

Chapter 4

2017

**ADDENDUMS TO NFP & MIECHV FORMS
AND INSTRUCTIONS**

MIECHV Demographics: Pregnancy – Intake

Client ID Client Name DOB

Client SSN

Date Nurse Home Visitor ID Nurse Home Visitor Name

Section I - Personal/Family – This section is to be entered into the View/Edit Client Demographics screen in ETO.

1. ♦Client's DOB: _____
M1. Client's EDD: ____/____/____
2. ♦Ethnicity (check one):
 - Hispanic or Latina
 - Not Hispanic or Latina
 - Declined to self-identify
3. ♦Race (check all that apply)
 - American Indian or Alaska Native
 - Asian
 - Black or African-American
 - Native Hawaiian or other Pacific Islander
 - White
 - Declined to self-identify
4. Client's Ancestry (check all that apply):

<ul style="list-style-type: none"> <input type="checkbox"/> Afro-Caribbean, excluding Haitian <input type="checkbox"/> Anglo-Dutch Caribbean <input type="checkbox"/> Arab <input type="checkbox"/> Bangladeshi/Bengali <input type="checkbox"/> Central American, including Mexican <input type="checkbox"/> Chinese <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Eritrean <input type="checkbox"/> Filipino <input type="checkbox"/> Haitian <input type="checkbox"/> Hmong <input type="checkbox"/> Indian (South Asian) <input type="checkbox"/> Israeli <input type="checkbox"/> Korean 	<ul style="list-style-type: none"> <input type="checkbox"/> Laotian <input type="checkbox"/> North African <input type="checkbox"/> Pakistani <input type="checkbox"/> Palestinian <input type="checkbox"/> Persian <input type="checkbox"/> Polish <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Russian <input type="checkbox"/> Somali <input type="checkbox"/> Sub-Saharan African <input type="checkbox"/> South American <input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____ (please specify)
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MIECHV Demographics: Pregnancy – Intake

5. ♦ Client's Primary Language (check only one):

- | | |
|---|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Mandarin |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Creole (Haitian) | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> French | <input type="checkbox"/> Tribal Languages |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Japanese | |

6. ♦ Client's Zip Code: _____

Section II – Other Demographics

1. ♦ Are you participating in this program voluntarily?

- Yes
 No

2. ♦ Marital Status:

- Married (legal or common law)
 Single - never married
 Widowed
 Divorced
 Separated
 Not Married – living with partner

3. ♦ How often do you usually see or talk to the baby's biological father?

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

4. ♦ With whom do you live? (check only one from options 1 – 5)

- Live with others (check all that apply)
- Client's mother
 - Father of Child (FoC)
 - Current husband/partner (not FoC)
 - Other family members
 - Infant/child
 - Other adults
- Live alone (or with infant/child)
 Live in a group home/shelter
 Confined to an institutional facility (residential treatment facility, incarcerated)
 Homeless
- Homeless and sharing housing (skip to 6)
 - Homeless and living in emergency or transitional shelter (skip to 6)
 - Other (skip to 6)

MIECHV Demographics: Pregnancy – Intake

5. ♦ If you are not homeless, where do you currently live?
- Owns or shares own home, condominium, or apartment
 - Rents own home, condominium, or apartment
 - Lives in public housing
 - Lives with parent or family member
 - Other
6. ♦ Which members of your family are in the Military – active or reserve? (check all that apply)
- Self (client)
 - Client's spouse
 - Client's parent(s)
 - Father of child (FoC)
 - None

M2. Which members of your family are currently serving or **formerly** served in the military – active or reserve? (*Check all that apply.*)

- | | |
|---|--|
| <input type="checkbox"/> Index Parent | <input type="checkbox"/> Father of the Child |
| <input type="checkbox"/> Index Parent's Spouse | <input type="checkbox"/> Mother of the Child |
| <input type="checkbox"/> Index Parent's Parents | <input type="checkbox"/> None |

