintain all instances when you complete a new Family Support Plan with a family on a single log form so it is easy to keep track of when the Plan has been initiated and renewed, and when it needs to be updated.

**Example:** *The Smith Family enrolled in an OCAP program on January 1, 2007. The first time this table is filled out, it will look like this:*

Date FSP Due	Date FSP Completed	FSP On Time	FSP Type
<u>02/15/2007</u>	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow-Up FSP
___/___/___	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow-Up FSP

The Support Worker for the Smith Family completed the initial Family Support Plan on February 18, 2007. The Family Support Worker would fill out the Family Support Plan as follows:

Date FSP Due	Date FSP Completed	FSP On Time	FSP Type
<u>02/15/2007</u>	<u>02/18/2007</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Initial FSP <input type="checkbox"/> Follow-Up FSP
<u>08/18/2007</u>	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow-Up FSP

## FAMILY SUPPORT PLAN LOG

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

PCG Intake Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FSW Name: \_\_\_\_\_

**FSP Information – Create 1<sup>st</sup> FSP within 45 days of enrollment i.e. the day the PCG intake form was completed. Renegotiate FSP every six months based on the 1<sup>st</sup> FSP date.**

Date FSP Due	Date FSP Completed	FSP On Time	FSP Type
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP
____/____/____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial FSP <input type="checkbox"/> Follow – up FSP

# Instructions for Home Visitation Log

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## Purpose

The purpose of the Home Visitation Log is to present a picture of what happens, in general, on home visits in your program.

## General Instructions

- ❖ **Whose** form: This is a PCG form.
- ❖ **When:** Complete this form each time a home visit is canceled, scheduled but not attended, or canceled.
- ❖ **What:** The form allows the program to monitor frequency, duration, type, and attendance at home visits. It also will give the program and supervisors a general idea of visit content.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first “Participant Activity Form”. Avoid alternate names, miss-spells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique id that will link all the family forms to one id.

**PCG First Name / Last Name / DOB:** The PCG’s first and last names and date of birth.

**FSW Name:** The first and last name of the FSW assigned to this family.

## Item Instructions

Each row contains the fields to complete for each separate home visit. Complete each column for the relevant row.

- **Column 1, Date/Time/Length of Visit (exclude travel):** Fill out the date of the visit or the date the visit was supposed to happen; the time the visit began, circling “am” or “pm” as appropriate; and the duration of the visit or how long it lasted in minutes.
- **Column 2, Was the visit:** Check whether the visit was completed, a no-show (scheduled and attempted but the family was not present), canceled by the family, or canceled by the FSW

- **Column 3, Level of visit:** Check the level of the visit; if the visit was a no-show or canceled, this item may be not applicable
- **Column 4, Who was present:** Check ALL of the persons who were present at the home visit; if the visit was canceled or a no-show, this item will not be applicable
- **Column 5, Percent of time spent on each program goal:** Out of the total time you spent at the home visit working towards the overall program goals (1 through 5, see below), estimate the percent of time you spent related to that general topic area. All of the percentages should add up to 100%.
  - **Goal 1, Maternal Health:** Discussions, education, assessment, activities and referrals related to the mother’s prenatal or postnatal health, including topics such as nutrition, exercise, substance abuse, pre- or interconception health, and mental health/depression. *What percent of the time you spent working towards program goals was focused on maternal health?*
  - **Goal 2, Child Health and Development:** Discussions, education, assessment, activities and referrals related to the child’s health and/or development, including topics such as breastfeeding, nutrition, immunizations, preventive health care, well-child checkups, reading and language skills, and developmental screening. *What percent of the time you spent working towards program goals was focused on child health and development?*
  - **Goal 3, Self Sufficiency:** Discussions, education, assessment, activities and referrals related to family self sufficiency, including education, employment, family planning, and accessing needed financial resources. *What percent of the time you spent working towards program goals was focused on self-sufficiency?*
  - **Goal 4, Positive Parenting and Parent Child Interaction:** Discussions, education, assessment, activities and referrals related to positive parenting practices and positive parent-child interaction, including reading infant cues, father involvement, attachment and bonding, communication, the importance of play, etc. *What percent of the time you spent working towards program goals was focused on positive parenting and parent-child interaction?*
  - **Goal 5, Family Safety:** Discussions, education, assessment, activities and referrals related to family safety, including home safety practices, environmental safety, injury prevention, domestic violence, and preventing child abuse and neglect. *What percent of the time you spent working towards program goals was focused on family safety?*
- **Column 6, Date and time of next visit scheduled:** Write the date and time of the next home visit; circle “am” or “pm” as appropriate.

## HOME VISITATION LOG

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

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

### Home Visitation Information

Date/Time/Length of visit (exclude travel)	Was the visit:	Level of visit:	Who was present:	Percent of time spent on each program goal:	Date and time of next visit scheduled:
Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm  Minutes: ____min	<input type="checkbox"/> Completed <input type="checkbox"/> No Show <input type="checkbox"/> Canceled by Family <input type="checkbox"/> Canceled by FSW	<input type="checkbox"/> 1 – PN <input type="checkbox"/> 1 – SS <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> X	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Other children <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other	1. Maternal Health: ____% 2. Child Health & Development: ____% 3. Self-Sufficiency: ____% 4. Positive Parenting & Parent Child Interaction: ____% 5. Family Safety: ____%	Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm
Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm  Minutes: ____min	<input type="checkbox"/> Completed <input type="checkbox"/> No Show <input type="checkbox"/> Canceled by Family <input type="checkbox"/> Canceled by FSW	<input type="checkbox"/> 1 – PN <input type="checkbox"/> 1 – SS <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> X	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Other children <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other	1. Maternal Health: ____% 2. Child Health & Development: ____% 3. Self-Sufficiency: ____% 4. Positive Parenting & Parent Child Interaction: ____% 5. Family Safety: ____%	Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm
Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm  Minutes: ____min	<input type="checkbox"/> Completed <input type="checkbox"/> No Show <input type="checkbox"/> Canceled by Family <input type="checkbox"/> Canceled by FSW	<input type="checkbox"/> 1 – PN <input type="checkbox"/> 1 – SS <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> X	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Other children <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other	1. Maternal Health: ____% 2. Child Health & Development: ____% 3. Self-Sufficiency: ____% 4. Positive Parenting & Parent Child Interaction: ____% 5. Family Safety: ____%	Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm
Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm  Minutes: ____min	<input type="checkbox"/> Completed <input type="checkbox"/> No Show <input type="checkbox"/> Canceled by Family <input type="checkbox"/> Canceled by FSW	<input type="checkbox"/> 1 – PN <input type="checkbox"/> 1 – SS <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> X	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Other children <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other	1. Maternal Health: ____% 2. Child Health & Development: ____% 3. Self-Sufficiency: ____% 4. Positive Parenting & Parent Child Interaction: ____% 5. Family Safety: ____%	Date (mm/dd/yyyy): ____/____/____  Time: ____am/pm

# Instructions for OCAP Service Utilization Form

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## Purpose

The purpose of the Service Utilization Form is to document the services to which OCAP families are referred, the participant's action taken on a referral, whether the participant was able to access and utilize the service, and the ultimate result of the referral.

## General Instructions

- ❖ **Whose form:** The PCG / child's form.
- ❖ **When:** This form is completed at each home visit.
- ❖ **What:** The form gathers information on each stage of a participant's utilization of a particular service to which he or she was referred while participating in the OCAP program. The stages include initial referral, actions taken or not taken by the participant, availability and accessibility of services, initiation of service, and conclusion of service.
- ❖ **File:** This form is filed in the family folder at the OCAP program site providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Birth Form". Avoid alternate names, misspells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique id that will link all the family forms to one id.

**PCG First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Child First Name / Last Name / DOB:** The Child's first and last names and date of birth.

**Today's Date:** The date on which the referral was made. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

## Item Instructions

There are columns for the Primary Caregiver (PCG) and the child (C). Determine if the service is for the PCG or the child, then record the option in the PCG or child's column next to the service to indicate the stage of service utilization.

**Only record the referrals and follow-up status of those referrals that were given to the participant by the OCAP Family Support Worker.**

**Only continue to record the participant's status on a particular service until the referral/service has been resolved. Options for resolving a referral/service are 3,4,6,7, 8,9 and 10. However, if in the future, you refer the participant again to that same service, indicate the initial referral on this form and continue to record the participant's status with that service at every visit until it is resolved.**

### **Stage of Service Utilization**

- Option 1. Use to indicate that an initial referral was made during the visit.
- Option 2. Use to indicate the current use of a service.
- Option 3. Use this to indicate that the participant is no longer receiving the service (record only once at the time services ended).
- Option 4. Use to indicate that the participant has chosen to not take action on a previous referral (record only once to indicate the conclusion of the referral process).
- Option 5. Use to indicate that the participant has acted on the referral but is waiting for services or for the first appointment.
- Option 6. Use to indicate that a referral has been made or is needed, but the service is not available in the area.
- Option 7. Use to indicate that a referral has been made, but the service is closed to new program participants (full) and there is no waiting list.
- Option 8. Use to indicate that a referral was made and the participant has followed up on the referral, but that s/he cannot afford the service.
- Option 9. Use to indicate that a referral was made and the service was available, but the participant cannot get to the service because of transportation issues.
- Option 10. Use to indicate that a referral was made or offered, but the participant refused to accept the referral or to follow-up on it.
- Option 11. Use this option to indicate the status of a referral ONLY if it is not listed among options 1-11 above.

## SERVICE UTILIZATION FORM

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Child First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Today's Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ FSW Name: \_\_\_\_\_

Stage of Service Utilization			
1 Family referred	5 Waiting to receive service	9 No transportation to service	
2 Service Initiated – Ongoing	6 No service available in area	10 Refused referral	
3 Service Initiated – Resolved	7 Service in area full	11 Other	
4 Referred but no action taken	8 Referred but cannot afford service		

Please choose the most recent status of referral

PCG	C	Service	PCG	C	Service
		<b>Financial Assistance</b>			<b>Developmental Services</b>
		1. Medicaid / SoonerCare			30. Sooner Start/Early Intervention
		2. TANF / Welfare			31. Child Guidance
		3. Food Stamps			32. Counseling/Therapy for children
		4. Social Security/ SSI			<b>Educational Programs</b>
		5. Rent / Utility Assistance			33. GED, Alternative HS, etc.
		<b>Nutritional Services</b>			34. Education Beyond High School
		6. WIC			35. ESL Classes
		7. Lactation Services			36. Literacy program
		<b>Crises Intervention</b>			37. Parenting Class
		8. Domestic violence			38. Childbirth Education Class
		9. Child Welfare / DHS Referral			39. Fatherhood groups
		<b>Health Care Services</b>			40. Family Expectations
		10. Indian Health Services (HIS)			41. Head Start
		11. Maternity Clinic			42. Pre-Kindergarten programs
		12. Immunizations			<b>Charitable Services</b>
		13. PCP – PCG			43. Clothing (ex: baby clothes, blankets, diapers)
		14. PCP – Child			44. Furniture (ex: cribs, bassinets)
		15. Lead Screening			45. Food (including formula)
		16. Dental			<b>Other</b>
		17. Hearing			46. Relationship Counseling (ex: OMI)
		18. Vision			47. Respite
		19. Speech			48. Child Support
		20. Family Planning			49. Legal Services
		<b>Injury Prevention</b>			50. Adoption Services
		21. Car Seat			51. Childcare
		22. Bike helmet			52. Job Training
		23. Smoke alarm			53. Housing
		24. Water safety devices			54. Transportation
		25. Gun locks			55. Center-Based Services (OCAP)
		<b>Substance use / Mental Health</b>			56. Parent Support Groups
		26. Mental Health Treatment or Therapy			57. Other: _____
		27. Alcohol Treatment			58. Other: _____
		28. Drug Treatment			59. Other: _____
		29. Smoking Cessation			60. Other: _____

# Instructions for Primary Caregiver Intake Form

---

## Purpose

Primary Caregiver Intake Form gathers demographic and initial pregnancy related information on the person who accepts program services. The form is to be completed during the first home visit.

## General Instructions

**Whose form:** The primary caregiver (PCG) form.

**When:** Completed after a positive screening and assessment, when the family enrolls in the home visitation program.

**What:** The form gathers information on the demographics and initial pregnancy related information.

**File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, misspells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Today's Date:** The date on which the PCG Intake Form screening was conducted. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

## Item Instructions

PC1: Check the appropriate box indicating the gender of the primary caregiver.

PC2: Check the appropriate box indicating the race of the primary caregiver. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the primary caregiver. If the PCG is American Indian/Alaskan Native, he/she can specify the tribe.

PC3: Check the appropriate box indicating whether the primary caregiver is Hispanic or Latino.

PC4: Check the appropriate box indicating the marital status of the primary caregiver.

PC5: Check the appropriate box indicating the highest level of education the primary caregiver has completed. Only choose one box.

PC6: Check the appropriate box indicating whether the primary caregiver is currently enrolled in school, a vocational program, or an educational program.

PC7: Check the appropriate box indicating the primary caregiver's annual household income. Only choose one box.

PC8: Record the number of adults living in the home in which the primary caregiver resides.

PC9: Record the number of children living in the home in which the primary caregiver resides.

PC10: Check the appropriate boxes indicating all adults other than the primary caregiver that live in the home in which the primary caregiver resides. Check all boxes that apply. If the "Others" box is checked, please specify the relationship to the primary caregiver of the other person/people.

PC11: For all children living in the home in which the primary caregiver resides, record the first and last names, the date of birth in mm/dd/yyyy format, the gender, and the relationship of the child to the primary caregiver. Relationships include biological child, adopted child, stepchild, grandchild, niece/nephew, unrelated, and other.

PC12: Check the appropriate box indicating whether the primary caregiver has health insurance that covers health expenses. If the primary caregiver does not have health insurance, skip to PC14.

PC13: Check the appropriate box indicating the type of health insurance the primary caregiver has. If the "Other" box is checked, indicate the specific type of health insurance.

PC14: Check the appropriate box indicating the type of housing in which the primary caregiver resides. Choose only one box. If the "Other" box is checked, indicate the specific type of housing.

PC15: Check the appropriate box indicating whether the primary caregiver rents or owns the home in which he/she resides.

PC16: Check the appropriate box indicating the primary caregiver's type of employment. Choose only one box. If the "Other" box is checked, indicate the specific type of employment.

PC17: Record the number of live births the primary caregiver has had up to this point in time. If the response is "0," skip to PC19.

PC18: Check the appropriate box indicating the adult with which the primary caregiver's children currently live. Additionally, record the number of the primary caregiver's children that live with the primary caregiver and that live with someone else.

PC19: Check the appropriate box indicating whether the primary caregiver is currently pregnant. If the response is “no,” skip to PC23.

PC20: Record the number of weeks pregnant the primary caregiver is currently.

PC21: Record the expected due date of the primary caregiver. Use mm/dd/yyyy format.

PC22: Record the number of weeks pregnant the primary caregiver was when prenatal care began for the current pregnancy.

- PC22a – Record the number of weeks pregnant for the primary caregiver
- PC22b – Record the number of prenatal care visits the primary caregiver has attended thus far
- PC22c – Check the box if the primary caregiver has not received any prenatal care for the current pregnancy.

PC23: Check the appropriate box describing the primary caregiver’s feelings toward becoming pregnant at the time just before becoming pregnant with the current baby. Continue to PC24 only if the box for “I wanted to be pregnant later” is checked; otherwise, skip to PC25.

PC24: Check the appropriate box indicating how much later the primary caregiver would have liked to wait before becoming pregnant.

PC25: Check the appropriate box indicating whether the primary caregiver or his/her partner is using a method to prevent pregnancy. If “No” is checked, skip to PC27.

PC26: Check the appropriate box(es) indicating the type of birth control method(s) the primary caregiver is currently using (Check all that apply). If the “Other” box is checked, indicate the specific type of birth control method used.

PC27: Check the appropriate “Yes” or “No” box indicating for each reason whether it was an issue for the primary caregiver and his/her partner to not use the birth control method. If the “Yes” box is checked for “Other”, indicate the specific reason.

## PRIMARY CAREGIVER INTAKE FORM

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FSW Name: \_\_\_\_\_

PC1. Gender:  Male  Female

PC2. Which of the following is your race?

(Please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> American Indian/ Alaskan Native; Specify tribe: _____ | <input type="checkbox"/> Caucasian                        |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> Black/African American                                | <input type="checkbox"/> Other, specify _____             |

PC3. Are you Hispanic or Latino?  Yes  No

PC4. Marital Status:  Married  Widowed  Separated  
 Single, never married  Divorced

PC5. What is the highest level of school you have completed?

(Please choose one)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 8th grade or less                                   | <input type="checkbox"/> Some college, no degree | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade, no diploma | <input type="checkbox"/> Vo-tech certification   | <input type="checkbox"/> Beyond college    |
| <input type="checkbox"/> High school graduate or GED completed               | <input type="checkbox"/> Associate Degree        |  |

PC6. Are you currently enrolled in any kind of school, vocational or educational program?

Yes  No

PC7. Annual Household income:

(Please choose one)

- |  |  |                                  |
|--|--|----------------------------------|
| <input type="checkbox"/> Under \$5,000       | <input type="checkbox"/> \$25,000 - \$34,999 | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> \$5,000 - \$14,999  | <input type="checkbox"/> \$35,000 - \$44,999 |                                  |
| <input type="checkbox"/> \$15,000 - \$24,999 | <input type="checkbox"/> \$45,000 and above  |                                  |

PC8. How many *adults* live in the home? \_\_\_\_\_ Adults

PC9. How many *children* live in the home? \_\_\_\_\_ Children

PC10. Who are the *other adults* who live in the home:

(Other than yourself, check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> None                           | <input type="checkbox"/> Grandmother of the child | <input type="checkbox"/> Your Sister           |
| <input type="checkbox"/> Father of child                | <input type="checkbox"/> Grandfather of the child | <input type="checkbox"/> Your Brother          |
| <input type="checkbox"/> Stepfather of child            | <input type="checkbox"/> Your Aunt                | <input type="checkbox"/> Your Friend           |
| <input type="checkbox"/> Boyfriend/ Not father of child | <input type="checkbox"/> Your Uncle               | <input type="checkbox"/> Others, specify _____ |

PC11. Information about *all* children living in the home:

Name of child (First Name and Last Name)	Date of Birth (mm/dd/yyyy)	Gender (Female/Male)	Relationship to You (Biological Child, Adopted Child, Step-Child, Grandchild, Niece/Nephew, Unrelated, Other)

PC12. Do you have health care insurance that covers your health expenses?

Yes  No **(If No, skip to PC14)**

PC13. What kind of health care insurance?

Private Insurance  Medicaid /SoonerCare  Military Facility  
 Indian (I.H.S./Tribal Health Service)  Other, specify: \_\_\_\_\_

PC14. Type of housing:

(Please choose one)  Apartment  Mobile Home  
 House  Other, specify: \_\_\_\_\_

PC15. Do you rent or own your residence?

Rent  Own  Live with someone else

PC16. Employment:

**(Please choose one)**  Full time employed (35+ hours/week)  Odd jobs/irregular employment  
 Unemployed, but looking  Medical leave/disability  
 Part time employed (<35 hours/week)  Other, specify \_\_\_\_\_  
 Unemployed, not looking

PC17. How many live births have *you* had up until now? \_\_\_\_\_ Live births **(If 0, Skip to PC 19)**

PC18. Where are these children living and how many?

With you, # of children: \_\_\_\_\_  With someone else, # of children: \_\_\_\_\_

PC19. Are you currently expecting a baby?

Yes  No **(If No, Skip to PC23)**

PC20. If yes, how many weeks pregnant are you now? \_\_\_\_\_ Weeks

PC21. What is your due date (mm/dd/yyyy)? \_\_\_/\_\_\_/\_\_\_\_\_

PC21. What is your due date (mm/dd/yyyy)? \_\_\_/\_\_\_/\_\_\_\_\_

PC22. How many weeks pregnant were you when you began getting prenatal care for this pregnancy?

- a. Number of weeks pregnant \_\_\_\_\_
- b. Number of prenatal care visits so far \_\_\_\_\_
- c.  I have not gotten prenatal care for this pregnancy yet

PC23. Thinking back to *just before* you got pregnant with your *new* baby, how did you feel about becoming pregnant? (Choose one answer)

- I wanted to be pregnant sooner (Skip to PC25)
- I wanted to be pregnant later
- I wanted to be pregnant then (Skip to PC25)
- I didn't want to be pregnant then or at any time in the future (Skip to PC25)

PC24. How much later did you want to become pregnant?

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to less than 4 years
- 4 years or more

PC25. Are you or your partner doing anything now to keep from getting pregnant? (Some things people do to keep from getting pregnant include not having sex at certain times [rhythm], or withdrawal, and using birth control methods such as pill, condoms, cervical ring, IUD, having their tubes tied or their partner having a vasectomy.)

- Yes
- No (Skip to PC27)

PC26. Which type(s) of birth control methods are you currently using? (Please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Male condom  | <input type="checkbox"/> Cervical ring                               |
| <input type="checkbox"/> Natural family planning, rhythm method                       | <input type="checkbox"/> Quarterly birth control shot (Depo-Provera) |
| <input type="checkbox"/> Spermicides, jelly, foam, cream suppositories, vaginal cream | <input type="checkbox"/> Monthly birth control shot (Lunelle)        |
| <input type="checkbox"/> Diaphragm  | <input type="checkbox"/> Progestrone IUD                             |
| <input type="checkbox"/> Cervical cap   | <input type="checkbox"/> Non-progestrone IUD                         |
| <input type="checkbox"/> Sponge   | <input type="checkbox"/> Emergency contraception                     |
| <input type="checkbox"/> Withdrawal method  | <input type="checkbox"/> Female condom                               |
| <input type="checkbox"/> Birth control pills  | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Patch  |  |

PC27. What are your or your partner's reasons for not doing anything to keep from getting pregnant now?

Choose 'Yes' if it is a reason, and choose 'No' if it is not.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. I am not having sex                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. I want to get pregnant                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I don't want to use birth control                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. My husband or partner doesn't want to use anything | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. I don't think I can get pregnant (sterile)         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. I can't pay for birth control                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. I am pregnant now                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Other, Please tell us: _____                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

# Instructions for Primary Caregiver Update Form

---

## Purpose

Primary Caregiver Update Form gathers demographic and initial pregnancy related information on the person who accepts program services. The form is to be completed every six months to measure the changes that have occurred since enrollment into the program.

## General Instructions

**Whose form:** The primary caregiver (PCG) form.

**When:** The form is completed six months from the date of intake and at six-month intervals.

**What:** The form gathers updated information on the demographics and initial pregnancy related information. Outcome measures are determined by comparing intake status to update status over time.

**File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, misspells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Today's Date:** The date on which the screening was conducted. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

**Reporting Time:** Check the box indicating the appropriate time frame (PCG intake or every 6 months calculated from the enrollment date). Many program outcomes are measured over time, and this field helps to determine time sequence.

## Item Instructions

PCU1: Check the appropriate box indicating the gender of the primary caregiver.

PCU2: Check the appropriate box indicating the race of the primary caregiver. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the primary caregiver. For American Indian PCG's, they can specify their tribe.

PCU3: Check the appropriate box indicating whether the primary caregiver is Hispanic or Latino.

PCU4: Check the appropriate box indicating the marital status of the primary caregiver.

PCU5: Check the appropriate box indicating the highest level of education the primary caregiver has completed. Only choose one box.

PCU6: Check the appropriate box indicating whether the primary caregiver is currently enrolled in school, a vocational program or an educational program.

PCU7: Check the appropriate box indicating the primary caregiver's annual household income. Only choose one box.

PCU8: Record the number of adults living in the home in which the primary caregiver resides.

PCU9: Record the number of children living in the home in which the primary caregiver resides.

PCU10: Check the appropriate boxes indicating all adults other than the primary caregiver that live in the home in which the primary caregiver resides. Check all boxes that apply. If the "Others" box is checked, please specify the relationship to the primary caregiver of the other person/people.

PCU11: For all children living in the home in which the primary caregiver resides, record the first and last names, the date of birth in mm/dd/yyyy format, the gender, and the relationship of the child to the primary caregiver. Relationships include biological child, adopted child, stepchild, grandchild, niece/nephew, unrelated, and other.

PCU12: Check the appropriate box indicating whether the primary caregiver has health insurance. If the primary caregiver does not have health insurance, skip to PC14.

PCU13: Check the appropriate box indicating the type of health insurance the primary caregiver has. If the "Other" box is checked, indicate the specific type of health insurance.

PCU14: Check the appropriate box indicating the type of housing in which the primary caregiver resides. Choose only one box. If the "Other" box is checked, indicate the specific type of housing.

PCU15: Check the appropriate box indicating whether the primary caregiver rents or owns the home in which he/she resides.

PCU16: Check the appropriate box indicating whether the primary caregiver has moved within the previous 6 months. If the primary caregiver has not moved in the last 6 months, skip to PCU18.

PCU17: Record the number of times the primary caregiver has moved within the previous 6 months.

PCU18: Check the appropriate box indicating the primary caregiver's type of employment. Choose only one box. If the "Other" box is checked, indicate the specific type of employment.

PCU19: Record the number of live births the primary caregiver has had up to this point in time.

PCU20: Check the appropriate box indicating the adult with which the primary caregiver's children currently live. Additionally, record the number of the primary caregiver's children that live with the primary caregiver and the number of primary caregiver's children that live with someone else.

PCU21: Check the appropriate box indicating whether the primary caregiver has been pregnant since the birth of the index child. If the "Yes" box is checked, complete PCU21a, PCU21b, and PCU21c. If the "No" box is checked, skip to PCU24.

PCU21a: Record the month and year in which the primary caregiver's most recent pregnancy began.

PCU21b: Check the appropriate box indicating the outcome of the primary caregiver's most recent pregnancy. If any box other than "Still Pregnant" is checked, skip to PCU22.

PCU21c: Check the appropriate box indicating whether the primary caregiver is currently getting prenatal care.

PCU22: Check the appropriate box describing the primary caregiver's feelings toward becoming pregnant at the time just before becoming pregnant with the current baby. If the box for "I wanted to be pregnant later" is checked, continue to PCU23; otherwise, skip to PCU24.

PCU23: Check the appropriate box indicating how much later the primary caregiver would have liked to wait before becoming pregnant.

PCU24: Check the appropriate box indicating whether the primary caregiver or his/her partner is using a method to prevent pregnancy. If "No" is checked, skip to PCU26.

PCU25: Check the appropriate box indicating the type(s) of birth control method(s) the primary caregiver is currently using (Check all that apply). If the "Other" box is checked, indicate the specific type of birth control method used.

PCU26: Check the appropriate "Yes" or "No" box indicating for each reason whether it was an issue for the primary caregiver and his/her partner to not use the birth control method. If the "Yes" box is checked for "Other", indicate the specific reason.

## PRIMARY CAREGIVER UPDATE FORM

*First Name:* \_\_\_\_\_ *Last Name:* \_\_\_\_\_ *DOB (mm/dd/yyyy):* \_\_\_\_/\_\_\_\_/\_\_\_\_

*Today's Date (mm/dd/yyyy):* \_\_\_\_/\_\_\_\_/\_\_\_\_ *FSW Name:* \_\_\_\_\_

**Reporting Time:**    6                      12                      18                      24                      30                      36  
 (Months from enrollment date) 42                      48                      54                      60                      66                      72

PCU1. Gender:     Male                       Female

PCU2. Which of the following is your race?  
(Please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian/ Alaskan Native; Tribe: _____<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black/African American | <input type="checkbox"/> Caucasian<br><input type="checkbox"/> Native Hawaiian/Pacific Islander<br><input type="checkbox"/> Other, specify _____ |
|---|--|

PCU3. Are you Hispanic or Latino?                       Yes                       No

PCU4. Marital Status:     Married                       Widowed                       Separated  
                                   Single, never married                       Divorced

PCU5. What is the highest level of school you have completed?  
**(Please choose one)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 8th grade or less                                   | <input type="checkbox"/> Some college, no degree | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade, no diploma | <input type="checkbox"/> Vo-tech certification   | <input type="checkbox"/> Beyond college    |
| <input type="checkbox"/> High school graduate or GED completed               | <input type="checkbox"/> Associate Degree        |  |

PCU6. Are you currently enrolled in any kind of school, vocational or educational program?  
 Yes                       No

PCU7. Annual Household income:  
**(Please choose one)**

- |  |  |                                  |
|--|--|----------------------------------|
| <input type="checkbox"/> Under \$5,000       | <input type="checkbox"/> \$25,000 - \$34,999 | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> \$5,000 - \$14,999  | <input type="checkbox"/> \$35,000 - \$44,999 |                                  |
| <input type="checkbox"/> \$15,000 - \$24,999 | <input type="checkbox"/> \$45,000 and above  |                                  |

PCU8. How many *adults* live in the home? \_\_\_\_\_ Adults

PCU9. How many *children* live in the home? \_\_\_\_\_ Children

PCU10. Who are the *other adults* who live in the home:  
**(Other than yourself, check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> None                           | <input type="checkbox"/> Grandmother of the child | <input type="checkbox"/> Your Sister           |
| <input type="checkbox"/> Father of child                | <input type="checkbox"/> Grandfather of the child | <input type="checkbox"/> Your Brother          |
| <input type="checkbox"/> Stepfather of child            | <input type="checkbox"/> Your Aunt                | <input type="checkbox"/> Your Friend           |
| <input type="checkbox"/> Boyfriend/ Not father of child | <input type="checkbox"/> Your Uncle               | <input type="checkbox"/> Others, specify _____ |

PCU11. Information about *all* children living in the home:

Name of child (First Name and Last Name)	Date of Birth (mm/dd/yyyy)	Gender (Female/Male)	Relationship to You (Biological Child, Adopted Child, Step-Child, Grandchild, Niece/Nephew, Unrelated, Other)

PCU12. Do you have health care insurance that covers your health expenses?

Yes  No **(If No, skip to PCU14)**

PCU13. What kind of health care insurance?

Private Insurance  Medicaid /SoonerCare  Military Facility  
 Indian (I.H.S./Tribal Health Service)  Other, specify: \_\_\_\_\_

PCU14. Type of housing:

**(Please choose one)**  Apartment  Mobile Home  
 House  Other, specify: \_\_\_\_\_

PCU15. Do you rent or own your residence?

Rent  Own  Live with someone else

PCU16. Have you moved in the last 6 months?

Yes  No **(If No, skip to PCU18)**

PCU17. How many times? \_\_\_\_\_

PCU18. Employment:

**(Please choose one)**  Full time employed (35+ hours/week)  Odd jobs/irregular employment  
 Unemployed, but looking  Medical leave/disability  
 Part time employed (<35 hours/week)  Other, specify \_\_\_\_\_  
 Unemployed, not looking

PCU19. How many live births have you had up till now? \_\_\_\_\_ Live births

PCU20. Where are these children living and how many?

With you, # of children: \_\_\_\_\_  With someone else, # of children: \_\_\_\_\_

PCU21. Have you been pregnant since you had (identified child)?

Yes  No **(If No, skip to PCU24)**

PCU21 a. When did the pregnancy begin? Month \_\_\_\_\_ Year \_\_\_\_\_  
PCU21 b: What was the outcome?

- Live Birth (Skip to PCU22)
- Still Birth (Skip to PCU22)
- Miscarriage (Skip to PCU22)
- Abortion (Skip to PCU22)
- Still pregnant

PCU21 c: Are you getting prenatal care?  Yes  No

PCU22. Thinking back to *just before* you got pregnant with your *new* baby, how did you feel about becoming pregnant? (Choose one answer)

- I wanted to be pregnant sooner (Skip to PCU24)
- I wanted to be pregnant later
- I wanted to be pregnant then (Skip to PCU24)
- I didn't want to be pregnant then or at any time in the future (Skip to PCU24)

PCU23. How much later did you want to become pregnant?

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to less than 4 years
- 4 years or more

PCU24. Are you or your partner doing anything now to keep from getting pregnant? (Some things people do to keep from getting pregnant include not having sex at certain times [rhythm], or withdrawal, and using birth control methods such as pill, condoms, cervical ring, IUD, having their tubes tied or their partner having a vasectomy.)

- Yes  No (Skip to PCU26)

PCU25. Which type(s) of birth control method(s) are you currently using? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Male condom  | <input type="checkbox"/> Cervical ring                               |
| <input type="checkbox"/> Natural family planning, rhythm method                       | <input type="checkbox"/> Quarterly birth control shot (Depo-Provera) |
| <input type="checkbox"/> Spermicides, jelly, foam, cream suppositories, vaginal cream | <input type="checkbox"/> Monthly birth control shot (Lunelle)        |
| <input type="checkbox"/> Diaphragm  | <input type="checkbox"/> Progestrone IUD                             |
| <input type="checkbox"/> Cervical cap   | <input type="checkbox"/> Non-progestrone IUD                         |
| <input type="checkbox"/> Sponge   | <input type="checkbox"/> Emergency contraception                     |
| <input type="checkbox"/> Withdrawal method  | <input type="checkbox"/> Female condom                               |
| <input type="checkbox"/> Birth control pills  | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Patch  |  |

PCU26. What are your or your partner's reasons for not doing anything to keep from getting pregnant now? Choose 'Yes' if it is a reason, and choose 'No' if it is not.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. I am not having sex                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. I want to get pregnant                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I don't want to use birth control                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. My husband or partner doesn't want to use anything | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. I don't think I can get pregnant (sterile)         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. I can't pay for birth control                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. I am pregnant now                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Other, Please tell us: _____                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

# Instructions for Primary Caregiver Health Form

---

## Purpose

Primary Caregiver Health Form tracks changes in the primary caregiver health behaviors as a result of program interventions. The form is to be completed every six months to measure the changes that have occurred since enrollment into the program.

## General Instructions

**Whose form:** The primary caregiver (PCG) form.

**When:** The form is completed at the 2<sup>nd</sup> home visit and followed-up every six months from the date of enrollment.

**What:** The form gathers information on the use of tobacco, alcohol and drugs, and nutrition and exercise habits.

**File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, miss-spells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Today's Date:** The date on which this form was completed by the PCG or FSW. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

**Reporting Time:** Check the box indicating the appropriate time frame (PCG intake or every 6 months calculated from the enrollment date). Many program outcomes are measured over time, and this field helps to determine time sequence.

## Item Instructions

PH1: **Using the time frame of the past 2 years**, mark if the PCG has smoked at least 100 cigarettes (5 packs).

PH2: **Using the time frame of the past 48 hours**, record the number of cigarettes the PCG has smoked. If cigarette use is reported in packs, recode the number of cigarettes. One half-pack is 10 cigarettes. Clarify time frames to assist PCGs with time orientation. For example, if

the visit date is Tuesday around 2:00 PM, the 48-hour timeframe began on Sunday, around 2:00 until now (Tuesday, 2:00 PM).

PH3: Read each of the 3 statements to the PCG and mark whether s/he reports that each does (Yes) or does not (No) apply to her.

- a. "I have quit smoking" means s/he has quit smoking at some point in the past, has not smoked since she quit and is not currently smoking.
- b. "I am trying to quit smoking" means that s/he currently smokes and is taking some sort of action to try and quit.
- c. "I have cut down on the number of cigarettes I smoke" means s/he smokes currently but has cut down on the number of cigarettes from the amount s/he smoked in the past.

PH4: Record the number of alcoholic drinks that are consumed by the PCG in an average week.

PH5: Record how often the PCG indicates usage of drugs. Although not listed, drugs also may include crystal methamphetamine, crack, and crank.

PH6: Record the consumption of fruit juices by the PCG per day, week or month (for example twice a week, three times a month, etc.)

PH7: Record the consumption of fruit **excluding fruit juices** by the PCG per day, week or month (for example twice a week, three times a month, etc.)

PH8: Record the consumption of green salad by the PCG per day, week or month (for example twice a week, three times a month, etc.)

PH9: Record the consumption of potatoes **excluding French fries, fried potatoes, or potato chips** by the PCG per day, week or month (for example twice a week, three times a month, etc.)

PH10: Record the number of times the PCG consumes carrots per day, week or month (for example twice a week, three times a month, etc.)

PH11: Record the consumption of vegetables **excluding carrots, potatoes, or salad** by the PCG per day, week or month (for example a serving of vegetables at both lunch and dinner would be two servings.)

PH12: **Using the time frame of the past 6 months**, mark if the PCG has participated in any physical activities or exercises (for example running, bicycling, vacuuming, gardening, heavy yard work, or brisk walk).

## PRIMARY CAREGIVER HEALTH FORM

First Name: _____	Last Name: _____	DOB (mm/dd/yyyy): ____/____/____					
Today's Date (mm/dd/yyyy): ____/____/____		FSW Name: _____					
Reporting Time:	<input type="checkbox"/> Intake	<input type="checkbox"/> 6	<input type="checkbox"/> 12	<input type="checkbox"/> 18	<input type="checkbox"/> 24	<input type="checkbox"/> 30	<input type="checkbox"/> 36
(Months from enrollment date)	<input type="checkbox"/> 42	<input type="checkbox"/> 48	<input type="checkbox"/> 54	<input type="checkbox"/> 60	<input type="checkbox"/> 66	<input type="checkbox"/> 72	

PH1. Have you smoked at least 100 cigarettes in the past 2 years? (A pack has 20 cigarettes)

- Yes  
 No

**(If No, skip to PH4.)**

PH2. In the last 48 hours, how many cigarettes have you smoked? By 48 hours I mean from (TIME AND DAY OF WEEK) to (TODAY AND TIME).

Number of cigarettes

PH3. Do any of the following statements apply to you?

- a. I have quit smoking  
b. I am trying to quit smoking  
c. I have cut down on the number of cigarettes I smoke

- Yes     No  
 Yes     No  
 Yes     No

PH4. How many alcoholic drinks do you have in an average week? (A drink is: one glass of wine, one wine cooler, one 12-oz container of beer, one shot of liquor, one mixed drink)

- Less than 1 drink a week                       7 to 13 drinks a week  
 1 to 3 drinks a week                             14 or more drinks a week  
 4 to 6 drinks a week                             I don't drink

PH5. How often do you use marijuana, cocaine, narcotics, or other recreational drugs?

- Once a day     Once a month  
 Every other day                                       Less than once a month  
 Once a week      I don't use drugs  
 Every other week

**These next questions are about the foods you usually eat or drink. Please tell me how often you eat or drink each one, for example, twice a week, three times a month, and so forth. Remember, I am only interested in the foods you eat. Include all foods you eat, both at home and away from home.**

PH6. How often do you drink fruit juices such as orange, grapefruit, or tomato?

- per day  
  per week  
  per month  
 Never

PH7. Not counting juice, how often do you eat fruit?

- per day
- per week
- per month
- Never

PH8. How often do you eat green salad?

- per day
- per week
- per month
- Never

PH9. How often do you eat potatoes not including French fries, fried potatoes, or potato chips?

- per day
- per week
- per month
- Never

PH10. How often do you eat carrots?

- per day
- per week
- per month
- Never

PH11. Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat? (Example: A serving of vegetables at both lunch and dinner would be two servings.)

- per day
- per week
- per month
- Never

PH12. During the past six months, other than your regular job, did you participate in any physical activities or exercises such as running, bicycling, vacuuming, gardening, heavy yard work or brisk walking for exercise?

- Yes
- No

# Instructions for Relationship Assessment Form

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## Purpose

The purpose of the Relationship Assessment Form is to identify the PCG's partner status, the involvement of the baby's biological father, the social support available to the PCG, and the extent to which the PCG has experienced intimate partner violence.

## General Instructions

- ❖ **Whose form:** The primary caregiver (PCG) form. *NOTE: If the PCG is the baby's biological father, he will respond to the questions accordingly, often responding about his own involvement with his child.*
- ❖ **When:** The form is completed at the 4th home visit and repeated every six months from the date of enrollment.
- ❖ **What:** The form gathers information on partner status, father involvement, social support, and intimate partner violence.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

It is important that you explain to program participants at enrollment into the program if you are mandated to report domestic violence. It is important to clarify if mandated reporting requirements pertain only to current incidences of violence, e.g., during this pregnancy.

**To assure the protection of the program participant as well as yourself, complete this form with the participant in private.** If other family members are routinely present during visits, you may need to think of creative ways of obtaining privacy in order to complete this form, e.g., suggesting to the participant that you go for a walk, arranging to meet the participant at a restaurant, calling the client to obtain information by telephone between visits.

If you are in doubt for any reason (even just an inner red flag) about the safety of completing this form with a client, please defer doing so until you can talk with your supervisor about your concerns.

If you feel you need to have more training in domestic violence issues, be sure to discuss this with your supervisor.

Do not consider that the time when you administer this form as the only time to discuss domestic violence with your participant. Domestic violence should be addressed at appropriate times during home visits.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, misspellings, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Today's Date:** The date on which this form was completed by the PCG or FSW. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

**Reporting Time:** Check the box indicating the appropriate time frame (PCG intake or every 6 months calculated from the enrollment date). Many program outcomes are measured over time, and this field helps to determine time sequence.

### Item Instructions

RA1. Indicate whether the PCG has a partner now and the partner's gender.

RA2. If applicable, indicate whether the PCG's partner is the baby's biological father.

RA3. Indicate how often the baby's biological father has spent taking care of and/or playing with the child **during the past 6 months or since the baby's birth**. *Note: If the PCG is pregnant, this question will not be applicable and should be skipped.*

RA4. Indicate whether the baby's father figure or biological father participated in any activity sponsored by your home visitation program, including home visitation or other events.

RA5. Indicate how much money the baby's biological father has provided for the PCG during a typical month. **Please write a dollar amount.** If the baby's biological father lives with the PCG, include his whole monthly income. If he has only provided material items, ask the PCG to estimate the dollar value of those items.

RA6. For each item a – f, indicate whether the PCG had the kind of help indicated during the past 6 months or the birth of the child; circle "yes" if they had it, and "no" if they did not.

A number of the following items inquire about the number of times clients may have experienced a certain type of violence. Please ask the question in an open-ended manner, use the response provided by the client, and check the appropriate response option. Do not just read all the possible response options.

RA7. Check whether a partner or someone important to her has ever emotionally or physically abused the client. **DO NOT SKIP THE NEXT QUESTION**

RA8. Check whether someone has physically hurt the client **within the last 6 months**. If "Yes", check all people whom the client says has physically hurt her. If "No," skip to RA15. *[Note: Choking is a type of physical injury.]*

RA9. Check how many times the client has been physically hurt **within the last 6 months**.

- RA10. Check how many times the client says somebody slapped or pushed her **within the last 6 months.**
- RA11. Check how many times the client says somebody punched, kicked or cut her **within the last 6 months.**
- RA12. Check how many times the client says somebody burnt her, severely bruised her, or broke her bone **within the last 6 months.**
- RA13. Check how many times the client says somebody caused her to have a head, internal, or permanent injury **within the last 6 months.**
- RA14. Check how many times the client says somebody used a weapon (client's perception) to hurt her **within the last 6 months.**
- RA15. Check whether the client has been forced to have sexual relations by someone **within the last 6 months.** If "Yes", check all people whom the client says have forced her to have sex with them. If "No," skip to RA17.
- RA16. Check how many times the client says somebody forced her to have sexual relations **within the last 6 months.**
- RA17. Check whether the client says she is afraid of any current or previous male partner or someone else important to her. If "1-Yes", check all people whom the client says she is afraid of.