Section III - Education and Income

7. ♦ Are you currently enrolled in middle or high school?
- Yes – middle school (6th – 8th grade)
 - Yes – high school or GED program (includes alternative and technical programs)
 - Not enrolled
8. ♦ Have you completed high school or a GED or vocational/certification program?
- Yes - completed high school
 - Yes - completed GED
 - Yes - completed vocational/certification program
 - No. If no, what is the last grade you have completed? grade (skip to 12)
9. ♦ If you have completed high school/GED, are you currently enrolled in any kind of school, vocational, certification or educational program?
- Yes
 - Full Time – 12 semester hours or equivalent
 - Part Time
 - 7 – 11 semester hours or equivalent
 - 6 or less semester hours or equivalent
 - No (skip to 11)
10. ♦ What type of educational program are you currently enrolled in?
- Post-high school vocational/certification/technical training
 - College

MIECHV Demographics: Pregnancy – Intake

11. ♦ Have you completed education other than high school/GED (mark the highest level)?

- Vocational/certification/technical training program (beyond high school)
- Some college (no degree)
- Associate's degree
- Bachelor's degree
- Master's degree
- Professional degree (e.g.: LLB, LD, MD, DDS)
- Doctorate degree (e.g.: PhD, EdD)
- No

12. ♦ Do you **have a** plan to enroll in any ***additional*** kind of school, vocational, certification or educational program?

- Yes
- No

M3. When you think about your ***most recent experience*** in school or classes, how would you rate your own learning and achievement level?

- High
- Average
- Low
- Unknown

13. ♦ Are you currently working?

- Yes
 - Full-time: 37+ hours per week
 - Part-time
 - 20 – 36 hours per week
 - 10 – 19 hours per week
 - less than 10 hours per week
- No
 - Unemployed and seeking employment
 - Not employed (student, homemaker, other)

MIECHV Demographics: Pregnancy – Intake

14. ♦ Which of the following categories best describes your total **yearly** household income and types of benefits you receive? Include your income and any other income you may have received. For the purpose of this question, the household should include only you and your child. Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).

Sources of household income include (please check all that

- apply) Salary/wages from employment
 Social Security/Disability
 TANF
 Alimony
 Child
 Support
 Rent from tenants
 Cash Assistance from friends/relatives
 Unemployment

Other income (please specify) _____

- Less than or equal to \$6,000
 \$6,001 - \$9,000
 \$9,001 - \$12,000
 \$12,001 - \$16,000
 \$16,001 - \$20,000
 \$20,001 - \$30,000
 Over \$30,000
 Client is dependent on parent/guardian

- M4. Last **month**, what was your gross **TOTAL HOUSEHOLD** income from employment and any benefits you receive? *All information will be kept private and will not affect any services you are now getting.*

- | | |
|--|--|
| <input type="checkbox"/> \$250 or less | <input type="checkbox"/> \$1,751 - \$2,000 |
| <input type="checkbox"/> \$251 - \$500 | <input type="checkbox"/> \$2,001 - \$2,250 |
| <input type="checkbox"/> \$501 - \$750 | <input type="checkbox"/> \$2,251 - \$2,500 |
| <input type="checkbox"/> \$751 - \$1,000 | <input type="checkbox"/> \$2,501 - \$2,750 |
| <input type="checkbox"/> \$1,001 - \$1,250 | <input type="checkbox"/> \$2,751 - \$3,000 |
| <input type="checkbox"/> \$1,251 - \$1,500 | <input type="checkbox"/> \$3,001 or more |
| <input type="checkbox"/> \$1,501 - \$1,750 | <input type="checkbox"/> Don't Know |

M5. Number of Adults in Household: _____ M6. Number of Children in Household: _____

15. ♦ Do you (client) qualify for TANF, Medicaid, WIC or Foodstamps?

- Yes
 No

MIECHV Demographics: Pregnancy – Intake

16. ♦ In the past 6 months, have you (client) obtained care at the hospital emergency room for any reason?

Yes

If yes, what was the purpose of the visit (please check all that apply)?