**NOTE:** If there are any missing responses to any non-skipped question on this form in the database, it will be assumed that the client refused to respond.

## RELATIONSHIP ASSESSMENT FORM

First Name: _____	Last Name: _____	DOB (mm/dd/yyyy): ____/____/____
Today's Date (mm/dd/yyyy): ____/____/____		FSW Name: _____
Reporting Time: (Months from enrollment date)	<input type="checkbox"/> Intake <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 18 <input type="checkbox"/> 24 <input type="checkbox"/> 30 <input type="checkbox"/> 36 <input type="checkbox"/> 42 <input type="checkbox"/> 48 <input type="checkbox"/> 54 <input type="checkbox"/> 60 <input type="checkbox"/> 66 <input type="checkbox"/> 72	

**The following questions are about family and friends relationships. These questions may or may not describe some of the ways your current or past partner or someone else important to you acts or acted towards you.**

RA1. Do you have a partner now?

- Yes, male
- Yes, female (Skip to RA3.)
- No (Skip to RA3.)

RA2. Is your (current partner) biological father of this baby?

- Yes
- No
- Don't know

RA3. **(SKIP during prenatal period)** During the past 6 months or since the birth of the child, how often did the child's biological father spend time taking care of and /or playing with the child?

- Not at all
- Less than once a week
- At least once a week but not daily
- Daily

RA4. During the past 6 months, did the father figure /biological father participate in any program sponsored activity such as home visitations or family support events?

- Yes
- No

RA5. Since you became pregnant /or after the birth of your child, how much money has the child's biological father provided for you during a typical month?

\$

RA6. During the past 6 months or since the birth of the child, would you have had the kinds of help listed below if you needed them? For each one, circle Y (Yes) if you would have had it or circle N (No) if not.

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Someone to help me if I were sick and needed to be in bed               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Someone to talk with about my problems                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Someone to loan me \$50   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Someone to take me to the clinic or doctor's office if I needed a ride  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Someone to take care of my child  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Someone to help me if I were tired and feeling frustrated with my child | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

RA7. Have you ever been emotionally or physically abused by your partner or someone important to you?

- Yes
- No

RA8. Within the last 6 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?

Yes → By whom? (Check all that apply.)

- Spouse
- Ex-spouse
- Boyfriend/ girlfriend
- Ex-Boyfriend/ girlfriend
- Other family member
- Friend/acquaintance
- Stranger

No → (If no, go to RA15)

RA9. How many times were you physically hurt in the last six months (Temporary or lasting injuries)?

- None
- One or two
- Three to five
- Six or more

RA10. In the last six months, how many times did someone slap or push you?

- None
- One or two
- Three to five
- Six or more

RA11. In the last six months, how many times did someone punch, kick or cut you?

- None
- One or two
- Three to five
- Six or more

RA12. In the last six months, how many times did someone do something that burned you, severely bruised you, or broke a bone?

- None
- One or two
- Three to five
- Six or more

RA13. In the last six months, how many times did someone cause you to have a head, internal, or permanent injury?

- None
- One or two
- Three to five
- Six or more

RA14. In the last six months, how many times did someone use a weapon to hurt you? (Weapon is client's perception.)

- None
- One or two
- Three to five
- Six or more

RA15. Within the last six months, has anyone forced you to have sexual relations?

- Yes → If **yes**, by whom? (Check all that apply.)
  - Spouse
  - Ex-spouse
  - Boyfriend/ girlfriend
  - Ex-Boyfriend/ girlfriend
  - Other family member
  - Friend/acquaintance
  - Stranger
- No → (If no, go to RA17)

RA16. In the last six months, how many times were you forced to have sexual relations?

- None
- One or two
- Three to five
- Six or more

RA17. Are you afraid of any current or previous male partner or someone else important to you?

- Yes → If **yes**, of whom? (Check all that apply.)
  - Spouse
  - Ex-spouse
  - Boyfriend/ girlfriend
  - Ex-Boyfriend/ girlfriend
  - Other family member
  - Friend/acquaintance
  - Stranger
  - No**

# Instructions for Pregnancy and Birth Form

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## Purpose

The purpose of this form is to collect information on events during the pregnancy, delivery, and the birth of the child that may impact maternal and child health outcomes. This form also provides a link between the mother and child's data.

## General Instructions

- ❖ **Who:** The child's form. In case of multiple births, this form is to be completed for all live births in OCAP program.
- ❖ **When:** Completed at the first home visit after enrollment or birth. However, in case of neonatal death or if the infant dies before the first home visit, the Pregnancy & Birth Form should be completed when possible. Follow up a completed Pregnancy & Birth Form for a deceased child with a Participant Activity Form that updates the status of the deceased child in the database.
- ❖ **What:** This form intakes the child into the program and begins the child's record in the program's database.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Birth Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**PCG First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Child First Name / Last Name / DOB:** The Child's first and last names and date of birth.

**Today's Date:** The date on which the referral was made. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

## Special Instructions for Multiple Births

There are some questions on this form that are pregnancy and mother-related (item PB9 to PB19). To keep from administering and entering these questions more than once for a mother:

- Complete and enter all the questions on the form, i.e. PB1 to PB19 for the first –borne child of a multiple birth.
- Complete and enter questions PB1 to PB8 for second and subsequent – born of a multiple birth.

### Item Instructions

PB1: Check the appropriate box indicating the gender of the child.

PB2: Record the birth weight of the infant in pounds (lbs) and ounces (oz).

PB3: Record the number of gestational weeks completed at the time of the delivery. For infants delivered more than 3 weeks prior to the mother's EDC, validate gestational age of infant at birth with the mother's health care provider.

PB4: Check the appropriate box indicating the race of the child. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the child.

PB5: Check the appropriate box indicating whether the child is Hispanic or Latino.

PB6: Check the appropriate box indicating the number of infants delivered. If the "Other" box is checked, please specify the plurality of the birth.

PB7: Check the appropriate box indicating whether the infant spent any time in the NICU or a special nursery at the time of birth.

PB7a: If the infant was in NICU or special care at the hospital and has already been released, check the "Yes" box next to PB7a and then record the specific number of days prior to discharge.

PB8: Check the appropriate box indicating the primary caregiver's relationship to the child.

PB9: Check the appropriate box indicating the type of health insurance the mother had just before becoming pregnant.

PB10: Check the appropriate box indicating how prenatal care was paid. Please check all boxes that apply. If "Other" has been checked, please specify method used to pay for prenatal care.

PB11: Check the appropriate box indicating how the child's delivery was paid. Please check all boxes that apply. If "Other" has been checked, please specify method used to pay for the child's delivery.

PB12: Record the number of prenatal care visits the mother had during the pregnancy of this child. Exclude the appointment for the pregnancy test.

PB13: Check the appropriate box indicating the number of cigarettes the mother smoked on an average day in the 3 months prior to becoming pregnant. Note that a pack contains 20 cigarettes.

PB14: Check the appropriate box indicating the number of cigarettes the mother smoked on an average day during the last 3 months of the pregnancy. Note that a pack contains 20 cigarettes.

PB15: Check the appropriate box indicating the number of cigarettes the mother smokes on an average day now. Note that a pack contains 20 cigarettes.

PB16: Check the appropriate box indicating the number of alcoholic drinks the mother had in an average week in the 3 months prior to becoming pregnant. Note that a drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

PB17: Check the appropriate box indicating the number of alcoholic drinks the mother had in an average week during the last 3 months of pregnancy. Note that a drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

PB18: Check the appropriate box indicating the number of times the mother used marijuana, cocaine, narcotics or other drugs in the 3 months prior to becoming pregnant.

PB19: Check the appropriate box indicating the number of times the mother used marijuana, cocaine, narcotics or other drugs during the last 3 months of pregnancy.

## PREGNANCY & BIRTH FORM

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

Child First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ FSW Name: \_\_\_\_\_

PB1. Gender of the child:       Male       Female

PB2. Birthweight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

PB3. Gestational age at birth: \_\_\_\_\_ weeks

PB4. Race of the child (Please check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian or Native Alaskan; Tribe: _____ | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> White or Caucasian                  |
| <input type="checkbox"/> Black or African American                       | <input type="checkbox"/> Other, specify: _____               |

PB5. Is your child Hispanic or Latino?       Yes       No

PB6. Please describe the plurality of the birth:

- Single       Twin       Triplet       Other, specify: \_\_\_\_\_

PB7. Did the child have to spend any time in the NICU or a special nursery because of problems?

- Yes, he/she is still in the NICU  
 Yes → PB7a. For how many days prior to discharge? \_\_\_\_\_ days  
 No

PB8. What is your relationship to the child?

- |                                      |                                      |   |
|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Mother      | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Foster Parent  |
| <input type="checkbox"/> Father      | <input type="checkbox"/> Aunt        | <input type="checkbox"/> Legal Guardian |
| <input type="checkbox"/> Grandmother | <input type="checkbox"/> Uncle       | <input type="checkbox"/> Other: _____   |

**NOTE: For PB9-19, Complete only for the first-born child of multiples.**

PB9. Just before the mother got pregnant, did she have health insurance?

- Yes, She had Medicaid  
 Yes, She had private health insurance  
 No, She did not have health insurance

PB10. How was the prenatal care paid for? (Please check all that apply)

- Medicaid  
 Personal income (cash, check, or credit card)  
 Health insurance or HMO (including insurance from your work or your partner's work)  
 Indian Health Service or Tribal  
 Community or public health clinic  
 Other, specify: \_\_\_\_\_

PB11. How was the delivery paid for? (Please check all that apply)

- Medicaid
- Personal income (cash, check, or credit card)
- Health insurance or HMO (including insurance from your work or your partner's work)
- Indian Health Service or Tribal
- Community or public health clinic
- Other, specify: \_\_\_\_\_

PB12. How many prenatal care visits did the mother have during the pregnancy? \_\_\_\_\_ # of visits

PB13. In the *3 months before* the mother got pregnant, how many cigarettes did she smoke on an average day?  
(A pack has 20 cigarettes)

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- None (0 cigarettes)

PB14. In the *last 3 months* of the mother's pregnancy, how many cigarettes did she smoke on an average day?  
(A pack has 20 cigarettes)

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- None (0 cigarettes)

PB15. How many cigarettes does the mother smoke on an average day *now*?

(A pack has 20 cigarettes)

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- None (0 cigarettes)

PB16. During the *3 months before* the mother got pregnant, how many alcoholic drinks did she have in an average week? (A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.)

- 14 drinks or more a week
- 7 to 13 drinks a week
- 4 to 6 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

PB17. During the *last 3 months* of the mother's pregnancy, how many alcoholic drinks did she drink in an average week? (A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.)

- 14 drinks or more a week
- 7 to 13 drinks a week
- 4 to 6 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

PB18. During the *3 months before* the mother got pregnant, how many times did she use marijuana, cocaine, narcotics, or other drugs?

- Once a day
- Every other day
- Once a week
- Every other week
- Once a month
- More than once a month
- Less than once a month
- I didn't use drugs

PB19. During the *last 3 months* of the mother's pregnancy, how many times did she use marijuana, cocaine, narcotics, or other drugs?

- Once a day
- Every other day
- Once a week
- Every other week
- Once a month
- More than once a month
- Less than once a month
- I didn't use drugs

# Instructions for Child Health Form

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## Purpose

The purpose of this form is to gather information on changes in health insurance coverage, the child's general health, maternal breastfeeding, nutrition, physical activity, exposure to cigarette smoking; visits to emergency room/urgent care centers, and hospitalizations over time. This helps track child health and development outcomes for the babies in the program.

## General Instructions

- ❖ **Whose form:** The child's form. For multiple children, there should be one form completed for each multiple.
- ❖ **When:** The form is completed at 2 months from birth/enrollment and followed-up every 6 months according to the child's age.
- ❖ **What:** Collects data on factors related to the child's health such as health insurance coverage, health conditions, health status, injuries, illnesses, ingestions, nutrition, exercise and exposure to cigarette smoke.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Birth Form". Avoid alternate names, misspells, hyphens, parenthesis or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**PCG First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Child First Name / Last Name / DOB:** The Child's first and last names and date of birth.

**Today's Date:** The date on which the Home Safety form was completed. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

**Reporting Time:** Check the box indicating the appropriate time frame (child birth/ enrollment or every 6 months calculated from the child's birth date). Many program outcomes are measured over time, and this field helps to determine time sequence.

## Item Instructions

CH1. Indicate whether the child currently has health insurance (any type of health insurance, including private insurance, Medicaid, SoonerCare, etc.). If the child does not have any health insurance, skip to CH3.

CH2. Read each type of insurance to the PCG and check each type of insurance that s/he says the child has.

CH3. Indicate where the PCG says s/he takes the child most often for routine well-child visits.

CH4. Indicate where the PCG says s/he takes the child most often for care when the child is sick.

CH5. Read the list of health conditions to the PCG and, for each, check whether a health care provider has ever said that the child has that condition. If Yes, check "Y" and if No, check "N."

CH6. Based on the FSW's assessment. Check if the child is on schedule for recommended immunizations. If the child received a series of shots within the recommended age range, then the immunizations are current. If the child was outside the recommended age range when the shot was received, or the shot was not given in the month it was due, then the child's immunizations are not current.

CH7. Indicate how many **hours per day**, on average, the child is in the same room or car with someone who is smoking.

CH8. Record the PCG's response to the statement that best describes the rules about smoking inside her/his home.

***Ask items CH9, CH10, CH11 and CH12 only when the child is less than 2 years of age.***

CH9. Record whether the mother of the child ever breast fed or pumped milk for the baby after delivery. If not, check "Yes" and skip to CH11.

CH10. Record all the reasons that the PCG says are reasons she did not breastfeed her new baby. If she has a reason not in the list, check "Other" and describe using the PCG's words.

CH11. Record the child's age, if the PCG says that the child has been introduced to any other food than breast milk. If any other food has not been introduced yet, then skip to CH17.

CH12. Record until what age the baby was fed exclusively breast milk, in weeks or months, rounding to the nearest whole figure.

CH13. Indicate the number of cups of juice that the PCG indicates the child drinks every day.

CH14. Indicate the number of cups of milk that the PCG indicates the child drinks every day.

CH15. Indicate the amount of fruit that the PCG indicates the child eats every day. (One cup equals two servings)

CH16. Indicate the amount of vegetables that the PCG indicates the child eats every day. (One cup equals two servings)

***Ask item CH17 and CH18 only when the child is 1 year of age or older.***

CH17. Using the time frame of the past seven days, indicate whether the PCG says that the child participated in physical activity for at least 20 minutes.

CH18. Record the number of **hours per day** that the PCG says the child spends in front of the TV or computer screen on an average weekday.

CH19. Record the average number of **hours per week** that the PCG says the child stays in child/daycare. If child is not in daycare, skip to CH22.

CH20. Indicate if the PCG says the child/daycare facility is DHS licensed. If no, skip to CH22.

CH21. Indicate PCG's response to the DHS star rating of the child/daycare facility being used.

***Ask item CH22 and CH23 only when the child is 6 months of age or older.***

CH22. Using the time frame of the past six months, indicate the number of times the child was taken to the ER. Specify the number of visits for illness or infections, Injuries or ingestions, accidents, or poisonings.

CH23. Using the time frame of the past six months, indicate the number of times the child was admitted to the hospital. Specify the number of admissions for illness or infections, Injuries or ingestions; accidents or poisonings.

## CHILD HEALTH FORM

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Child First name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FSW Name: \_\_\_\_\_

Time Frame:  Birth/Enrollment  6  12  18  24  30  
 (Child's age in months)  36  42  48  54  60  66  72

CH1. Does your child currently have health insurance?  
 Yes  No **(If No, skip to CH3)**

CH2. What kind of health insurance?  
 Private insurance  Medicaid/SoonerCare  
 Indian (I.H.S.)/Tribal Health service  Military facility  
 Other, specify: \_\_\_\_\_

CH3. Where do you usually take your child for routine check-ups (well-child care)?  
 My child sees a health care provider only when s/he is sick  Community or free clinic  
 Private doctor's office  Indian/Tribal Health service (HIS)  
 Hospital Clinic  Military facility  
 Hospital emergency room  Other: \_\_\_\_\_  
 Health Department

CH4. Most of the time, where does your child go for care when he/she is sick? **(Check one.)**  
 My child has not needed sick care  Community /free clinic  
 Private doctor's office  Indian /Tribal Health Service (HIS)  
 Hospital clinic  Military facility  
 Hospital emergency room  Other: \_\_\_\_\_  
 Health department

CH5. Has a health care provider ever said that your child has any of the following conditions?  
**Check Yes (Y) or No (N) for each.**

1. Asthma <input type="checkbox"/> Y <input type="checkbox"/> N	6. Poor eye sight <input type="checkbox"/> Y <input type="checkbox"/> N
2. Croup, bronchitis, bronchiolitis <input type="checkbox"/> Y <input type="checkbox"/> N	7. Poor hearing <input type="checkbox"/> Y <input type="checkbox"/> N
3. Pneumonia <input type="checkbox"/> Y <input type="checkbox"/> N	8. Baby bottle tooth decay <input type="checkbox"/> Y <input type="checkbox"/> N
4. Developmental delay <input type="checkbox"/> Y <input type="checkbox"/> N	9. Other tooth decay / cavities <input type="checkbox"/> Y <input type="checkbox"/> N
5. Anemia (low blood iron) <input type="checkbox"/> Y <input type="checkbox"/> N	10. Lead poisoning <input type="checkbox"/> Y <input type="checkbox"/> N

CH6. Are your child's shots (immunizations) up-to-date?  Yes  No

CH7. How many hours per day, on average, is your child in the same room or car with someone who is smoking? (Please include time your child spends with baby-sitters, relatives, or anyone else who smokes)  
 None  7 – 10 hours  
 1 - 3 hours  More than 10 hours a day  
 4 – 6 hours

CH8. Which of the following statements best describes the rules about smoking *inside* your home?

- No one is allowed to smoke anywhere inside my home
- Smoking is allowed in some rooms or at some times
- Smoking is permitted anywhere inside my home

**Complete items #CH9, CH10, CH11, and CH12 for children less than 2 years:**

CH9. Did you ever breastfeed or pump breast milk to feed the baby after delivery?

- Yes (If yes, skip to CH11)
- No

CH10. What were your reasons for not breastfeeding your new baby? (Check all that apply.)

- I had too many household duties
- I didn't like breastfeeding
- I was embarrassed to breastfeed
- I went back to work or school
- I couldn't afford/ didn't have access to an effective pump
- My husband or partner didn't want me to breastfeed
- Other: \_\_\_\_\_

CH11. How old was your child when you introduced foods other than breast milk?

(Other foods include formula, cereal, baby food, juice, and cow's milk etc.)

- months old
- Less than one month old
- I have not yet introduced any other food (Skip to CH17.)

CH12. Until what age was your baby fed exclusively breast milk (no formula, cereal or other foods)?

Weeks OR  Months

CH13. How much juice does your child drink each day? (One cup equals eight ounces)

- None
- Less than one cup
- One cup
- Two cups
- Three cups
- Four or more cups

CH14. How much milk does your child drink each day? (One cup equals eight ounces)

- None
- Less than one cup
- One cup
- Two cups
- Three cups
- Four or more cups

CH15. How much fruit does your child eat each day? (One cup equals two servings)

- None
- One serving
- Two servings
- Three servings
- Four servings
- Five or more servings
- More than 5 servings

CH16. How many vegetables does your child eat each day? (One cup equals two servings)

- None
- One serving
- Two servings
- Three servings
- Four servings
- Five servings
- More than 5 servings

**Complete items CH17 and CH18 for children one year or older:**

CH17. On how many of the *past 7 days*, did your child participate in physical activity, such as swimming, riding a bicycle, playing soccer, or running for at least 20 minutes??

- None
- 1 – 2 days
- 3 – 4 days
- 5 – 6 days
- 7 days

CH18. On an *average weekday*, how many hours does your child spend watching TV, playing computer games, surfing the internet, or playing video games?

- None
- One hour or less per day
- 2 - 3 hours per day
- 4 – 5 hours per day
- 6 hours or more per day

CH19. What is the average number of hours per week that your child stays in child/daycare?

- My child is not in child/day care → Skip to CH22
- 1-9 hours/week
- 10-19 hours/week
- 20-29 hours/week
- 30-39 hours/week
- 40 hours or more per week

CH20. Is the child/ day care facility licensed?

(Child/ day care facility includes day care center and day care home)

- Yes
- No (If no, skip to CH22)

CH21. What is the DHS star rating of the child/day care facility being used?

- 3 star
- 2 Star
- 1star plus
- 1 star

**Complete Items CH22 and CH 23 for children 6 months and older:**

CH22. In the past 6 months, how many times have you taken your child to the hospital emergency room/urgent care center?

How many of those visits were for: illnesses or infections \_\_\_\_\_

Injuries or ingestions \_\_\_\_\_

Accidents or poisonings \_\_\_\_\_

CH23. During the past 6 months, how many times has he/she been admitted to the hospital (that is, had to spend at least one night there)?

How many of those admissions were for: illnesses or infections \_\_\_\_\_

Injuries or ingestions \_\_\_\_\_

Accidents or poisonings \_\_\_\_\_

# Instructions for OCAP Immunization Log

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## Purpose

The Immunization Log collects information on immunizations the child has received for the purpose of reporting the immunization status of children participating in OCAP programs.

## General Instructions

- ❖ **Whose form:** The child's form. For multiple births, this form should be completed for each child.
- ❖ **When:** Administer this form following the immunization schedule. It should be completed at least at the first visit postpartum and when the child is 2 months, 4 months, 6 months, 15 months, and 18 months old.
- ❖ **What:** The form gathers information on the immunizations that the child receives.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Birth Form". Avoid alternate names, miss-spells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**PCG First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Child First Name / Last Name / DOB:** The Child's first and last names and date of birth.

**Today's Date:** The date on which the Home Safety form was completed. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

## IM1: Immunizations

Indicate where the source of information was obtained 1-written shot record, 2-mothers report, 3-OSIS reports, 4-other. Written documentation is the preferable choice.

**Vaccine, Dose, Date Given:** If there is written documentation, copy the information completely onto the form. If there is another source available to complete the information other than the mother's self report, please use that source. Date given is extremely important in later data analysis to verify that the child was on schedule per shot, per series, or per recommended immunizations.

For each immunization dose, please check “Yes” if the child has received it and “No” if the child has not. Thus, every time this form is submitted for data entry, there should be a “Yes” or “No” checked for each vaccine dose on the page. For responses with a “Yes,” record the date that the child received that dose of the vaccine.

Recommended Immunization Schedule	Dose	Child’s Age
DtaP (Diphtheria, Tetnus, Pertussis)	1	2 months
	2	4 months
	3	6 months
	4	15-18 months
	5	4-6 years
Hepatitis B	1	Birth
	2	2 months
	3	6-18 months
Hib (H. Influenza type b)	1	2 months
	2	4 months
	3	6 months
	4	12-15 months
Polio (Inactivated)	1	2 months
	2	4 months
	3	6-18 months
	4	4-6 years
MMR (Measles, Mumps, Rubella)	1	12-15 months
	2	4-6 years
Varicella (Chicken Pox)	1	12-18 months
Hep A (Hepatitis A)	1	12-23 months
	2	6 months after 1st

## IMMUNIZATION LOG

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Child First name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FSW Name: \_\_\_\_\_

Instructions to FSW: Please indicate whether the child has or has not received each vaccine dose by checking "Yes" or "No" for each vaccine dose. If the child received a dose since the last time this form was completed, indicate the date given.

**IM1. What was your source of information about the child's immunization status today?**

- Written Record                       OSIIS  
 Mother's self-report                 Other: \_\_\_\_\_

Vaccine	Dose	Date
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IM2. Diphtheria, Tetanus, Pertussis (DtaP)	Yes	No	Date Given (mm/dd/yyyy)
Has the child received <u>Dose 1?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 2?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 3?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 4?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 5?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

*Recommended schedule: 1<sup>st</sup> dose @ 2 mos.; 2<sup>nd</sup> dose @ 4 mos.; 3<sup>rd</sup> dose @ 6 mos.; 4<sup>th</sup> dose @ 15-18 mos.; 5<sup>th</sup> dose @ 4-6 years*

IM3. Hepatitis (HepB)	Yes	No	Date Given (mm/dd/yyyy)
Has the child received <u>Dose 1?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 2?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 3?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

*Recommended schedule: 1<sup>st</sup> dose @ birth.; 2<sup>nd</sup> dose @ 2 months; 3<sup>rd</sup> dose @ 6-18 months.*

IM4. H. Influenza type b (Hib)	Yes	No	Date Given (mm/dd/yyyy)
Has the child received <u>Dose 1?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 2?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 3?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 4?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
<b>Has the child received <u>PedvaxHIB or ComVax*?</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

*Recommended schedule: 1<sup>st</sup> dose @ 2 mos.; 2<sup>nd</sup> dose @ 4 mos.; 3<sup>rd</sup> dose @ 6 mos.\*; 4<sup>th</sup> dose @ 12-15 mos. (\* If PedvaxHIB or ComVax (Merck) is administered at 2, 4, & 12 mos.; a dose @ 6 mos. is not required*

IM5. Inactivated Polio (IPV)	Yes	No	Date Given (mm/dd/yyyy)
Has the child received <u>Dose 1?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 2?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 3?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 4?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

*Recommended schedule: 1<sup>st</sup> dose @ 2 months; 2<sup>n</sup> dose @ 4 months; 3<sup>rd</sup> dose @ 6-18 months.; 4<sup>th</sup> dose @4-6 years.*

IM6. Measles, Mumps Rubella (MMR)	Yes	No	Date Given (mm/dd/yyyy)
Has the child received <u>Dose 1?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 2?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

*Recommended schedule: 1<sup>st</sup> dose @ 12-15 mos.; 2<sup>nd</sup> dose @ 4-6 years.*

IM7. Varicella (Var)	Yes	No	Date Given (mm/dd/yyyy)
Has the child received <u>Dose 1?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

*Recommended schedule: 1<sup>st</sup> dose @ 12-18 mos.*

IM8. Hepatitis A (HepA)	Yes	No	Date Given (mm/dd/yyyy)
Has the child received <u>Dose 1?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Has the child received <u>Dose 2?</u>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

*Recommended schedule: 1<sup>st</sup> dose @ 12-23 months; 2<sup>nd</sup> dose 6 months after 1<sup>st</sup> dose.*

# Instructions for Home Safety Form

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## Purpose

The purpose of the Home Safety Form is to determine whether the program has made an impact on the home environment. It provides the opportunity to gather data on how well parents have followed through on the safety teaching provided during prior home visits. It also allows the home visitor to identify some areas where more education may be needed.

## General Instructions

- ❖ **Whose form:** The PCG's form. If the child's mother is no longer the caregiver, administer the form with the new caregiver.
- ❖ **When:** This form is administered initially within 2 months of the child's birth (or the family's enrollment) and followed up every six months according to the child's age.
- ❖ **What:** This form collects information on the safety of the home environment where the child lives.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Special Instructions for Multiple Births

There are some questions on this form that are child-specific. To keep from administering and entering this form more than once for a PCG:

- Pick the first-born of a multiple birth to complete the form and enter only that one form.
- The Home Safety form does not have to be completed for multiple births other than the first-borne of the multiple births.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Birth Form". Avoid alternate names, miss-spells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**PCG First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Child First Name / Last Name / DOB:** The Child's first and last names and date of birth.

**Today's Date:** The date on which the Home Safety form was completed. Use mm/dd/yyyy format.

**FSW Name:** The first and last name of the FSW assigned to this family.

**Reporting Time:** Check the box indicating the appropriate time frame (Child birth/ enrollment or every 6 months calculated from the child's birth date). Many program outcomes are measured over time, and this field helps to determine time sequence.

### **Item Instructions**

Note: Read the bold instructional message at the beginning of the form prior to administering it with the client. The option "N/A" means that there is not an applicable response, either because that situation does not apply to the program participator or that the item in question was not able to be inspected or observed by the home visitor. If there is NOT an "N/A" response to the question, it is relying on the client's self-reported response only.

#### *Sleep Safety*

**Ask these questions only when the child is less than 1 year of age.**

HS1. Record how often the PCG says that the baby is placed on his/her back when put to sleep.

HS2. Record how often the PCG says that the baby shares a sleeping surface with other people (either adults or children). A sleeping surface could be a crib, bed, couch, an inflatable mattress, the floor, or any other place where the baby is put to sleep.

HS3. Indicate if the baby's sleeping surface is free of items that could cover his/her face and block his/her mouth. If the FSW cannot observe the baby's sleeping surface with the mother while administering the form, check "N/A."

HS4. Indicate if the bars on the baby's crib are 2 and 3/8 inches apart or closer. If the baby doesn't have a crib, or if the FSW cannot observe the baby's sleeping surface with the PCG while administering the form, check "N/A."

HS5. Indicate if the mattress on the baby's crib fits snugly. If the baby doesn't have a crib, or if the FSW cannot observe the baby's sleeping surface with the PCG while administering the form, check "N/A."

#### *Heat Safety*

HS6. Indicate how often the client says that hot liquids and foods are kept out of the baby's reach.

HS7. Indicate how often the PCG says that she or someone else holds the baby while cooking, carrying or eating hot liquids or food.

HS8. Indicate if the hot water temperature is set within the recommended range (120 degrees F). If the FSW is not able to observe the hot water temperature setting, check "N/A."

#### *Supervision*

HS9. Using the time frame of the past month, indicate whether the PCG says that any of these events (1-5) have occurred involving the child.

HS10. Indicate whether there is a pool, hot tub, pond, or other body of water (such as a decorative pond) where the child lives.

- If "Yes," indicate whether it is protected by a self-closing, self-locking gate on all sides. If the FSW is not able to observe the body of water, check "N/A."
- If "No," go to the next question.

#### *Fire Safety*

HS11. Indicate whether all space heaters are in safe condition and are not accessible to the infant. If the FSW is not able to observe the location and accessibility of space heaters, or if the FSW does not use space heaters, check "N/A."

HS12. Indicate whether there is a fireplace, wall furnace, or floor furnace where the child lives.

- If “Yes,” indicate whether (a) each has a protective covering so that the child cannot get near it and (b) whether each is at a safe distance from flammable items (such as cloth, paper, etc.). If the FSW is not able to inspect the heat source(s), mark “N/A.”
- If “No,” go to the next question.

HS13. Indicate whether there is a fire extinguisher in the home that has not passed its expiration date. If the FSW is not able to observe the fire extinguisher and check its expiration date, check “N/A.”

HS14. Write down the number of unobstructed exits the PCGs’ house or apartment has.

HS15. Verify whether the PCG has made a fire escape plan for her/his home (or wherever s/he lives). If s/he lives in a residential facility, verify that s/he knows of and understands the facility’s fire escape plan. “N/A” would be checked if the PCG is homeless.

HS16. Write down how many smoke detectors are in the home where the PCG and baby live.

HS17. Write down how many of the smoke detectors work. Rely on the PCGs’ response for this answer, and ensure that s/he knows how to check whether the smoke alarms are in working condition.

HS18. Write down what the PCG says about when the batteries were last changed in each identified smoke detector.

### *Car Safety*

HS19. Indicate how often the PCG says that the infant/toddler is buckled in a car safety seat when riding in a car.

HS20. Indicate whether the infant’s car seat is properly installed in the car. If the FSW is not able to observe the car seat, or if the PCG does not have a car or car seat, choose “N/A.”

HS21. Indicate whether the infant/toddler’s car seat is appropriate for his/her age, weight and height. If the FSW is not able to observe the car seat, or if the PCG does not have a car or car seat, choose “N/A.”

HS22. Using the time frame of the past month, indicate whether the PCG says that the event occurred involving the child.

HS23. Indicate whether the PCG says that s/he and visitors to the home make sure that the child is in a safe place before moving their car.

### *Fall Safety*

HS24. Indicate whether there is a gate at the top of the stairs in the PCG’s home where the child lives. If there are not stairs, or if the PCG is homeless, mark “N/A.”

HS25. Indicate whether there is a gate at the bottom of the stairs in the PCG’s home where the child lives. If there are not stairs, or if the PCG is homeless, mark “N/A.”

HS26. Indicate how many gates in the home are of the accordion type.

- If there are no gates in the home, or if the PCG is homeless, skip this question.

HS27. Indicate if there are any open or unguarded windows in rooms above the 1<sup>st</sup> floor of the PCG’s home/apartment that are within the child’s reach? Unguarded means that a child would be able to open them. If the house/apartment is not on or does not have a 2<sup>nd</sup> story, or if the PCG is homeless, or if the FSW is not able to observe the windows, mark “N/A.”

HS28. Using the time frame of the past month, indicate if the participant says the events (a-b) have happened.

### *Home Safety*

HS29. Indicate how often the PCG says that small objects (such as small toys, nails, quarters, and small food items like grapes) are kept out of baby's reach.

HS30. Indicate whether household items with cords (ex: blinds, drapes, the cord of a wall telephone, ceiling fans, etc.) are out of the infant's reach – especially close to places where the infant is often kept for longer periods of time, such as a play area or crib. If the FSW is not able to observe the house or if there are no items in the house with cords, check "N/A."

HS31. Indicate whether all unused electrical outlets within the child's reach have plastic covers over them. If the FSW is not able to observe electrical outlets to confirm that they are covered with plastic covers, mark "N/A."

HS32. Indicate whether matches or lighters have been left on tables within the child's reach. If the FSW is unable to observe, mark "N/A."

HS33. Indicate whether cleaning supplies are stored in locked cabinets out of the child's reach. If the FSW is unable to observe, mark "N/A."

### *Poison Safety*

HS34. Indicate whether medicines and vitamins are stored in locked cabinets out of the child's reach. If the FSW is unable to observe, mark "N/A."

HS35. Indicate whether the Poison Control Center phone number is posted on or near each phone in the house/apartment where the PCG lives. If the PCG does not have a telephone, or if FSW is unable to observe, mark "N/A."

### *Gun Safety*

**Note: There is not a N/A option on the gun safety questions because these questions rely on PCG self-report and do not expect the FSW to inspect the conditions in which the PCG or the PCG's family store guns and ammunition.**

HS36. Indicate whether the PCG says there are guns and/or rifles in the home where the child lives.

HS37. Indicate whether the PCG says that the guns are stored unloaded or not.

HS38. Indicate whether the PCG says that the ammunition is stored separate from the guns and stored in locked cabinets.

HS39. Indicate whether the PCG says that the ammunition is stored in locked cabinets, out of the child's reach.

### *Wheeled Activities Safety – Only complete this for children 2 years old and older.*

**Note: There is not a N/A option on the wheeled activities questions because these questions rely on PCG self-report.**

HS40. Using the time frame of the past six months, record whether the PCG says that the child has participated in the wheeled activities indicated.

HS41. Record the number of times the PCG says that the child uses a helmet while participating in the wheeled activities indicated.

HS42. Using the time frame of the past six months, record whether the PCG says that the child has used an All Terrain Vehicle.

HS43. Record the number of times the PCG says that the child uses a helmet while using an All Terrain Vehicle.

## HOME SAFETY FORM

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Child First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FSW Name: \_\_\_\_\_

Time Frame:  Birth/Enrollment  6  12  18  24  30  
(Child's age in months)  36  42  48  54  60  66  72

Instructions to FSW: Please complete this Home Safety form with the PCG, using direct observations when completing items as much as possible. "N/A" means Not Applicable or not inspected by the FSW.

### SLEEP SAFETY (For children less than 1 year of age)

HS1. How often is baby placed on his/her back to go to sleep?

- All of the time
- Most of the time
- Some of the time
- None of the time

HS2. How often does baby share a sleeping surface with other people, adults or children?

- All of the time
- Most of the time
- Some of the time
- None of the time

HS3. Is baby's sleeping surface firm, free of blankets/pillows/stuffed animals or other items that could cover his/her face and block his/her nose & mouth?  Yes  No  N/A

HS4. Are the bars on baby's crib 2-3/8" apart (or less)?  Yes  No  N/A

HS5. Does the crib mattress fit snugly? (SAFE = no more than 2 fingers distance between mattress and crib railing)?  Yes  No  N/A

### HEAT SAFETY

HS6. How often are hot liquids and foods kept out of baby's reach?

- All of the time
- Most of the time
- Some of the time
- None of the time

HS7. How often do you or somebody else hold baby while cooking, carrying or eating hot liquids or food?

- All of the time
- Most of the time
- Some of the time
- None of the time

HS8. Is the hot water temperature set within recommended range (120° F)?  Yes  No  N/A

### SUPERVISION

HS9. At any time during the past month, has [child's name] been...

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Left alone, unsupervised in a tub of water                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Left in a bathtub to be watched by a sibling or other child?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Unsupervised near water (lake, pond, pool, etc.) for any amount of time?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Unsupervised near a bucket of water, open toilet, or other container of water? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Around or near water (lake, pond, pool, etc.) without a life jacket on?        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

HS10. Is there a pool, hot tub, pond or other body of water where the child lives?  
 IF YES: a. Is it protected by a self-closing, self-locking gate on all sides?  Yes  No  N/A  
 Yes  No  N/A

**FIRE SAFETY**

HS11. Are all space heaters in safe condition and inaccessible to infant/toddler?  
 (SAFE = stable, with protective covering, and at least 36 inches from  
 containers, papers and furniture. Check cord and plug for fraying or  
 exposed wires).  Yes  No  N/A

HS12. Is there a fireplace, wall furnace or floor furnace where the child lives?  
 IF YES:  Yes  No  N/A  
 a. Does each heat source have a protective covering so the child cannot  
 get near it?  Yes  No  N/A  
 b. Is each heat source at a safe distance from cloth, paper, furniture or other  
 flammable things?  Yes  No  N/A

HS13. Is there a fire extinguisher in the home that has not expired?  Yes  No  N/A

HS14. How many unobstructed exits does your house or apartment have, in case of fire or other emergency?

HS15. Have you made a fire escape plan for your home?  
 (Ask mother/responder to describe to verify plan exists.)  Yes  No  N/A

HS16. How many smoke detectors are in the home?

HS17. How many of the smoke detectors work?

HS18. When were the batteries last changed?  Months ago  
 Months ago  
 Months ago

**CAR SAFETY**

HS19. How often, when riding in a car, is [child's name] buckled in a car safety seat?  
 All of the time  
 Most of the time  
 Some of the time  
 None of the time

HS20. Is the infant/booster car seat properly installed?  Yes  No  N/A

HS21. Is the infant/booster car seat appropriate for the child's age, weight & height?  Yes  No  N/A

HS22. At any time during the past month, has [child's name] been left in a car alone?  Yes  No

HS23. Do you and visitors to your home make sure the child is in a safe place before  
 moving their car?  Yes  No

**FALL SAFETY**

HS24. Is there a gate at the top of the stairs inside the home?  Yes  No  N/A

HS25. Is there a gate at the bottom of the stairs?  Yes  No  N/A

HS26. How many of the gates in home are of the accordion type?

HS27. Are there any open or unguarded windows in rooms above the first floor that are  
 within the child's reach?  Yes  No  N/A

HS28. At any time during the past month, has [child's name] been...  
 a. Left alone on a changing table, couch, bed, chair or other high surface?  Yes  No  N/A  
 b. Put in a baby walker?  Yes  No  N/A

### HOME SAFETY

HS29. How often are small objects kept out of baby's reach, including small food objects like grapes?

- All of the time
- Most of the time
- Some of the time
- None of the time

HS30. Are all household items with cords (such as drapes, blinds, wall phones, etc.) out of baby's reach?  Yes  No  N/A

HS31. Are there plastic outlet covers in all unused electrical outlets within child's reach?  Yes  No  N/A

HS32. Are there any matches or lighters left on tables within child's reach?  Yes  No  N/A

HS33. Are cleaning supplies stored in locked cabinets or out of child's reach?  Yes  No  N/A

### POISON SAFETY

HS34. Are medicines & vitamins stored in locked cabinets or out of child's reach?  Yes  No  N/A

HS35. Is the Poison Control Center number posted on or near each phone in house/apartment?  Yes  No  N/A

### GUN SAFETY

*The following questions about guns in the home are PCG's self-report only, unless the FSW's observations differ.*

HS36. Are there guns and/or rifles in the home? → IF NO, SKIP TO HS40  Yes  No

HS37. Are guns and/or rifles stored unloaded?  Yes  No

HS38. Is ammunition stored separate from guns and in locked cabinets?  Yes  No

HS39. Are guns stored in locked cabinets or out of child's reach?  Yes  No

### WHEELED ACTIVITIES SAFETY

**Complete items HS40-43 for children 2 years and older**

*The following questions about wheeled activities are PCG's self-report only, unless the FSW's observations differ.*

HS40. During the past 6 months, has your child ridden a bike, scooter, skateboard, roller skates or roller blades?  Yes  No (If No, Skip to HS42)

HS41. How often does he/she wear a helmet when riding a bike, scooter, skateboard, roller skates or roller blades?  Never  Sometimes  Usually  Always

HS42. During the past 6 months, has your child ridden an All Terrain Vehicle (ATV)?  Yes  No (If No, STOP HERE)

HS43. How often does he/she wear a helmet when ridden an All Terrain Vehicle (ATV)?  Never  Sometimes  Usually  Always

Source: Cox, MB: OSDH Children First Program. Home Safety Checklist: 11/06/06.

# Instructions for Child Development Screening Log

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## Purpose

The purpose of the Child Development Screening Log is to monitor when the ASQ and ASQ-SE tests are administered to participants and record children's scores on the tests. This allows the program to see if the test is being administered in a timely manner, if participating children have delays, and if referrals are made for assessments when appropriate.

## General Instructions

- ❖ **Whose** form: This is a child form. For multiple births, do one for each child.
- ❖ **When:** Complete this form each time an ASQ or ASQ-SE test is administered to the family.
- ❖ **What:** The form allows the program to monitor use of the ASQ and ASQ-SE tools and to tell whether children who have possible delays receive appropriate referrals.
- ❖ **File:** This form is filed in the family folder at the OCAP program site that is providing services.

## Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Birth Form". Avoid alternate names, miss-spells, hyphens, parenthesis, or typos etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**PCG First Name / Last Name / DOB:** The PCG's first and last names and date of birth.

**Child First Name / Last Name / DOB:** The Child's first and last names and date of birth.

## Item Instructions

- Maintain all instances when you utilize the ASQ/ASQ-SE screening tool with a family on a single log form so it is easy to keep track of which months have been done and to see the patterns that may develop.
- Each time the FSW administers the ASQ or ASQ-SE screening tool to a family, find the appropriate line for that tool (4 months, 6 months, etc.). On that line, record the date that the tool was administered.

- Moving from left to right on that same line, check whether that ASQ or ASQ: SE was performed on time.
- Next, check whether the child has a possible delay or not based on the results of that screening.
- Then check whether you (the FSW) made a referral for assessment based on the screening results.
- Finally, if you did refer the family for assessment, write in the last column where you referred the family.