- Injury – Accidental, how many times? times
- Injury – Intentional self inflicted, how many times? times
- Injury – Intentional other inflicted, how many times? times
- Injury – Declined, how many times? times
- Ingestion – Accidental, how many times? times
- Ingestion – Intentional self inflicted, how many times? times
- Ingestion – Intentional other inflicted, how many times? times
- Ingestion – Declined, how many times? times
- Respiratory infection, how many times? times
- Fever, how many times? times
- Other (please specify) _____, how many times? times

No

17. ♦ In the past 6 months, have you (client) obtained care at the urgent care center for any reason?

Yes

If yes, what was the purpose of the visit (please check all that apply)?

- Injury – Accidental, how many times? times
- Injury – Intentional self inflicted, how many times? times
- Injury – Intentional other inflicted, how many times? times
- Injury – Declined, how many times? times
- Ingestion – Accidental, how many times? times
- Ingestion – Intentional self inflicted, how many times? times
- Ingestion – Intentional other inflicted, how many times? times
- Ingestion – Declined, how many times? times
- Respiratory infection, how many times? times
- Fever, how many times? times
- Other (please specify) _____, how many times? times

No

MIECHV Demographics: Pregnancy – Intake

18. ♦ Do you (client) have health insurance coverage?

- Yes (If yes, which type of health insurance do you use when you go for medical care; please check all that apply)
- Medicaid
 - CHIP
 - Tri-Care
 - Private
 - Other (please specify) _____
- No

M7. Do you have a history of substance abuse or need substance abuse treatment?

- Yes
- No
- Unknown

M8. Do you use tobacco products?

- Yes
- No

M9. Have you had a history of child abuse or neglect and/or involvement with child welfare services either as a child or as an adult?

- Yes
- No
- Unknown

Instructions for the MIECHV DEMOGRAPHICS: PREGNANCY INTAKE Form

When to complete this form: At the time of Enrolling the Client into the MIECHV program (1st Visit).

The following MIECHV Reporting Data Points have been incorporated into the ETO Demographics: Pregnancy Intake form:

Item Instructions

Item	Guidelines
M1. Expected delivery date	The date that the mother's current pregnancy's baby is estimated to be delivered on. <i>MM/DD/20YY</i>
M2. Which members of your family are currently serving or formerly served in the military – active or reserve? (Check all that apply)	<i>Based on self-report</i> , families that include individuals who are serving or formerly served in the Armed Forces.
M3. When you think about your (client's) most recent experience in school or classes, how would you rate your own learning and achievement level?	<i>Based on self-report</i> , mother's self-perception of their achievement level during their most recent experience in school or classes.
M4. Last month, what was your (parent's) gross TOTAL HOUSEHOLD income from employment and any benefits you receive? All information will be kept private and will not affect any services you (parent) are now getting.	Reassure parent that income information will not be used to determine eligibility in any programs or affect any services they are now getting. <i>Based on self-report</i> , what was the total household income, before taxes, last month? <u>For 2-parent households, include both parents' income and benefits. If household income/benefit source includes someone other than parents, include that also.</u> Include all of these Income Sources: Paycheck or money from a job Benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) Money from a business, fees, dividends, or rental income Child support or alimony Social security, workers' compensation, disability, veteran benefits or pensions Unemployment benefits
M5. Number of adults in household	Total number of adults living in household. Include any adults who stay in the household at least 4 nights a week.
M6. Number of children in household	Total number of children living in household. Includes Index child and any other children, ages Birth – 18 yrs old, who stay in the household at least 4 nights a week.
M7. Do you have a history of substance abuse or need substance abuse treatment?	<i>Based on self-report</i> , a mother who has a history of substance abuse or who has been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.
M8. Does you use tobacco products?	<i>Based on self-report</i> , mothers who use tobacco products in the home or who have been identified as using tobacco through a substance abuse

	screening administered during intake. Include use of smokeless tobacco and electronic cigarettes.
M9. Have you had a history of child abuse or neglect and/or involvement with child welfare services either as a child or as an adult?	<i>Based on self-report</i> , a Client who has a history of abuse or neglect and/or has had involvement with child welfare services either as a child or as an adult.