## CHILD DEVELOPMENT SCREENING LOG

PCG First Name: _____	Last Name: _____	DOB (mm/dd/yyyy): __/__/____
Child First Name: _____	Last Name: _____	DOB (mm/dd/yyyy): __/__/____

### ASQ / ASQ-SE Developmental Screening

Screening Schedule (Month)	Date Given	Screened On Schedule	Possible Delay	Referral Made For Assessment	Referred To
ASQ 4	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 6	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 6	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 8	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 10	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 12	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 12	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 14	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 16	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 18	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 18	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 20	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 22	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 24	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 24	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 27	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 30	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 30	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 33	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 36	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 36	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 42	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 48	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 48	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 54	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ 60	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ASQ-SE 60	___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Instructions for the Administration of the Healthy Families Parenting Inventory (HFPI)

### Overview

The Healthy Families Parenting Inventory is an inventory developed by Dr. Craig LeCroy and colleagues at LeCroy & Milligan Associates, Inc. The 63 item inventory includes 9 subscales designed to assess parent change related to the overarching goals of Healthy Families—the development of healthy parenting skills and behaviors that will in turn reduce child abuse and neglect.

- The 9 subscales included in the HFPI include:
  - Social Support
  - Problem-Solving/Coping
  - Depression
  - Personal Care
  - Mobilizing Resources
  - Role Satisfaction
  - Parent/Child Interaction
  - Home Environment
  - Parenting Efficacy

The HFPI should be considered a direct measure of the intervention provided by the Healthy Families program. In other words, the Healthy Families program should impact what is being measured—such things as the parent's sense of competence, efficacy, depression, perceptions of social support, and problem-solving and coping skills.

### Identified Population

The HFPI is designed for the primary caregiver with children birth through age 10 and for expectant parents. It can be administered and shared with families by trained professionals.

### Materials Needed

The only materials needed are a copy of the HFPI and a pencil to mark the answers on the form. There is a separate scoring form.

### Time Requirement

There is no time limit for answering the questions. The HFPI should take 15-20 minutes to answer for someone with at least a fifth grade education.

### Administration Schedule

For the Office of Child Abuse Prevention Program, the HFPI is administered according to the family's status at the time of enrollment i.e ***prenatal family*** or ***enrolling with child***.

**For prenatal families:** Administer the 1st HFPI by *second home visit* (Time Frame: prenatal/enrollment); follow up (2nd HFPI) at child's birth (Time Frame: Birth); then follow up every 6 months according to child's age (Time Frame: 6,12,18 etc.)

**Complete HFPI up to question 31 for prenatal families**

**For families enrolling with child:** Administer the 1st HFPI at enrollment (Time Frame: Enrollment); then follow up every 6 months according to child's age (Time Frame: 6,12,18 etc.)

The completed instrument should be scored, data entered into the OCAPPA database, and filed in the family file folder.

## Administration Procedures— background for the professional

1. Take care to establish rapport with the individual completing the inventory. Establish a quiet, uninterrupted atmosphere if possible. Explain the purpose of the HFPI to the individual. The purpose of the HFPI is to examine feelings, attitudes, and behaviors related to parenting, and learn about the areas of strengths and concerns for the parent.
2. The HFPI is an objective inventory designed to assess attitudes and behaviors. There are no right or wrong answers, just differences in attitudes and perceptions about one's behavior. It is important NOT to refer to the inventory as a test.
3. If a parent does not know the meaning of a word or phrase, you may assist in explaining any unknown words. Care should be taken to insure that you do not provide information or engage in discussion that would modify the individual's values or attitudes.
4. It is essential that each of the items in the inventory have only ONE response. Instruct the individual to mark only one answer per item.
5. Determine the literacy of the parent. If the parent has difficulty reading then offer to read the items to the parent.
6. When the individual has completed the questions, scan the HFPI quickly to be sure that all questions have been answered and that only one answer is given for each question. If a question is missed, encourage the individual to go back and complete that item.
7. Collect the completed inventory and thank the individual.

## Verbal Instructions

The following script can be used directly when administering the HFPI to the parent.

“Parenting is a time of many changes. You may be experiencing feelings and thoughts that are different than you had before you had your baby. We are interested in the kind of changes you may notice in yourself. This information will help us design and plan better services for parents involved in the OCAP Program. The information is very important to us so I hope you will take your time and answer each question. Afterwards, we can discuss your experience—I think you will find this very interesting.”

“This survey has 63 statements. We hope you will take your time and answer each item carefully.”

“This survey is confidential—in other words, this information will not be shared with anyone outside this program without your permission.”

“When you answer this survey you decide *how often you experience feelings or situations* like those described in each statement. Then you color in the circle for one of the numbers on the side of each statement.”

If you feel the statement is true always or most of the time, you color circle “5”.

If you feel the statement is true a good part of the time, you color circle “4”.

If you feel the statement is just some of the time, you color circle “3” if you feel the statement is true only a little of the time, you color circle “2” if you feel the statement is rarely or never true for you, you color circle “1”.

“Let’s do a sample question and you’ll see that this is not too difficult. Decide how you feel about this statement:

‘I know where to find resources for my family.’”

“As you can see, there really is no right or wrong answer, only your experience or opinion. Some parents feel they know right where to go for a resource for their family; others may not know where to find resources or don’t feel there are any good resources for their family, for example. Sometimes the question will be hard to answer—go with whatever feels right first.”

“So, how would you answer the above statement? Is it true for you: *Always/Most of the time, Good part of the time, Some of the time, A little of the time, or Never/Rarely true?*” (After they answer, say, “Ok, good, you went with your first impression.”)

- “As you answer the questions, keep in mind 4 things:
  1. Please be honest and truthful. We are really trying to learn about parenting and your experiences, and it is important that you say what you feel, not what you may think is the right thing to say.
  2. Answer each question as quickly as you can. Don’t spend too much time thinking about what to answer. Use whatever comes to your mind.
  3. Don’t skip any questions, and fill in only ONE circle answer for each question. It may be difficult to say how you feel but go with your first hunch.
  4. Some questions may sound alike, but no two questions are exactly the same.”
- “If you don’t understand something, please ask me. If you aren’t sure of what a word means, ask, and I’ll tell you. Also, if you’d like, I can read you the statements while you answer.”
- “If there are no other questions, let’s get started.”

## Healthy Families Parenting Inventory Instructions for Scoring

### Scoring

1. The items on the HFPI Inventory are scored by assigning a number to each of the checked responses and adding them. Scoring sheets have been developed to simplify the scoring process.
2. Use the HFPI Scoring Sheet to score the HFPI.
3. The items on the HFPI are arranged into 9 successive blocks of questions. The HFPI Score Sheet that accompanies the HFPI materials can be used to examine areas of concern, “red flags,” and strengths for the parent.
4. The subscale scores are obtained by adding the value of all items in the scale. Low total scores may indicate areas of concern.

Questions	Subscale	Low Scores indicating area of concern
1-5	Social Support	14
6-11	Problem-solving/Coping	17
12-20	Depression	23
21-25	Personal Care	14
26-31	Mobilizing Resources	17
32-37	Role Satisfaction	17
38-47	Parent/Child Interaction	29
48-57	Home Environment	29
58-63	Parenting Efficacy	17

5. “Red Flag” questions are the shaded questions on the score sheet. A score of “4” or “5” on any of these 7 items is a “red flag” which means it is an area of concern that should be discussed with the supervisor immediately to determine next steps with the family.
6. Areas of strength can be noted by examining the individual items. In general, high total scores on the subscales would indicate strengths.
7. The HFPI is scored at the office and feedback is given to the parent on the following home visit.

## Sharing and Using Healthy Families Parenting Inventory Results

The process of interpreting the HFPI and giving feedback to parents is a process that combines an examination of the actual scores, your own clinical judgments, and discussion with your supervisor. The interpretations should be viewed as working hunches, the validity of which needs to be established through discussion with the parent. It is important to consider all the strengths and difficulties expressed by the parents.

Perhaps the greatest use of the HFPI is in providing you with information about what additional or focused support a family may need. You should approach your interpretation of the HFPI with the parents from this viewpoint. This is an inventory to learn more about the parents and how they are responding to the unique aspects of parenthood. It doesn't represent the "truth," only one snapshot of their perspectives. You must combine the information from the HFPI with your home visit observations and discussions with the family.

Some general guidelines for discussing the results:

1. The results of the HFPI should be shared only with the parent who filled it out or with appropriate written consent from the parent. If the home visitor wants to address items with the parent, the parent's confidentiality must be protected (i.e., even with parental consent, do not share results in front of other family members or friends).
2. Once you have scored the HFPI, review the results with the parent. Reiterate that there are no "right or wrong" scores on the questionnaire. Ask the parent if she feels the score reflects how they are feeling. For example, ask, "Your score in social support seems to show that you are feeling a lot of stress or feeling alone as a new parent. Do you feel this is true for you?"
3. If the parent agrees, the home visitor can then ask the parent if she would like to increase her support and help her to think about what options she has available. Together the visitor and the parent can problem-solve possible ideas. The FSW can use a "focused intervention" for the next few months, and the parent might even want to use this as a goal for the FSP.
4. If the parent says she does NOT feel the score is true for her and feels she has a lot of support, the FSW and parent can move on to the next subscale. The FSW can then focus intervention on observing, supporting, and reinforcing the parent's positive social activities (focused intervention).
5. If the FSW says that the results of the HFPI do not correlate with home visit observations, the FSW can address it with the parent (depending on the relationship). For example, the FSW can say, "look how you scored in 'role satisfaction.' You scored high in this area, yet you and I have been talking about how trapped you feel sometimes as a parent. That feeling often happens for many new parents. What do you think this means?"

6. As you discuss these issues, new insights could be gained, e.g.;
- The parent could learn that she has more support or confidence than perceived and reframe her thinking.
  - The parent could tell you that she filled out the HFPI by trying to figure what the “right” answer is rather than using her true feelings as a guide.
  - The parent could tell you that the HFPI is not a good way to understand her situations or feelings and still request support from the FSS to deal with parenting concerns.
  - Be sure and document comments and explanations such as the above.

## Using the HFPI to Inform Practice

In using the HFPI to inform and guide practice, FSW's and supervisors should consider four ways of using the data:

1. to assess severity of concerns or problems,
2. to identify critical needs,
3. to identify targets for treatment, and
4. to identify strengths.

### ► Assessing Severity—RED FLAG ITEMS

The following items can be used to assess severity:

12. I feel sad.
15. I feel unhappy about everything.
16. I feel hopeless about the future.
18. I have so many problems I feel overwhelmed by them.
33. I feel trapped by all the things I have to do for my child.
34. I feel drained dealing with my child.
37. I feel frustrated because my whole life seems to revolve around my child.

A score of 4 (good part of the time) or 5 (always or most of the time) on any of these seven items is a “red flag.” Any parent with a red flag needs to be immediately discussed with the supervisor. The FSW and supervisor should determine (based on the scores) if the parent is experiencing mild distress or serious distress. Parents with mild distress may be monitored more closely, referred to a clinical specialist, or referred for brief treatment. Parents with serious distress may need specialized treatment, hospitalization, pharmacological therapy, or other treatment options.

### ► Identify Critical Needs

Workers and supervisors can identify critical needs by examining items that, if endorsed by the parent, would draw clinical attention. To identify critical needs, review all items and look for extreme scoring. This may be 1 or 2 for some items, or 3 or 4 for other items. Look at each item logically to determine this. For example, “I have family or friends who I can turn to for help” (1) rarely or never, or (2) a little of the time - suggests this may be a critical need. At the other end of the scoring, an item such as, “I feel trapped by all the things I have to do for my child”– (4) good part of the time, or (5) always or most of the time– suggests this may be a critical need.

Examples of items that identify critical needs:

- If I have trouble, I feel there is someone I can turn to for help.
- I think about my problems too much.
- I feel trapped by all the things I have to do for my child.
- I can be patient with my child.
- I read to my child a lot.
- I have set goals about how I want to raise my child.

## ► Identifying Targets for Treatment

The HFPI was designed to measure clearly changeable factors like social support, coping ability, and depression. Low scores on any of the subscales suggest home visitors need to address this area. A low score on any subscale suggests that area should be a target for additional treatment.

<u>Subscales:</u>	<u>Low Scores</u>
Social Support	14
Problem-solving/Coping	17
Depression	23
Personal Care	14
Mobilizing Resources	17
Role Satisfaction	17
Parent/Child Interaction	29
Home Environment	29
Parenting Efficacy	17

## ► Identifying Strengths

As we know, clinicians and helping professionals are often trained to look at problems. Unlike a lot of other instruments, the Healthy Families Parenting Inventory allows opportunity to assess strengths. The strengths can be used to help formulate a family service plan and to facilitate parent improvement. It can be an opportunity to reinforce the parent and develop rapport. Review the items to note where the parent is displaying particular strengths.

Examples of items that suggest areas of strength:

	<u>Scores</u>
▪ I feel others care about me.	4 or 5
▪ If I have trouble, I feel there is always someone I can turn to for help.	4 or 5
▪ When I have a problem, I take steps to solve it.	4 or 5
▪ I remain calm when new problems come up.	4 or 5
▪ I feel positive about myself.	4 or 5
▪ I have organized my home for raising my child.	4 or 5
▪ I plan to do a variety of activities with my child everyday.	4 or 5
▪ I can remain calm when my child is upset.	4 or 5
▪ I am proud of myself as a parent.	4 or 5
▪ I learn new parenting skills and use them with my child.	4 or 5

## HEALTHY FAMILIES PARENTING INVENTORY©

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FSW Name: \_\_\_\_\_

Directions: Please choose ONE answer that best fits for you and color in the circle. ●

	Rarely or never ①	A little of the time ②	Some of the time ③	Good part of the time ④	Always or most of the time ⑤
1. I feel supported by others.	①	②	③	④	⑤
2. I feel that others care about me.	①	②	③	④	⑤
3. I discuss my feelings with someone.	①	②	③	④	⑤
4. If I have trouble, I feel there is always someone I can turn to for help.	①	②	③	④	⑤
5. I have family or friends who I can turn to for help.	①	②	③	④	⑤
6. I learn new ways of doing things from solving problems.	①	②	③	④	⑤
7. I deal with setbacks without getting discouraged.	①	②	③	④	⑤
8. When I have a problem, I take steps to solve it.	①	②	③	④	⑤
9. When I am faced with a problem, I can think of several solutions.	①	②	③	④	⑤
10. I am good at dealing with unexpected problems.	①	②	③	④	⑤
11. I remain calm when new problems come up.	①	②	③	④	⑤
12. I feel sad.	①	②	③	④	⑤
13. I feel positive about myself.	①	②	③	④	⑤
14. The future looks positive for me.	①	②	③	④	⑤
15. I feel unhappy about everything.	①	②	③	④	⑤
16. I feel hopeless about the future.	①	②	③	④	⑤
17. There isn't much happiness in my life.	①	②	③	④	⑤
18. I have so many problems I feel overwhelmed by them.	①	②	③	④	⑤
19. It is hard for me to get in a good mood.	①	②	③	④	⑤
20. My life is fulfilling and meaningful.	①	②	③	④	⑤

Directions: Please choose ONE answer that best fits for you and color in the circle. ●

	Rarely or never ①	A little of the time ②	Some of the time ③	Good part of the time ④	Always or most of the time ⑤
21. I find ways to care for myself.	①	②	③	④	⑤
22. I take care of my appearance.	①	②	③	④	⑤
23. I get enough sleep.	①	②	③	④	⑤
24. I am a better parent because I take care of myself.	①	②	③	④	⑤
25. I take time for myself.	①	②	③	④	⑤
26. I know where to find resources for my family.	①	②	③	④	⑤
27. I know where to find important medical information.	①	②	③	④	⑤
28. I can get help from the community if I need it.	①	②	③	④	⑤
29. I am comfortable in finding the help I need.	①	②	③	④	⑤
30. I know community agencies I can go to for help.	①	②	③	④	⑤
31. It is hard for me to ask for help from others.	①	②	③	④	⑤
32. Because I'm a parent, I've had to give up much of my life.	①	②	③	④	⑤
33. I feel trapped by all the things I have to do for my child.	①	②	③	④	⑤
34. I feel drained dealing with my child.	①	②	③	④	⑤
35. There are times my child gets on my nerves.	①	②	③	④	⑤
36. I feel controlled by all the things I have to do as a parent.	①	②	③	④	⑤
37. I feel frustrated because my whole life seems to revolve around my child.	①	②	③	④	⑤
38. I have a hard time managing my child.	①	②	③	④	⑤
39. I can be patient with my child.	①	②	③	④	⑤
40. I respond quickly to my child's needs.	①	②	③	④	⑤
41. I do activities that help my child grow and develop.	①	②	③	④	⑤
42. When my child is upset, I'm not sure what to do.	①	②	③	④	⑤
43. I use positive words to encourage my child.	①	②	③	④	⑤
44. I can tell what my child wants.	①	②	③	④	⑤

Directions: Please choose ONE answer that best fits for you and color in the circle. ●

	Rarely or never ①	A little of the time ②	Some of the time ③	Good part of the time ④	Always or most of the time ⑤
45. I am able to increase my child's good behavior.	①	②	③	④	⑤
46. I can remain calm when my child is upset.	①	②	③	④	⑤
47. I praise my child everyday.	①	②	③	④	⑤
48. My child has favorite things to comfort him/her.	①	②	③	④	⑤
49. I read to my child.	①	②	③	④	⑤
50. I plan and do a variety of activities with my child every day.	①	②	③	④	⑤
51. I have made my home exciting and fun for my child.	①	②	③	④	⑤
52. I have organized my home for raising a child.	①	②	③	④	⑤
53. I check my home for safety.	①	②	③	④	⑤
54. My child has a schedule for eating and sleeping in my home.	①	②	③	④	⑤
55. I set limits for my child consistently.	①	②	③	④	⑤
56. I make plans for our family to do things together.	①	②	③	④	⑤
57. I set rules for behavior in my home.	①	②	③	④	⑤
58. I feel I'm doing an excellent job as a parent.	①	②	③	④	⑤
59. I am proud of myself as a parent.	①	②	③	④	⑤
60. I am more effective than most parents.	①	②	③	④	⑤
61. I have set goals about how I want to raise my child.	①	②	③	④	⑤
62. I am a good example to other parents.	①	②	③	④	⑤
63. I learn new parenting skills and use them with my child.	①	②	③	④	⑤

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## Healthy Families Parenting Inventory© (Spanish)

Nombre _____ Apellido _____
Fecha de Nacimiento: _____ / _____ / _____
Fecha de Hoy: _____ / _____ / _____ FSW Nombre: _____

Direcciones: Por favor escoja la respuesta que es mejor para Ud. Y llena el círculo.	Raramente o nunca ①	Un poco del tiempo ②	Algo del tiempo ③	Buena parte del tiempo ④	Siempre o la mayor parte del tiempo ⑤
1. Yo siento que otros me apoyan.	①	②	③	④	⑤
2. Yo siento que otros me cuidan.	①	②	③	④	⑤
3. Platico mis sentimientos con alguien.	①	②	③	④	⑤
4. Si algo me preocupa, se que siempre hay alguien que podria ayudarme.	①	②	③	④	⑤
5. Tengo familia o amigo(as) con quien puedo contar si necesito ayuda.	①	②	③	④	⑤
6. Aprendo nuevas maneras de como hacer las cosas cuando resuelvo algun problema.	①	②	③	④	⑤
7. Enfrento a los contratiempos sin desanimarme.	①	②	③	④	⑤
8. Cuando tengo un problema tomo medidas para resolverlo.	①	②	③	④	⑤
9. Cuando me encuentro con un problema, puedo pensar en varias soluciones.	①	②	③	④	⑤
10. Se enfrentar bien problemas inesperados.	①	②	③	④	⑤
11. Me quedo calmada cuando ocurren nuevos problemas.	①	②	③	④	⑤
12. Me siento triste.	①	②	③	④	⑤
13. Me siento positivo(a) de mi mismo/a.	①	②	③	④	⑤
14. Me siento positivo(a) sobre mi futuro.	①	②	③	④	⑤
15. Me siento infeliz.	①	②	③	④	⑤
16. Me siento sin esperanza sobre el futuro.	①	②	③	④	⑤
17. No hay mucha alegria en mi vida.	①	②	③	④	⑤
18. Tengo muchos problemas y me siento presionada.	①	②	③	④	⑤
19. Es dificil mantener un buen sentido de humor.	①	②	③	④	⑤

Direcciones: Por favor escoja la respuesta que es mejor para Ud. Y llena el círculo.	Raramente o nunca ①	Un poco del tiempo ②	Algo del tiempo ③	Buena parte del tiempo ④	Siempre o la mayor parte del tiempo ⑤
20. Mi vida es completa y significativa.	①	②	③	④	⑤
21. Encuentro maneras de cuidarme.	①	②	③	④	⑤
22. Cuido de mi apariencia.	①	②	③	④	⑤
23. Duermo bastante.	①	②	③	④	⑤
24. Soy mejor padre/madre porque me cuido.	①	②	③	④	⑤
25. Yo tomo tiempo para mí.	①	②	③	④	⑤
26. Sé donde encontrar recursos para mi familia.	①	②	③	④	⑤
27. Sé donde encontrar la información médica importante.	①	②	③	④	⑤
28. Puedo conseguir ayuda de la comunidad si la necesito.	①	②	③	④	⑤
29. Estoy cómodo(a) en encontrar la ayuda que necesito.	①	②	③	④	⑤
30. Conozco las agencias de la comunidad a las que puedo ir por ayuda.	①	②	③	④	⑤
31. Es duro pedir ayuda a otros.	①	②	③	④	⑤
32. Debido a que soy padre/madre, he tenido que renunciar a muchas cosas en mi vida.	①	②	③	④	⑤
33. Me siento atrapada por toda las cosas que tengo que hacer para mi niño(a).	①	②	③	④	⑤
34. Me siento agotado(a) cuidando a mi niño(a).	①	②	③	④	⑤
35. Hay momentos en que mi niño(a) me pone los nervios de punta.	①	②	③	④	⑤
36. Siento que todas las cosas que tengo que hacer como padre/madre me controlan.	①	②	③	④	⑤
37. Me siento frustrado(a) porque toda mi vida parece que se mueve alrededor de mi niño(a).	①	②	③	④	⑤
38. Se me hace difícil dirigir a mi niño(a).	①	②	③	④	⑤
39. Puedo ser paciente con mi niño(a).	①	②	③	④	⑤
40. Respondo rápidamente a las necesidades de mi niño(a).	①	②	③	④	⑤
41. Hago actividades que ayudan a mi niño(a) a crecer y desarrollarse.	①	②	③	④	⑤
42. Cuando mi niño(a) está molesto, no estoy segura qué hacer.	①	②	③	④	⑤

Direcciones: Por favor escoja la respuesta que es mejor para Ud. Y llena el circulo.	Raramente o nunca ①	Un poco del tiempo ②	Algo del tiempo ③	Buena parte del tiempo ④	Siempre o la mayor parte del tiempo ⑤
43. Utilizo palabras positivas para animar a mi niño(a).	①	②	③	④	⑤
44. Me doy cuenta rapidamente de lo que mi niño(a) desea.	①	②	③	④	⑤
45. Puedo aumentar el comportamiento bueno en mi niño(a).	①	②	③	④	⑤
46. Puedo mantenerme calmada cuando mi niño(a) está molesto.	①	②	③	④	⑤
47. Yo elogio a mi niño(a) a diario.	①	②	③	④	⑤
48. Para confortar a mi niño(a) yo le doy sus cosas favoritas.	①	②	③	④	⑤
49. Le leo a mi niño(a).	①	②	③	④	⑤
50. Planeo y hago una variedad de actividades con mi niño(a) cada día.	①	②	③	④	⑤
51. He hecho de mi casa un lugar alegre y divertido para mi niño(a).	①	②	③	④	⑤
52. He organizado mi hogar en funcion de poder criar a un niño.	①	②	③	④	⑤
53. Yo reviso mi casa para mantenerla segura.	①	②	③	④	⑤
54. Mi niño(a) tiene una rutina para comer y dormir en mi hogar.	①	②	③	④	⑤
55. He puesto límites consistentemente para mi niño(a).	①	②	③	④	⑤
56. Hago planes para que nuestra familia haga cosas juntas.	①	②	③	④	⑤
57. Pongo reglas de comportamiento en mi hogar.	①	②	③	④	⑤
58. Yo siento que estoy haciendo un trabajo excelente como padre/madre.	①	②	③	④	⑤
59. Estoy orgulloso de mí misma/o como padre/madre.	①	②	③	④	⑤
60. Siento que soy más eficaz que la mayoría de los padres.	①	②	③	④	⑤
61. Tengo metas sobre cómo deseo criar a mi niño(a).	①	②	③	④	⑤
62. Soy un buen ejemplo para otros padres.	①	②	③	④	⑤
63. Aprendo nuevas habilidades sobre como ser padre/madre y las utilizo con mi niño(a).	①	②	③	④	⑤

**¡Gracias por completar esta encuesta!**

## Healthy Families Parenting Inventory – Score Sheet

PCG First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FSW Name: \_\_\_\_\_

Time Frame:     Prenatal             Birth             Enrollment             6             12             18             24             30  
 (Child's age in months)     36             42             48             54             60             66             72

**Instructions:**

1. Enter each score from the inventory under the "Actual Score" column.
2. Under the "Scale Score" column, enter the same score for all questions except the ones marked "reverse."  
 For these questions, the actual score (these are in a box) will need to be reversed as follows:  
     If the actual score is **1**, enter **5**  
     If the actual score is **2**, enter **4**  
     If the actual score is **3**, enter **3**  
     If the actual score is **4**, enter **2**  
     If the actual score is **5**, enter **1**
3. Total the "Scale Score" column for each area and review for any low scores.
4. The **shaded boxes** under the "Actual Score" column indicate **RED FLAG QUESTIONS**. These questions should be of particular concern if the score is a **4 or 5 (Questions 12, 15, 16, 18, 33, 34, 37)**.
5. Administer the "**Edinburgh Postnatal Depression Scale (EPDS)**" if the score is 23 or less for the Depression sub-scale of HFPI. Record scores for EPDS in the section below according to the EPDS form instructions.

<u>Social Support</u>	<u>Problem-Solving</u>	<u>Depression</u>	<u>Personal Care</u>	<u>Mobilizing Resources</u>																																																																																																																		
<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Actual Score</th> <th style="width: 50%;">Scale Score</th> </tr> <tr> <td>1 _____</td> <td>_____</td> </tr> <tr> <td>2 _____</td> <td>_____</td> </tr> <tr> <td>3 _____</td> <td>_____</td> </tr> <tr> <td>4 _____</td> <td>_____</td> </tr> <tr> <td>5 _____</td> <td>_____</td> </tr> <tr> <td><b>TOTAL</b> _____</td> <td></td> </tr> <tr> <td colspan="2">A score 14 or lower indicates area of concern</td> </tr> </table>	Actual Score	Scale Score	1 _____	_____	2 _____	_____	3 _____	_____	4 _____	_____	5 _____	_____	<b>TOTAL</b> _____		A score 14 or lower indicates area of concern		<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Actual Score</th> <th style="width: 50%;">Scale Score</th> </tr> <tr> <td>6 _____</td> <td>_____</td> </tr> <tr> <td>7 _____</td> <td>_____</td> </tr> <tr> <td>8 _____</td> <td>_____</td> </tr> <tr> <td>9 _____</td> <td>_____</td> </tr> <tr> <td>10 _____</td> <td>_____</td> </tr> <tr> <td>11 _____</td> <td>_____</td> </tr> <tr> <td><b>TOTAL</b> _____</td> <td></td> </tr> <tr> <td colspan="2">A score 17 or lower indicates area of concern</td> </tr> </table>	Actual Score	Scale Score	6 _____	_____	7 _____	_____	8 _____	_____	9 _____	_____	10 _____	_____	11 _____	_____	<b>TOTAL</b> _____		A score 17 or lower indicates area of concern		<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Actual Score</th> <th style="width: 50%;">Scale Score</th> </tr> <tr> <td>12 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____</td> <td>_____</td> </tr> <tr> <td>13 _____</td> <td>_____</td> </tr> <tr> <td>14 _____</td> <td>_____</td> </tr> <tr> <td>15 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____</td> <td>_____</td> </tr> <tr> <td>16 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____</td> <td>_____</td> </tr> <tr> <td>17 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____</td> <td>_____</td> </tr> <tr> <td>18 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____</td> <td>_____</td> </tr> <tr> <td>19 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____</td> <td>_____</td> </tr> <tr> <td>20 _____</td> <td>_____</td> </tr> <tr> <td><b>TOTAL</b> _____</td> <td></td> </tr> <tr> <td colspan="2">A score 23 or lower indicates area of concern</td> </tr> </table>	Actual Score	Scale Score	12 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____	_____	13 _____	_____	14 _____	_____	15 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____	_____	16 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____	_____	17 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____	_____	18 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____	_____	19 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____	_____	20 _____	_____	<b>TOTAL</b> _____		A score 23 or lower indicates area of concern		<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Actual Score</th> <th style="width: 50%;">Scale Score</th> </tr> <tr> <td>21 _____</td> <td>_____</td> </tr> <tr> <td>22 _____</td> <td>_____</td> </tr> <tr> <td>23 _____</td> <td>_____</td> </tr> <tr> <td>24 _____</td> <td>_____</td> </tr> <tr> <td>25 _____</td> <td>_____</td> </tr> <tr> <td><b>TOTAL</b> _____</td> <td></td> </tr> <tr> <td colspan="2">A score 14 or lower indicates area of concern</td> </tr> </table>	Actual Score	Scale Score	21 _____	_____	22 _____	_____	23 _____	_____	24 _____	_____	25 _____	_____	<b>TOTAL</b> _____		A score 14 or lower indicates area of concern		<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Actual Score</th> <th style="width: 50%;">Scale Score</th> </tr> <tr> <td>26 _____</td> <td>_____</td> </tr> <tr> <td>27 _____</td> <td>_____</td> </tr> <tr> <td>28 _____</td> <td>_____</td> </tr> <tr> <td>29 _____</td> <td>_____</td> </tr> <tr> <td>30 _____</td> <td>_____</td> </tr> <tr> <td>31 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____</td> <td>_____</td> </tr> <tr> <td><b>TOTAL</b> _____</td> <td></td> </tr> <tr> <td colspan="2">A score 17 or lower indicates area of concern</td> </tr> </table>	Actual Score	Scale Score	26 _____	_____	27 _____	_____	28 _____	_____	29 _____	_____	30 _____	_____	31 <input style="background-color: #cccccc;" type="checkbox"/> reverse _____	_____	<b>TOTAL</b> _____		A score 17 or lower indicates area of concern																							
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**Edinburgh Postnatal Depression Scale (EPDS)**  
**Form No. 444**

**Purpose:** The purpose of this form is to provide a standardized tool to assist in identifying mothers participating in OCAP home visitation service and suffering from signs of postnatal depression.

**Use:** This form is administered during postpartum (up to 1 year postpartum or when the baby is 12 months old) when signs or symptoms indicate.

PCG – Provide the name, initial, date of birth of mother.

Weeks PP – Provide the number of weeks postpartum or since birth of child.

Date – Provide the date the scale was administered.

The EPDS consists of 10 short statements, each with four responses. The mother checks the response that most closely matches how she has been feeling in the previous 7 days. Response categories are scored 0, 1, 2, and 3, according to the severity of the symptom. Items marked with an asterisk are reverse scored (i.e., 3, 2, 1, and 0). All 10 items must be completed. The total score is calculated by adding together the scores for each of the 10 items and should be documented on the “Healthy Families Parenting Inventory – Score Sheet”. **Mothers with scores of 12 or above should be referred to their PCP or local resources. Mothers who answer question #10 “yes,” should also be referred to their PCP or local mental health professional regardless of the total score. If the response is “yes, quite often,” or similar, the referral should be made as soon as possible.**

Care should be taken to avoid the possibility of the mother discussing her answers with others. The mother should complete the EPDS herself, unless she has limited English or has difficulty reading. The EPDS will not detect mothers with anxiety disorders, phobias, or personality disorders.

**Routing and Filing:** The original copy of this form is filed in the PCG’s family folder at the OCAP program site providing the home visitation service.

# Edinburgh Postnatal Depression Scale

PCG \_\_\_\_\_ DOB \_\_\_\_\_ Weeks PP \_\_\_\_\_ Date \_\_\_\_\_

As you have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **in the past 7 days**, not just how you feel today.

## In the past 7 days:

<p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> As much as I always could</li> <li><input type="checkbox"/> Not quite so much now</li> <li><input type="checkbox"/> Definitely not so much now</li> <li><input type="checkbox"/> Not at all</li> </ul> <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> As much as I ever did</li> <li><input type="checkbox"/> Rather less than I used to</li> <li><input type="checkbox"/> Definitely less than I used to</li> <li><input type="checkbox"/> Hardly at all</li> </ul> <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, most of the time</li> <li><input type="checkbox"/> Yes, some of the time</li> <li><input type="checkbox"/> Not very often</li> <li><input type="checkbox"/> No, never</li> </ul> <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No, not at all</li> <li><input type="checkbox"/> Hardly ever</li> <li><input type="checkbox"/> Yes, sometimes</li> <li><input type="checkbox"/> Yes, very often</li> </ul> <p>*5. I have felt scared or panicky for no good reason</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, quite a lot</li> <li><input type="checkbox"/> Yes, sometimes</li> <li><input type="checkbox"/> No, not much</li> <li><input type="checkbox"/> No, not at all</li> </ul>	<p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all</li> <li><input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual</li> <li><input type="checkbox"/> No, most of the time I have coped quite well</li> <li><input type="checkbox"/> No, I have been coping as well as ever</li> </ul> <p>*7. I have been so unhappy that I have had difficulty Sleeping</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, most of the time</li> <li><input type="checkbox"/> Yes, sometimes</li> <li><input type="checkbox"/> Not very often</li> <li><input type="checkbox"/> No, not at all</li> </ul> <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, most of the time</li> <li><input type="checkbox"/> Yes, quite often</li> <li><input type="checkbox"/> Not very often</li> <li><input type="checkbox"/> No, not at all</li> </ul> <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, most of the time</li> <li><input type="checkbox"/> Yes, quite often</li> <li><input type="checkbox"/> Only occasionally</li> <li><input type="checkbox"/> No, never</li> </ul> <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, quite often</li> <li><input type="checkbox"/> Sometimes</li> <li><input type="checkbox"/> Hardly ever</li> <li><input type="checkbox"/> Never</li> </ul>
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**Source:** Cox, J. L., Sagovsky, R, 1987 Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

## ESCALA DE EDINBURGO (Spanish Version)

Como usted hace poco tuvo un bebé, nos gustaría saber como se ha estado sintiendo. Por favor SUBRAYE la respuesta que más se acerca a como se ha sentido en los últimos 7 días.

Or

Por favor haga un círculo alrededor de la respuesta que más se acerca a como se ha sentido en los últimos 7 días.

Éste es un ejemplo ya completo:

Me he sentido contenta:

0 Sí, siempre

1 Sí, casi siempre

2 No muy a menudo

3 No, nunca

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas:

0 Tanto como siempre

1 No tanto ahora

2 Mucho menos

3 No, no he podido

2. He mirado al futuro con placer:

0 Tanto como siempre

1 Algo menos de lo que solía hacer

2 Definitivamente menos

3 No, nada

3. Me he culpado sin necesidad cuando las cosas marchaban mal:

3 Sí, casi siempre

2 Sí, algunas veces

1 No muy a menudo

0 No, nunca

4. He estado ansiosa y preocupada sin motivo:

0 No, nada

1 Casi nada

2 Sí, a veces

3 Sí, a menudo

5. He sentido miedo o pánico sin motivo alguno:

3 Sí, bastante

2 Sí, a veces

1 No, no mucho

0 No, nada

En los últimos 7 días:

6. Las cosas me oprimen o agobian:

3 Sí, casi siempre

2 Sí, a veces

1 No, casi nunca

0 No, nada

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:

3 Sí, casi siempre

2 Sí, a menudo

1 No muy a menudo

0 No, nada

8. Me he sentido triste y desgraciada:

3 Sí, casi siempre

2 Sí, bastante a menudo

1 No muy a menudo

0 No, nada

9. He estado tan infeliz que he estado llorando:

3 Sí, casi siempre

2 Sí, bastante a menudo

1 Sólo ocasionalmente

0 No, nunca

10. He pensado en hacerme daño a mí misma:

3 Sí, bastante a menudo

2 Sí, a menudo

1 Casi nunca

0 No, nunca

## Scoring and Other Information

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom. Items 3, 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect the copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression, a distressing disorder more prolonged than the “blues” (that occurs in the first week after delivery) but less severe than puerperal psychosis.

Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected, and it is possible that there are long-term effects on the family.

The EPDS was developed at health centers in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than 5 minutes.

The validation study showed that mothers who scored above a threshold 12-13 were likely to be suffering from a depressive illness of varying severity. Nevertheless the EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week, and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

### Instructions for users

1. The mother is asked to underline the response, which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women, or during pregnancy. The child health clinic, postnatal check-up, or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

This Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245. [mike-ohara@uiowa.edu](mailto:mike-ohara@uiowa.edu).

**Oklahoma Childhood Lead Poisoning Prevention Program  
Lead Exposure Risk Assessment Questionnaire (LERAQ)**

\_\_\_\_\_  
**CHILD'S NAME**

\_\_\_\_\_  
**DATE OF BIRTH**

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Current Residential Zip Code: \_\_\_\_\_

1. Is the above zip code an High Risk zip code area? (see back of this form )	Yes	No	Don't Know
2. Does your child have Medicaid (SoonerCare)? If yes this child must have a blood lead test at 12 and 24 months of age.	Yes	No	Don't Know
3. Does your child live in or often visit a house or child care site with peeling paint that was built prior to 1950?	Yes	No	Don't Know
4. Does your child live in or often visit a house or child care site built prior to 1978 with new repairs or remodeling in the last 6 months?	Yes	No	Don't Know
5. Does your child live in or often visit a house or child care site that has vinyl or plastic mini blinds?	Yes	No	Don't Know
6. Does your child have friends, siblings, house mates, or a play mate that has or did have lead poisoning?	Yes	No	Don't Know
7. Does your child live with an adult who has a job or hobby where lead is used? (such as oil field worker, bridge painter, demolition/renovation of buildings, automobile work with batteries or radiators, lead solder, leaded glass, lead shot, bullets or lead fish sinkers)	Yes	No	Don't Know
8. Is your child given any home or folk remedies that may have lead in them? (such as imported items called Greta, Azarcon, Rudea)	Yes	No	Don't Know
9. Does your child eat food cooked in or served from pottery made outside the United States (especially Mexico)?	Yes	No	Don't Know

Lead Poisoning Prevention Program  
Screening, Special Services & SoonerStart  
Oklahoma State Department of Health  
07/24/07  
1000 NE 10<sup>th</sup> Street

Telephone: (405) 271-6617

OSDH Form #386-Rev

**HIGH RISK ZIP CODES**

73106    73108    73111    73119    73521    74104    74110    74127    74401    74447  
73107    73109    73117    73129    73701    74106    74115    74354    74403    74631  
74848

Purpose: **The LERAQ is to be used to screen for lead poisoning at annual well child visits for children 6 - 72 months old.**

**Use: This assessment should be administered by medical staff verbally with the primary care taker of the child.** Any "Yes" or "don't know" answer is considered a positive answer thus requires the child to have a blood lead test. If a child has a blood lead test  $\leq 9\mu\text{g/dL}$  and there are no changes in risk factors, a repeat blood lead test is not required.

Routing and Filing: **Retain this record in the client's record to review annually.**

Lead Poisoning Prevention Program  
Screening, Special Services & SoonerStart  
Oklahoma State Department of Health  
1000 NE 10<sup>th</sup> Street  
Oklahoma City, OK 73117-1299  
405-271-6617

Telephone: (405) 271-6617

OSDH Form #386-Rev 07/24/07

**Programa de prevención de envenenamiento por plomo infantil del estado de Oklahoma  
Cuestionario de Evaluación de los riesgos a exposición al plomo (LERAQ)**

**Nombre del Niño(a):** \_\_\_\_\_ **Fecha de Nacimiento:** \_\_\_\_\_  
(Name) (DOB)

**Dirección:** \_\_\_\_\_ **Ciudad:** \_\_\_\_\_ **Código Postal:** \_\_\_\_\_  
(Address) (City) (Zip Code)

**Fecha:** \_\_\_\_\_  
(Date)

1. ¿ Está su código postal en una área de riesgo? (Léa al reverso de esta forma)	SI	NO	No Sé
2. ¿Tiene su niño(a) el seguro médico del Medicaid o del SoonerCare? (Si el niño(a) tiene el Medicaid, este niño(a) debe de tener un exámen de plomo en la sangre a los 12 y a los 24 meses de edad)	SI	NO	No Sé
3. ¿Su niño(a) vive o visita con frecuencia una casa o una guardería (centro de cuidado de niños) que tenga pintura descarapelada y que fuera construida antes del 1950?	SI	NO	No Sé
4. ¿ Su niño(a) vive o visita con frecuencia una casa o una guardería (centro de cuidado de niños) que fué construida antes del 1978 en la cual se han realizado nuevas reparaciones o remodelaciones en los ultimos 6 meses?	SI	NO	No Sé
5. ¿ Su niño(a) vive o visita con frecuencia una guardería (centro de cuidado de niños) que tiene persianas de vinil o plástico?	SI	NO	No Sé
6. ¿ Su niño(a) tiene amigos, hermanos o compañeros en la casa o de juegos que tienen o tuvieron envenenamiento por plomo en la sangre?	SI	NO	No Sé
7. ¿ Su niño(a) vive con un adulto que tiene un trabajo o un pasatiempo donde utiliza el plomo? (Ejemplo: pintando puentes (trabajo de asate), demolición/renovación de edificios, trabajo con baterías o radiadores de autos, soldador de plomo, vidrio emplomado, balas de plomo, pesas de plomo para pescar).	SI	NO	No Sé
8. ¿ Ha tomado su niño(a) algún remedio casero que pueda contener plomo? (Ejemplos; productos importados como la Greta, el Azarcón o la Rudea)	SI	NO	No Sé
9. ¿ Come su niño(a) alimentos que son cocinados y servidos en cerámicas hechas fuera de los Estados Unidos. (especialmente de México)?	SI	NO	No Sé

Programa de Prevención de Envenenamiento por Plomo Infantil del Departamento de Salud del Estado de Oklahoma. Teléfono (405)-271-6617

**Propósito:** El LERAQ es para ser utilizado para examinar el envenenamiento por plomo en chequeos regulares y anuales en niños de 6 a 72 meses de edad.

**Cualquier respuesta de "Si" o "No Sé" es considerada una respuesta positiva y es recomendable que al niño(a) se le haga un análisis de plomo en la sangre.** Si un niño tiene un resultado  $\leq$  9ug/dl y no han surgido cambios en los factores de riesgos, no es necesario hacer otro análisis de la sangre.