N1
Addendum to Clinical IPV Assessment Form
5th – 7th VISIT
To be completed within 6 months of parent's enrollment

***Reminder: Only return this Addendum to state. Do not return Clinical IPV Assessment to state.*

Name of Home Visitor: _____

NFP ID # of Mother: _____

Name of Mother: _____

1. Clinical IPV Assessment completed (with *mother*)?

Yes, completed → **Date Assessment completed:** ____ / ____ / 20 ____ → *Go to Question 1a.*

1a. If Yes, result of Clinical IPV:

Score indicates risk of IPV → *Go to Question 1b.*

Score does not indicate risk of IPV

1b. If Score indicates risk of IPV, did you give referral information?

Yes

No, client refused a referral and/or services

No, an earlier referral is still in process

No, the client is not ready for a referral

No, a referral is not needed at this time

No, other reason

No, not completed → *Go to Question 1c.*

1c. If No, reason why Clinical IPV not completed:

Concern previously identified

Client not currently in a relationship

Other

Instructions for the MIECHV

N1

Addendum to: CLINICAL IPV ASSESSMENT Form

When to complete this form: Within 6 months of Enrolling the Client into the MIECHV program, at the 5th – 7th visit.

Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this family.
NFP ID # of Mother	The Mother's NFP ID #.
Name of Mother	The Mother who signed up to participate in the MIECHV Program.
Clinical IPV Assessment Completed (with <i>mother</i>)?	Was the Clinical IPV Assessment completed to screen for Domestic Violence? If it was, enter the date that the assessment was completed. If it was completed, go to Question 1a. DO NOT send the Clinical IPV Assessment to the state.
If Yes, Result of Clinical IPV	If the Clinical IPV Assessment was completed, indicate if the score indicates risk of IPV or does not indicate risk of IPV. If the score does indicate risk of IPV, go to Question 1b.
If a Score indicates risk of IPV, did you give referral information?	Was a referral made? If not, indicate the reason why.
If No, reason why Clinical IPV not completed	If the Clinical IPV Assessment was not completed, indicate if the reason was either because Concern previously identified, Client not currently in a relationship, or Other reason.

M2B
MIECHV REFERRALS TRACKING & FOLLOW-UP – INDEX PARENT
 Please send this form to the State MONTHLY with updates
 (due by the 15th of the following month)

Name of Home Visitor: _____

Home Visiting Program: Early Head Start Healthy Families Oregon Nurse-Family Partnership

Parent ID #: _____

Name of Index Parent: _____

	INITIAL REFERRAL	FOLLOW-UP
Type of Service	Date Referred to Service	Date Service Started/Received
1) Depression	/ / 20	/ / 20
1A) Depression	/ / 20	/ / 20
1B) Depression	/ / 20	/ / 20
1C) Depression	/ / 20	/ / 20
2) Tobacco Cessation	/ / 20	/ / 20
2A) Tobacco Cessation	/ / 20	/ / 20
2B) Tobacco Cessation	/ / 20	/ / 20
2C) Tobacco Cessation	/ / 20	/ / 20

Instructions for the MIECHV

M2B-REFERRAL TRACKING & FOLLOW-UP FORM - INDEX PARENT

When to complete this form:

Initial Referral Section: Identification of needed services should be completed at the time of enrolling the Index Parent into the MIECHV program using your standard Home Visiting Model Process. The date referrals are made to needed services should be recorded ***any time they are made for the parent.*** This form should be sent to the state when any initial referral is made for the parent.

Note: For MIECHV, tracking is required for the limited number of referrals on this form. For your home visiting model, you will likely make and track additional referrals, however these are not required to be reported to MIECHV.

Follow-up Section: Following the initial referral for service, when the parent receives the service, record the date service is started or received. If the parent has not received the service, continue to follow up as appropriate encouraging the parent to access services for themselves when ready. During this time of follow up with the parent, send the referral tracking form monthly to the state when updates are made. A reminder email will be sent monthly to your program from the state requesting the updated form.