**Códigos postales de areas de riesgos**

73106 73108 73111 73119 73521 74104 74110 74127 74401 74447  
73107 73109 73117 73129 73701 74106 74115 74354 74403 74631  
74848

Purpose: The LERAQ is to be used to screen for lead poisoning at annual well child visits for children

## Instructions for OCAP Lead Assessment Log

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### Purpose

The purpose of the Lead Assessment Log is to record when the FSW assesses the identified child for lead exposure using the LERAQ tool, the assessment result, whether a referral was made for lead screening, and the follow-up to that referral.

### General Instructions

- ❖ **Whose** form: This is a Child form. For multiple births (twins, etc.), do one for each child.
- ❖ **When:** Complete this form each time the FSW uses the LEARQ tool to assess the child for lead exposure. The recommended schedule is to assess the child at 6 months old, 1 year old, 2 years old, 3 years old, 4 years old, 5 years old, and 6 years old.
- ❖ **What:** The form allows the program to monitor whether children are being assessed for lead exposure and the outcome of that assessment.
- ❖ **File:** This form is filed in the family folder at the OCAP program site providing services.

### Gray Box Item Instructions

Note:

You must complete all fields listed in the gray box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first “Participant Activity Form”. Similarly the information submitted for the child should be consistent with the “Pregnancy and Birth Form”. Avoid alternate names, misspells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the gray box will be used to create a unique ID that will link all the family forms to one ID.

**PCG First Name / Last Name / DOB:** The PCG’s first and last names and date of birth.

**Child First Name / Last Name / DOB:** The Child’s first and last names and date of birth.

### Item Instructions

- Record all instances when a child is assessed for lead exposure on a single log form so it is easy to reference when the assessment was conducted.
- Each time the FSW assesses a child for possible lead exposure, find the appropriate line that corresponds to the child’s age. On that line, record the date the FSW conducted the assessment.
- Moving from left to right on that same line, indicate the result of the assessment (Positive or Negative) by checking the appropriate box.

- Next, check whether the FSW referred that child/family for a lead-screening test (Blood test).
- Finally, at the next home visit, follow up with the referral to see what happened, and document the result.

## LEAD ASSESSMENT LOG

**PCG** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Child** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Suggested Schedule	Date Assessed (mm/dd/yyyy)	Assessment Result	Referral Made for Lead Screening (Blood Test)	Follow up to Referral
6 months	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Test did not take place <input type="checkbox"/> Test result positive <input type="checkbox"/> Test result negative
1 year	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Test did not take place <input type="checkbox"/> Test result positive <input type="checkbox"/> Test result negative
2 years	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Test did not take place <input type="checkbox"/> Test result positive <input type="checkbox"/> Test result negative
3 years	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Test did not take place <input type="checkbox"/> Test result positive <input type="checkbox"/> Test result negative
4 years	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Test did not take place <input type="checkbox"/> Test result positive <input type="checkbox"/> Test result negative
5 years	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Test did not take place <input type="checkbox"/> Test result positive <input type="checkbox"/> Test result negative
6 years	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Test did not take place <input type="checkbox"/> Test result positive <input type="checkbox"/> Test result negative

# Instructions for Center Based Services Intake Form

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## Purpose

The Center-Based Services Intake Form is used to gather initial demographic information on persons who accept center-based services. The form is to be completed before services are provided. The form is valid for one State Fiscal Year. A Center-Based Services Intake Form must be completed for each adult receiving center-based services at the first time they attend a center-based activity each State Fiscal Year.

## General Instructions

- ❖ **Whose form:** Participant (adult) receiving center-based services. **When:** The first time a person attends a Structured Parent Education or Circle of Parents® group (each state fiscal year)
- ❖ **What:** The form gathers demographic information on the participants.
- ❖ **File:** This form is filed at the OCAP program site providing center-based service.

## Gray Box Item Instructions

**First Name / Last Name / DOB:** The participant's first and last names and date of birth. Avoid alternate names, misspells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

**Today's Date:** The date on which the intake took place. Use mm/dd/yyyy format.

**Instructor/Leader Name:** The first and last name of the instructor for that program site.

## Item Instructions

CI1: Record the street address of the participant. Include the apartment number if applicable.

CI2: Record the city in which the participant resides.

CI3: Record the county in which the participant resides.

CI4: Record the state in which the participant resides.

CI5: Record the participant's zip code.

CI6: Record the telephone number, including area code, of the primary phone where the participant can be reached. Check the appropriate box indicating the type of telephone for this number.

CI7: Record the telephone number, including area code, of the secondary phone where the participant can be reached. Check the appropriate box indicating the type of telephone for this number.

CI8: Check the appropriate box indicating the participant's gender.

CI9: Check the appropriate box indicating the race of the participant. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the participant.

CI10: Check the appropriate box indicating whether the participant is Hispanic or Latino.

CI11: Check the appropriate box indicating the marital status of the participant.

CI12: Check the appropriate box indicating the highest level of education the participant has completed. Only choose one box.

CI13: Check the appropriate box indicating whether the participant is currently enrolled in school, a vocational program or an educational program.

CI14: Check the appropriate box indicating the participant's annual household income. Only choose one box.

CI15: Check the appropriate box indicating the participant's type of employment. Choose only one box. If the "Other" box is checked, indicate the specific type of employment.

CI16: Record the number of children less than 6 years of age in the home.

CI17: For each in the family, who is attending the center-based services, record the first and last names, the date of birth in mm/dd/yyyy format, and the relationship of the child to the participant.

CI18: Check the appropriate box indicating whether the participant is currently pregnant. If not pregnant, skip to CI19.

CI19: Check the appropriate box to indicate if the participant is receiving any prenatal care for a current pregnancy.

CI20: Check the boxes that correspond to the services that your family is currently receiving.

***Answer for families receiving this program's home visitation services.***

CI21(a,b,c): Primary caregiver information. The PCG's first and last names and date of birth.

Ensure that the information pertaining to the PCG is consistent with that submitted for enrollment (i.e. the first "Participant Activity Form"). Avoid alternate names, misspells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

## CENTER-BASED SERVICES INTAKE FORM

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

Today's Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Instructor / Leader Name: \_\_\_\_\_

This information will be entered into a database for program evaluation purposes alone. The program is evaluated to improve the quality of the services provided to you. Only the program and the program evaluator will see this information. Your name will not be used in the results.

### General Information

C11. Street Address: \_\_\_\_\_ C12. City: \_\_\_\_\_

C13. County: \_\_\_\_\_ C14. State: \_\_\_\_\_ C15. Zip Code: \_\_\_\_\_

C16. Phone 1: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Home  Cell  Message  Pager  Work

C17. Phone 2: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Home  Cell  Message  Pager  Work

C18. What is your gender?       Female       Male

C19. Which of the following is your race?

(Please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> American Indian/ Alaskan Native; Tribe: _____ | <input type="checkbox"/> Caucasian                        |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> Black/African American                        | <input type="checkbox"/> Other, specify _____             |

C110. Are you Hispanic or Latino?       Yes       No

C111. What is your marital status?

- |  |                                   |                                    |
|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Married               | <input type="checkbox"/> Widowed  | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Single, never married | <input type="checkbox"/> Divorced |                                    |

C112. What is the highest level of school you have completed?

(Please choose one)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 8th grade or less                                   | <input type="checkbox"/> Some college, no degree | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade, no diploma | <input type="checkbox"/> Vo-tech certification   | <input type="checkbox"/> Beyond college    |
| <input type="checkbox"/> High school graduate or GED completed               | <input type="checkbox"/> Associate Degree        |  |

C113. Are you currently enrolled in any kind of school, vocational or educational program?

- Yes       No

CI14. Annual Household income:  
(Please choose one)

- Under \$5,000
- \$5,000 - \$14,999
- \$15,000 - \$24,999
- \$25,000 - \$34,999
- \$35,000 - \$44,999
- \$45,000 and above
- Unknown

CI15. Current employment status:

- (Please choose one)
- Full time employed (35+ hours/week)
  - Unemployed, but looking
  - Part time employed (<35 hours/week)
  - Unemployed, not looking
  - Odd jobs/irregular employment
  - Medical leave/disability
  - Other, specify \_\_\_\_\_

*Family Information*

CI16. How many children under 6 years old live in your household:

CI17. Names, ages and relationship to you of children in the family who are attending:

CI17a. First Name	CI17b. Last Name	CI17c. Date of Birth (mm/dd/yyyy)	CI17d. Relationship to you

CI18. Are you currently expecting a baby?  Yes  No **(If No, Skip to CI20)**

CI19. Are you getting prenatal care for this pregnancy?  Yes  No

CI20. Does your family currently receive services from any of the following? **(Check "Yes" or "No" for each.)**

- This program's home visitation  Yes  No
- Children First  Yes  No
- SoonerStart  Yes  No
- Child Guidance  Yes  No
- Other, \_\_\_\_\_  Yes  No

Please complete the following question if your family receives this program's home visitation services:

CI21. Are you the Primary Caregiver?  Yes  No **(If No, Complete the Primary Caregiver Information below)**

Primary caregiver information:

CI21a. First Name: \_\_\_\_\_

CI21b. Last Name: \_\_\_\_\_

CI21c. DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_

# Instructions for Center Based Activity Summary Form

---

## Purpose

The Center-Based Activity Summary Form is used to gather information about each center-based Structured Parent Education or Circle of Parents activity.

## General Instructions

- ❖ **Whose form:** The activity Instructor or Leader completes this form.
- ❖ **When:** This form is completed each time a center-based Structured Parent Education or Circle of Parents<sup>®</sup> activity is done. **What:** The form gathers basic information about the activity, including what type of activity, frequency, topic/theme, number of adult and child participants, and type of attendant.
- ❖ **File:** This form is filed at the OCAP program site providing center-based service.

## Item Instructions

CA1. Select the type of activity, a-Structured Parent Education, or b-Circle of Parents. Under a- or b-, select the frequency that the activity is conducted.

CA2. Write the topic or theme for the activity. Please be brief yet descriptive.

CA3. Indicate whether, during this activity, a parent-child interactive activity was conducted.

CA4. If a parent-child interactive activity was done, please state the topic/theme, being brief yet descriptive. SKIP if no such activity was done. (Note this is a required activity.)

CA5. Write the number of adults that attended the activity. It does not matter if participants were late.

CA6. Write the number of children the attended the activity.

NOTE: In order to answer CA7 and CA8, you will have to poll the adult attendees to see which categories they fit into. This is best done at the end of the activity so that all attendees are documented.

CA7. Categorize the adults that attended the activity into one of the following categories: mothers, fathers, grandmothers, grandfathers, and others. Write the number of each. The numbers should add up to the number in CA5.

CA8. Categorize the adults according to the number of sessions they have attended, including today's session. The numbers in the boxes should add up to the number in CA5.

## CENTER-BASED ACTIVITY SUMMARY FORM

Date of Activity (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Instructor /Leader First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

### **Center-Based Activity Information**

CA1. Type of Activity (**Select one**):

CA1a.  Structured Parent Education (**Choose one**):  
 Weekly  
 Bi-weekly  
 Monthly

CA1b.  Circle of Parents (**Choose one**):  
 Weekly  
 Bi-weekly  
 Monthly

CA2. What was the topic /theme for the Center-Based activity?

Topic/Theme:

CA3. Was a parent-child interactive activity conducted?

Yes       No       Not applicable

CA4. What was the topic /theme for the parent-child interactive activity?

Parent-Child Interactive Activity Topic/Theme:

CA5. How many adults attended today's activity?

CA6. How many children attended today's activity?

CA7. How many of the following adults attended today's activity?

CA7a. Mothers	CA7b. Fathers	CA7c. Grandmothers	CA7d. Grandfathers	<b>CA7e. Others</b>

CA8. How many times have today's attendees attended Center-Based activities? Please put the number of adults who fit in each category (**Include this session**):

CA8a. Today was their first time	<b>CA8b. 2 – 5 times</b>	CA8c. 6 – 9 times	CA8d. 10 or more times

# Instructions for Program Information Form

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## **Purpose**

Program Information Form is used to record information about the program, its funding, identified populations, and community services. The form is completed and returned to the Office of Child Abuse Prevention at the beginning of the contract cycle.

## **Program Information**

PI1 *Contract Start* – Record when the current contract was initiated (mm/dd/yyyy).

PI2 *Contract End* – Record when the current contract expires (mm/dd/yyyy).

PI3 *Budget* – Record total community-based family resource and support program budget for one year.

PI4 *CAP Fund* – Record the Child Abuse Prevention Fund award amount for each year of the contract.

PI5 *Year Began* – Record the year the OCAP program began.

PI6 *Times Funded* – Record the number of times that the program has contracted with the Office of Child Abuse Prevention ending with the current contract cycle.

PI7 *Area* – Record the one most appropriate response to what type of area is served.

PI8 *Location* - Record if the program serves an urban, rural, or urban and rural location.

Use the check boxes to indicate the primary population served by the program.

PI9 *First Time Parents*.

PI10 *Second Time Parents*.

PI11 *Third Time or More Parents*.

PI12 *Teen Parents*.

PI13 *Hispanic Parents*.

PI14 *Native American Parents*.

PI15 *African American Parents*.

PI16 *Those not being served by Children First or SoonerStart*.

## **Community Services Information**

Check the appropriate boxes that describe the services available in the community:

### **County Health Department**

PI17 *Women, Infant, and Children (WIC)* – nutrition education and supplemental food program for pregnant women and children under 5 years.

PI18 *Maternity Clinic* – prenatal care for uninsured or underinsured women

PI19 *Family Planning Clinic* – exams and birth control for men and women

PI20 *Well-Baby Clinic*- check-up for well babies 2 weeks to 2 years

PI21 *Well-Child Clinic*- check-up for well children 2 years to 21 years

PI22 *Well-Woman Clinic* – breast exams and pap smears

PI23 *Guidance Services* – child psychological, developmental, speech, language, and hearing screenings and assessments with short term early intervention services

PI24 *SoonerStart* – early intervention program for children with developmental disabilities

PI25 *Immunizations* – infant, child care, school-aged, and adult immunizations

PI26 *Medical Clinics* - health care for sick or injured children

PI27 *Dental Clinics* – services for pregnant women and children

- PI28 *Chronic Disease* – screenings and education for hypertension, diabetes, and cancer  
 PI29 *STD/HIV* – testing and counseling for sexually transmitted diseases including HIV  
 PI30 *Children First* – health case-based home visitation for first time mothers who are < 28 wks pregnant
- Indian Health Services or Tribal Health Care**
- PI31 *Family medicine* – prenatal care, well-baby, illnesses, and injuries  
 PI32 *Nutrition* – outpatient planning and education  
 PI33 *Dentistry* – dental health needs  
 PI34 *Counseling* – outpatient services for counseling or health education
- Department of Human Services**
- PI35 *Temporary Assistance for Needy Families (TANF)* - cash assistance to meet basic needs for families on a time-limited basis (Formerly AFDC)  
 PI36 *Day Care Assistance* – assist families to meet the cost of day care while parent(s) are at work, at school, or work-related training  
 PI37 *Food Stamps* – monthly benefits to purchase food  
 Energy Assistance – seasonal assistance for winter heating bills or if family has received utility cut-off notices  
 PI38  
 PI39 *Disability Benefits (SSI/SSA)* – assistance for children with disabilities or special health care needs  
 PI40 *Family Support Assistance* –assist families caring for children with developmental disabilities
- Health Insurance**
- PI41 *Medicaid* - includes Sooner Care or Sooner Choice if received through the Health Care Authority.
- Housing and Urban Development**
- PI42 *Housing Assistance* - HUD, Section 8
- Other Community Services**
- PI43 *Childbirth or Prenatal Classes* – preparation for birth of child  
 PI44 *Adult Education Programs* - GED, College, Literacy, Vo-Tech  
 PI45 *Community Resources* - food, toys, diapers, clothing or furnishings  
 PI46 *Legal Aid*, legal assistance  
 PI47 *Family Violence Programs* - prevention, intervention, or treatment  
 PI48 *Crisis Intervention* - assistance with management of crisis situations  
 PI49 *Counseling (Individual/Group)* - family violence counseling  
 PI50 *Drugs/Alcohol Programs* - prevention, intervention, or treatment  
 PI51 *Emergency Child Care* – crisis related, emergency child care  
 PI52 *Job Readiness and Counseling* – services through the Oklahoma Employment Security Commission, vo-techs, colleges, or universities  
 PI53 *Other family support programs* – Parents as Teachers, Parents Anonymous, First Steps, Adopt-A-Caseworker  
 PI54 *Early Head Start* – early education and socialization of children  
 PI55 *Personal Safety/Violence Prevention Life Skills Training* – prevention lessons  
 PI56 *Life Management Skills Training* – teach living skills such as how to access health care, shopping, budgeting and financial management, problem-solving, and how to apply for employment  
 PI57 *Parenting Support Telephone Line* – answer questions about parenting, child development, community resources, and concerns

**Program Services**

- PI58 *Respite Care* – short term care services for children who are in danger of maltreatment
- PI59 *Parent Education Groups* – 4-10 weekly sessions, 1-2 hours per session, structured curricula with specific enrollment
- PI60 *Parent Support Group* – informal, open-ended regularly scheduled parent meetings in a discussion format
- PI61 *Individual Parent Education Consultation* – individual, agency-based sessions
- PI62 *Child Care* – *child* care that assists parent(s) in attending program services
- PI63 *Transportation Assistance* – to community resources such as health care or program services

**Other Services**

- PI64 Smoking Cessation
- PI65 (specify)
- PI66 (specify)

## PROGRAM INFORMATION FORM

### **Program Information**

Name of Program: \_\_\_\_\_

Contract period: PI1 From \_\_\_/\_\_\_/\_\_\_\_\_ PI2 to \_\_\_/\_\_\_/\_\_\_\_\_

PI3 Total budget: (YEAR 1) \$\_\_\_\_\_,\_\_\_\_\_,\_\_\_\_\_.\_\_\_\_ PI4 CAP Fund award: (YEAR 1) \$\_\_\_\_\_

CAP Fund award: (YEAR 2) \$\_\_\_\_\_ CAP Fund award: (YEAR 3) \$\_\_\_\_\_

CAP Fund award: (YEAR 4) \$\_\_\_\_\_ CAP Fund award: (YEAR 5) \$\_\_\_\_\_

PI5 Year program began: \_\_\_\_\_ PI6 Number of times program has received OCAP contract: \_\_\_\_\_

PI7 Geographic area served:       Multiple counties                       Single city/town  
     Single county                                       Neighborhoods  
     Multiple cities/towns

PI8 Geographic location:     Urban                       Rural                       Urban and Rural Areas

### **Target Population Information**

**Who does the program primarily serve:** (check all that apply)       PI9 First time parents  
 [Parents meaning parents who are expecting (beyond 29       PI10 Second time parents  
 weeks of pregnancy) or parents of newborns]       PI11 Third time or more parents  
     PI12 Teen parents  
     PI13 Hispanic parents  
     PI14 Native American parents  
     PI15 African American parents  
     PI16 Those not being served by  
    Children First or SoonerStart

### **Community Services Information** (Check the appropriate boxes)

Type of Service	Services Available in Program Area
<b>County Health Department</b>	
<i>Women, Infant, and Children (WIC)</i> –nutrition education and supplemental food program for pregnant women and children under 5 years.	PI17
<i>Maternity Clinic</i> – prenatal care for uninsured or underinsured women	PI18
<i>Family Planning Clinic</i> – exams and birth control for men and women	PI19
<i>Well-Baby Clinic</i> - check-up for well babies 2 weeks to 2 years	PI20
<i>Well-Child Clinic</i> - check-up for well children 2 years to 21 years	PI21
<i>Well-Woman Clinic</i> – breast exams and PAP smears	PI22
<i>Guidance Services</i> – child psychological, developmental, speech, language, and hearing screenings and assessments with short term early intervention services	PI23
<i>SoonerStart</i> – early intervention program for children with developmental disabilities	PI24
<i>Immunizations</i> – infant, child care, school-aged, and adult immunizations	PI25
<i>Medical Clinics</i> - health care for sick or injured children	PI26

<b>Type of Service</b>	<b>Services Available in Program Area</b>
<i>Dental Clinic</i> – services for pregnant women and children	PI27
<i>Chronic Disease</i> – screenings and education for hypertension, diabetes, and cancer	PI28
<i>STD/HIV</i> – testing and counseling for sexually transmitted diseases including HIV	PI29
<i>Children First</i> –home visitation for first time mothers who are < 28 weeks pregnant	PI30
<b>Indian Health Services or Tribal Health Care</b>	
Family medicine – <i>prenatal care, well-baby, illnesses, and injuries</i>	PI31
<i>Nutrition</i> – outpatient planning and education	PI32
<i>Dentistry</i> - dental health needs	PI33
<i>Counseling</i> – outpatient services for counseling or health education	PI34
<b>Department of Human Services</b>	
<i>Temporary Assistance for Needy Families (TANF)</i> - cash assistance to meet basic needs for families on a time-limited basis (Formerly AFDC)	PI35
<i>Day Care Assistance</i> – assist families to meet the cost of child care for children while parent(s) are at work, at school, or work-related training	PI36
<i>Food Stamps</i> – monthly benefits to purchase food	PI37
<i>Energy Assistance</i> – seasonal assistance for winter heating bills or if family has received utility cut-off notices	PI38
Disability Benefits (SSI/SSA) – <i>assistance for children with disabilities or special health care needs</i>	PI39
<i>Family Support Assistance</i> – help families to care for children with developmental disabilities	PI40
<b>Health Insurance</b>	
Medicaid - <i>includes SoonerCare Plus or SoonerCare Choice received through the Health Care Authority</i>	PI41
<b>Housing and Urban Development</b>	
<i>Housing Assistance</i> - HUD, Section 8	PI42
<b>Other Community Services</b>	
Childbirth or Prenatal Classes – <i>preparation for birth of child</i>	PI43
<i>Adult Education Programs</i> - GED, College, Literacy, Vo-Tech	PI44
<i>Community Resources</i> - food, toys, diapers, clothing or furnishings	PI45
<i>Legal Aid, legal assistance</i>	PI46
<i>Family Violence Programs</i> - prevention, intervention, or treatment	PI47
<i>Crisis Intervention</i> - assistance with management of crisis situations	PI48
<i>Counseling (Individual/Group)</i> - family violence, marital, etc.	PI49
<i>Drugs/Alcohol Programs</i> - prevention, intervention, or treatment	PI50
<i>Emergency Child Care</i> – crisis related, emergency child care	PI51
Job Readiness and Counseling – <i>services through the Oklahoma Employment Security Commission, vo-techs, colleges, or universities</i>	PI52
Other family support programs – <i>Parents as Teachers, Parents Anonymous, First Steps, Adopt-A-Caseworker</i>	PI53
Early Head Start – <i>early education and socialization of children</i>	PI54
<i>Personal Safety/Violence Prevention Life Skills Training</i> – prevention lessons	PI55
<i>Life Management Skills Training</i> – teach living skills such as how to access health care, shopping, budgeting and financial management, problem-solving and how to apply for employment	PI56

Type of Service	Services Available in Program Area
<i>Parenting Support Telephone Line – answer questions about parenting, child development, community resources, and concerns</i>	PI57
<b>Program Services</b>	
<i>Respite Care – short term care services for children who have disabilities, chronic or terminal illness, or experienced/in danger of maltreatment</i>	PI58
<i>Parent Education Groups – 4-10 weekly sessions, 1-2 hours per session, structured curricula with specific enrollment</i>	PI59
<i>Parent Support Group – informal, open-ended regularly scheduled parent meetings in a discussion format</i>	PI60
<i>Individual Parent Education Consultation – individual, agency-based sessions</i>	PI61
<i>Child Care – child care that assists parent(s) in attending program services</i>	PI62
<i>Transportation Assistance – to community resources such as health care or program services</i>	PI63
<b>Other Services</b>	
<b>Smoking Cessation</b>	
(Specify)	PI64
(Specify)	PI65
(Specify)	PI66

# Instructions for Staff/Volunteer Information Form

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## Purpose

Used to gather information on the program staff such as comparative statistics and experience with child abuse and neglect prevention and family support services. Only volunteer staff who serve in a professional capacity need to complete the form.

### Staff/Volunteer Information

SV1 *First Name* – Record the legal first name of the staff member or program volunteer.

SV2 *Maiden Name* – Record the legal maiden name of the staff member or program volunteer. If the staff member or program volunteer is male, record the last name.

SV3 *Last Name* – Record the legal last name of the program staff or program volunteer.

SV4 *Date of Employment* – Record the first day (mm/dd/yyyy) of employment for of the staff member, or the first day of service for the program volunteer.

SV5 *Date of Resignation* – Record the last day (mm/dd/yyyy) of service for the staff member or program volunteer.

SV6 *Languages* – Record language besides English that the staff member or program volunteer speaks in the home.

SV7 *Employment* – Record the level of staff member employment or the level of volunteerism for the program volunteer.

SV8 *Education* – Record the highest level of education that the staff member or program volunteer has achieved.

SV9 Record all of the job titles that describe the staff member's or program volunteer's position:

*Program Director/Manager* – Code Agency Administrator in this category.

*Program Coordinator* – Code Program Supervisor in this category.

*Administrative Supervisor.*

*Clinical Supervisor.*

*Family Assessment Worker.*

*Family Support Worker.*

*Community Outreach Worker.*

*Child Development Specialist.*

*Parent Educator* – Code Center-Based Services Leader in this category.

*Support Staff.*

*Child Care Worker.*

*Transportation Provider.*

*Public Speaker.*

*Other* – Record other job title.

*SV10 Months Educational Experience* – Record the number of months and educational experience the staff member or program volunteer has in child abuse and neglect and prevention issues.

*SV11 Months Class Experience* – Record the number of months experience the staff member or program volunteer has in parenting classes.

*SV12 Months Home Visiting Experience* – Record the number of months experience the staff member or program volunteer has in delivering home visitation services.

*SV13 Months Childhood Education Experience* – Record the number of months experience the staff member or program volunteer has in delivering childhood education programs.

## STAFF/VOLUNTEER INFORMATION FORM

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### **Staff/Volunteer Information**

SV1. First name: \_\_\_\_\_ SV2. Maiden name: \_\_\_\_\_ SV3. Last name: \_\_\_\_\_

SV4. Date of employment/volunteer effort (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

SV5. Date of resignation from position (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

SV6. Other languages spoken in home:  None  American Sign Language  
(Language other than English)  Spanish  Other, specify \_\_\_\_\_

SV7. Employment:  Full time employed (35+ hours/week)  Part time employed (<35 hours/week)  
(Check one)  Full time volunteer (35+ hours/week)  Part time volunteer (<35 hours/week)  
 Contract employee

**SV8. Education level:**  GED  Associates degree  
(Check highest level completed)  High school graduate  Bachelors degree  
 Some college/post high school training  Graduate degree

SV9. Job title(s):  Program Director/Manager  Child Development Specialist  
(Check all that apply)  Program Coordinator  Parent Educator  
 Administrative Supervisor  Support Staff  
 Clinical Supervisor  Child Care Worker  
 Family Assessment Worker  Transportation Provider  
 Family Support Worker  Public Speaker  
 Community Outreach Worker  Other, specify \_\_\_\_\_

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### **Prior Experience – at the time of initial employment/volunteering**

SV10. Number of months educational experience in child abuse and neglect/prevention issues: \_\_\_\_

SV11. Number of months experience in presenting parenting classes: \_\_\_\_

SV12. Number of months experience in home visiting: \_\_\_\_

SV13. Number of months experience in early childhood education programs: \_\_\_\_

## Appendix 1. Linking Forms to the Logic Model

The logic model is an integral part of the OCAP program structure and direction. The data collection forms are the main instruments by which we gain information to measure the elements on the logic model; however, it begs the question – How is the logic model related to the data collection forms? This quick guide will give you an idea of which elements on the logic model are measured by or related to the data collection forms.

Evaluation Domain	Evaluation Measure and Related Data Collection Form
<b>Primary Caregiver Health</b>	<ul style="list-style-type: none"> <li>❖ Health Insurance Coverage               <ul style="list-style-type: none"> <li>○ PCG Intake &amp; Update forms, Pregnancy &amp; Birth form</li> </ul> </li> <li>❖ Adequate Prenatal Care               <ul style="list-style-type: none"> <li>○ PCG Intake &amp; Update forms</li> </ul> </li> <li>❖ Reduction in smoking, alcohol and drugs use               <ul style="list-style-type: none"> <li>○ PCG Health form</li> </ul> </li> <li>❖ Personal Care               <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ Depression               <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory, Edinburgh Post-natal Depression Scale.</li> </ul> </li> <li>❖ Nutrition &amp; Exercise               <ul style="list-style-type: none"> <li>○ PCG Health Form</li> </ul> </li> </ul>
<b>Child Health &amp; Development</b>	<ul style="list-style-type: none"> <li>❖ Health Insurance Coverage               <ul style="list-style-type: none"> <li>○ Pregnancy and Birth Form, Child Health Form</li> </ul> </li> <li>❖ Immunizations               <ul style="list-style-type: none"> <li>○ Child Immunization Form</li> </ul> </li> <li>❖ Child Development               <ul style="list-style-type: none"> <li>○ ASQ/ASQ: SE</li> </ul> </li> <li>❖ Lead Assessment               <ul style="list-style-type: none"> <li>○ LERAQ &amp; Lead Assessment Log</li> </ul> </li> <li>❖ Normal birth weight delivery               <ul style="list-style-type: none"> <li>○ Pregnancy and Birth form</li> </ul> </li> <li>❖ Breast Feeding               <ul style="list-style-type: none"> <li>○ PCG Intake and Update Form, Child Health Form</li> </ul> </li> <li>❖ Home environment               <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ Nutrition/Physical Activity               <ul style="list-style-type: none"> <li>○ Child Health Form</li> </ul> </li> <li>❖ Reduction in smoking around children               <ul style="list-style-type: none"> <li>○ Child Health Form.</li> </ul> </li> <li>❖ Adequate Childcare               <ul style="list-style-type: none"> <li>○ Child Health Form</li> </ul> </li> </ul>

Evaluation Domain	Evaluation Measure and Related Data Collection Form
<b>Family Stability</b>	<ul style="list-style-type: none"> <li>❖ Referred to public assistance program <ul style="list-style-type: none"> <li>○ Services Utilization Form</li> </ul> </li> <li>❖ Improve family stability <ul style="list-style-type: none"> <li>○ PCG Intake and Update Form</li> </ul> </li> <li>❖ Housing stability <ul style="list-style-type: none"> <li>○ PCG Intake and Update Form.</li> </ul> </li> <li>❖ Problem-solving <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ Social Support <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ Mobilizing Resources <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ PCG update form Subsequent Pregnancy <ul style="list-style-type: none"> <li>○ PCG update Form</li> </ul> </li> <li>❖ Strengthen Parent Relationships <ul style="list-style-type: none"> <li>○ Service Utilization Form</li> </ul> </li> </ul>
<b>Positive Parenting &amp; Parent Child Interaction</b>	<ul style="list-style-type: none"> <li>❖ Parenting Efficacy <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ Role Satisfaction <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ Parent/Child Behavior <ul style="list-style-type: none"> <li>○ Healthy Families Parenting Inventory</li> </ul> </li> <li>❖ Father Involvement <ul style="list-style-type: none"> <li>○ Relationship Assessment Form</li> </ul> </li> </ul>
<b>Family Safety</b>	<ul style="list-style-type: none"> <li>❖ Improved Safety Practices <ul style="list-style-type: none"> <li>○ Home safety Form</li> </ul> </li> <li>❖ Utilization of ER &amp; Hospitalizations <ul style="list-style-type: none"> <li>○ Child Health Form</li> </ul> </li> <li>❖ Domestic Violence <ul style="list-style-type: none"> <li>○ Relationship Assessment Form</li> </ul> </li> <li>❖ Reporting to Child Protective Service <ul style="list-style-type: none"> <li>○ Participant Activity Form</li> </ul> </li> <li>❖ Decrease removal of children from their homes <ul style="list-style-type: none"> <li>○ Participant Activity Form</li> </ul> </li> </ul>

## References

### *The Development*

The development of the OCAP evaluation in 1999 (and subsequent revisions) was based upon extensive research of child abuse and neglect prevention programs in Oklahoma, other states, and countries, past and current program evaluations, recommendations for future prevention program evaluations, and the needs of the Office of Child Abuse Prevention.

#### INFORMATION SOURCES:

- Delaware Children's Trust Fund
- Wisconsin Children's Trust Fund
- Massachusetts Children's Trust Fund
- Tufts University
- Vermont Children's Trust Fund
- Alabama Children's Trust Fund
- Montgomery Children's Trust Fund
- Meld
- Oklahoma State Cooperative Extension – Healthy Families Pottawatomie County
- Great Plains Youth and Family Services
- Exchange Club Parent Child Center for the Prevention of Child Abuse of Oklahoma, Inc.
- Washington County Health Department
- Parent-Child Center of Tulsa, Inc.
- Help-in-Crisis, Inc., Tahlequah
- Oklahoma State University, Cooperative Extension
- University of Alabama
- McClain-Garvin County Youth and Family Center, Inc.
- Latino Community Development Agency
- Office of Child Abuse Prevention
- Children First
- OSDH Forms Committee
- OSDH DASH Committee
- Maternal and Child Health Service, Assistant Chiefs

#### REFERENCES (web site, published materials, and forms):

- National Indian Welfare Association (www)
- Welfare Information Network (www)
- National Network for Family Resiliency (www)
- Prevent Child Abuse America (www)
- Zero to Three (www)
- Evaluation Research – Child Abuse and Neglect Clearinghouse (www)
- Using Software Systems to Measure Non-Profit Program Outcomes – Kennedy School of Government (www)

#### REFERENCES (web site, published materials, and forms), continued:

- Overcoming Structural Barriers to the Prevention of Child Abuse and Neglect: A Discussion Paper, Australian Institute of Family Studies (www)
- Parenting Education Decision Framework (www)
- Mixed Methods Evaluation – National Science Foundation (www)
- Recommended Framework for Program Evaluation in Public Health, Centers for Disease Control and Prevention (CDC) (www)

- Investing in Our Children: What We Do Know and What We Don't Know About Costs and Benefits of Early Childhood Interventions, RAND Corporation (www)
- National Center on Child Abuse and Neglect, Nine Model Site Evaluations, Lessons Learned (www)
- Targeting Prevention Services: The use of Risk Assessment in Hawaii Healthy Start Program, Prevent Child Abuse America (www)
- Center for Evaluation Research (www)
- National Clearinghouse on Child Abuse and Neglect (www)
- Healthy People 2000 (published)
- Developing an Integrated Public Health Data System in New Mexico, Maternal and Child Health Bureau, Department of Health and Human Services (DHHS) (published)
- Guidelines for Evaluating Surveillance System, Morbidity and Mortality Weekly, CDC (published)
- Health State Initiative, Community Outreach, Health Resources and Services Administration (HRSA) (published)
- The Future of Children, Vol 8, no.1, Spring 1998, Packard Foundation (published)
- The Future of Children, Vol 9, no.1, Summer 1999, Packard Foundation (published)
- Healthy Families America, Using Research to Enhance Practice (published)
- Measures for Clinical Practice (published)
- Program Information Management System, Healthy Families America (manual)
- Prenatal Early Childhood Nurse Home Visitation, Kempe Prevention Research Center for Family and Child Health (manual)
- Parenting Program Evaluation Manual, The National Center on Child Abuse Prevention Research (manual)
- Community-Based Family Resource and Support Program Model Site Evaluation (manual)
- Adult-Adolescent Parenting Inventory, Family Development Resources
- H.O.M.E. scale, Home Inventory Limited Liability Company
- Client Satisfaction Survey, Tufts University
- KIDS Questionnaire, Dr. Arlene Fulton
- Problem Oriented Prenatal Risk Assessment System, (Oklahoma State Department of Health, Maternity Clinic manual)
- Immunization schedules
- Pregnancy Risk Assessment Monitoring System questionnaire
- Community-Based Family Resource and Support Programs (forms)
- Oklahoma State Department of Health Family Planning Clinic (manual)
- Oklahoma State Department of Health Invitation to Bid for 3-yr community-based family resource and support programs through the Child Abuse Prevention-Fund – SFY2000 (printed)
- The Oklahoma State Plan to Prevent Child Abuse: 1996-1998 (printed)
- The Oklahoma State Plan for the Prevention of Child Abuse and Neglect: Year 2002 (printed)
- Child Abuse Prevention Act (published)

## Frequently Asked Questions

1. What forms do I fill out if there is a **temporary** change of caregiver for the child?
  - DO NOT fill out a Participant Activity Form indicating that there has been a change of caregiver. This would be for a **permanent** change only.
  - The FSW should continue doing the data collection forms related to the child (i.e. all of the child forms) and the forms that relate to the visit process (i.e. the Home Visit Encounter Log and the Service Utilization Form).
2. **What forms do I fill out if there is a permanent change of caregiver for the child?**
  - Complete a Participant Activity Form indicating there has been a change of caregiver (Option #P2, a & b)
  - Complete a PCG Update Form with the new Primary Caregiver
  - Follow up forms are to be completed by new PCG according to forms schedule
  - Give the forms to the data entry staff person so that he/she can permanently change the PCG in OCAPPA
3. Do I fill out a Service Utilization Form if I provide the service to the participant?
  - No. The Service Utilization Form is intended to capture services to which you refer the participant and the result of those referrals. If you provide the service yourself (for example, you bring diapers that the family needs), that is not considered a referral and should not be indicated as such on the Service Utilization Form.
4. What if I can't get my completed forms in to the data support person within 24 hours?
  - You should always try to get your data form to the data entry staff person within 24 hours of completing the form. However, if this is not possible, get it to him/her as soon as you can once you return to the office.
5. On the Family Assessment Form, do I wait until I know the follow-up information to give the form to the data entry staff?
  - Yes. Wait until you have all of the pertinent information on the form to give the form to the data entry staff to put into OCAPPA.
6. On the forms that are "logs," do I wait until the whole log is completed to turn it in to the data entry staff?
  - NO. Data that is entered on logs (i.e., Home Visit Encounter Log, Child Development Screening Log, etc.) should be entered **after each log entry**.
7. On the Child Development Screening log, if I was not able to complete the ASQ for a certain time period, what do I put for the date it was completed?

- If one of the ASQ tools was not completed, you would not put a date. However, you would indicate that, for that particular ASQ, the child was not screened on schedule.

8. If somebody does not agree to participate in program evaluation, do I still administer all the forms?

- Yes, you would still complete the forms as with other families. Evaluation is part of service delivery, several evaluation forms inform the FSW of the strengths and weakness of a family and provide a guide to achieving program goals. However, if the participant insists on not including their information, inform the evaluator at OCAP central office. Those who did not consent to participate in evaluation will not be included in the statistical summary numbers.

9. On the Center-Based Activity Summary form, do we put how many times each participant has attended an activity since the beginning of the State Fiscal Year, or from when they began initially attending center-based activities?

- This is the number of times that the participants have ever attended, regardless of when they began.

20. What child forms do I fill out if there is a **family with multiple children from one birth?**

- If there are twins/triplets/quadruplets, complete the forms as outlined in the forms manual for multiples. The forms you do for each child in multiples are:

- Pregnancy and Birth
- Child Health
- Immunization Log
- Child Development Screening Log
- Lead Assessment Log

- If there are twins/triplets/quadruplets, complete the following forms for the FIRST BORN twin/triplet only:

- Safety Form
- HFPI

- If there are twins/triplets/quadruplets, add each child in the set to the PCG in OCAPPA and enter all paper forms.

11. The Home Visit log and the Lead Assessment log has a "today's date" on the computer form, but not on the paper form. What date do we put there?

- You can put the date of the most recent log entry, and update this date every time you enter the form to be the date of the most recent log entry. That way, when you look at the Family Tree View, you can automatically see the most recent entry that you did.

12. On the Child Health Form – CH6, “If the child was outside the recommended age range when the shot was received, or the shot was not given in the month it was due,

then the child's immunizations are not current." For an older child, if the shots were behind at some point will it always be "NO" on up-to-date?

- The current status of immunizations become "on schedule" after the immunization is given at the next opportunity. It should not be recorded as "not current" after one shot is missed or the child falls behind but is brought current.

13. On the Child Health Form – CH21, if the PCG doesn't know the star rating to look it up at the office. However, the instructions say "Indicate PCG's response to the DHS star rating of child care facility." It does not give an option if PCG does not know.

- The phone number to obtain the star rating is **888-962-2772**. The importance of the question is not to find out what the PCG knows, but the Star Rating level of the center the PCG chose for daycare.

14. On the Home Safety Form –HS28, could there be an "N/A" to mark for children too old for the situation?

- If you refer to the gray boxes that separate each section on the form, you will see that some of the sections indicate to complete only if the child is "less than one year".

15. If a family is re-activated, do we count the original enrollment date or the reinstatement date on our forms as the enrollment date?

- Enrollment date will always be the original date on which the family started the program not the reinstatement date.

16. How do we show services that we referred a family pre 02-04-08 that are still ongoing? i.e. Sooner Care or Food Stamps.

- On the Service Utilization Form, mark them as an ongoing service.

17. It is my understanding that the PAF should only have one entry on it. However, it is conceivable that the P1 (PCG) Assessment Positive – Enrolled and the P12 Child begins the program, so a & b could occur on the same date and could be documented on the same PAF. Is this possible?

- You can only use the PAF for one function at a time. Also, you should never enter the PAF for "child enrolled" – it is auto-generated when you add a new client to the family.

18. On the Service Utilization Form, once a specific service has been documented on the SUF, it is not completed again unless a change in service delivery has occurred, or is it completed every time even if the service delivery is the same as it was the previous home visit?

- The SUF is meant to be available on every home visit to document referrals or change of service. So if no changes have occurred with the family, or referrals made, then you would not fill it out for that visit. However it is important that if an FSW or FAW make a referral, whether the family act on it or not, the referral is documented.
19. Do we need to do the LERAQ on families whose identified child has already had a blood screening by the PCP?
- LERAQ has to be administered to all children each year even if they already have had a blood test in the past. Following schedule is important since the circumstances around the child can change each year and/or a positive blood test case may be resolved in a few months and can be at risk of having positive assessment result again at the next scheduled LERAQ administration. Also, in Oklahoma, not all of the Medicaid children are tested regularly by their PCP's for blood lead levels at 12 and 22 months. These children would remain undetected for lead poisoning if we do not administer LERAQ according to the schedule.
20. The local pediatrician's office does the same lead screen we use. Can we use his screen as documentation rather than doing one ourselves and duplicating?
- Yes, you can use his screening for documentation if you can get a copy to file in the family folder. Enter the result of that screen on the "Child Lead Assessment Log".
21. **What forms do I fill out if there is a family that is transferring to a new OCAP site?**
- Refer to Programs Procedure Manual SFY 2009, pg 66-67 for complete process
  - Old site enters all completed forms in the OCAPPA database
  - Old site completes and faxes the first half of the Family Transfer Form to new site & central office
  - New site completes a home visit with the transferring family
  - After a completed home visit, new site completes the second half of the transferring form and faxes to old site and central office.
  - OCAPPA administrator (Amber Sheikh or Lori Owen) transfer the family to the new site
  - New site completes a Participant Activity Form, choosing option P8.
  - If contact is not made with the family at new site then transfer does not take place; Old site completes a Participant Activity Form indicating option P3.b)