Referral Guidelines: A referral to services can be made directly by calling a community service agency and requesting services for the parent or by giving the parent a list of resources to call for assistance.

Referral Definitions:

1) Depression:

Referrals include those made for maternal depression. These referrals may include but are not limited to: mental health treatment, therapy, counseling, or primary care or other provider for prescription management. Please use your nursing judgment and talk with your supervisor if you are unsure if a referral you are making should be counted as a referral for depression treatment or services.

1A, 1B, 1C) Additional Referrals to Depression:

If there is more than one referral for Depression services, the second, third or fourth referrals can be recorded here.

2) Tobacco Cessation:

Referrals include those made for tobacco cessation counseling or services. These referrals may include: tobacco quit line, primary care provider, or other tobacco cessation programs.

2A, 2B, 2C) Additional Referrals to Tobacco Cessation:

If there is more than one referral for Tobacco Cessation services, the second, third or fourth referrals can be recorded here.

Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this index parent.
Parent ID#	The Mother's NFP ID #.
Name of Index Parent	Index Parent's name.
Initial Referral Section:	
Date Referred to Service	When a referral is made, date the referral to the service was made to the parent. <i>MM/DD/20YY</i>
Follow-up Section:	
Date Service Started/Received	Date service started or was received. <i>MM/DD/20YY</i>

MIECHV INFANT BIRTH



Infant ID	<input type="text"/>	Infant Name	<input type="text"/>	◆ Infant DOB*	<input type="text"/>
Client ID	<input type="text"/>	Client Name	<input type="text"/>	DOB	<input type="text"/>
Date	<input type="text"/>	Nurse Home Visitor ID	<input type="text"/>	Nurse Home Visitor Name	<input type="text"/>

Infant First Name: _____ Middle _____ Last _____

***Infant DOB to be entered into the View/Edit Client Demographics screen in ETO.**

Multiple birth

- Child's Ethnicity (check one):
 - Hispanic or Latina/Latino
 - Not Hispanic or Latina/Latino
- Child's Race (check all that apply)
 - American Indian or Alaska Native
 - Asian
 - Black or African-American
 - Native Hawaiian or other Pacific Islander
 - White
- Gender:
 - Male
 - Female
- Birth weight: grams or lbs. oz.
- ◆ Gestational age at birth: weeks
- ◆ Was (child's name) admitted to the NICU because of problems?
 - Yes, for how many days prior to being discharged? days
 - No. If no, did (child's name) have to spend any time in the special care nursery because of problems?
 - Yes, for how many days prior to being discharged? days
 - No

If yes, what was the purpose of the stay (please check all that apply)?

 - Low birth weight
 - Very low birth weight
 - Respiratory distress
 - Prematurity
 - Congenital defect
 - Other (please specify) _____
- ◆ What was your overall weight gain during pregnancy? lbs.
- ◆ Has your baby ever received breast milk?
 - Yes
 - No

MIECHV INFANT BIRTH



M1. If Yes receives breastmilk, is child continuing to get any breast milk?

- Yes
- No *If No, date child stopped getting breast milk? ____/____/____*

9. ♦ Type of labor

- Induced
- Not induced

10. ♦ Type of delivery

- Vaginal
- Caesarean

11. ♦ Did your child receive a newborn screening test in the nursery?

- Yes
- No
- Don't know

12. ♦ Did your child receive a hearing screening in the nursery?

- Yes
- No
- Don't know

Safe Sleep: For questions 13, 14, and 15, select 'N/A' if the infant is in the hospital when the form is completed

13. ♦ How often do you place your infant to sleep on their back?

- Always
- Sometimes
- Never
- N/A

14. ♦ How often do you bed-share with your infant?

- Always
- Sometimes
- Never
- N/A

15. ♦ How often does your infant sleep with soft bedding?

- Always
- Sometimes
- Never
- N/A

MIECHV INFANT BIRTH



16. ♦ During a typical week, how many days do you (and/or a family member) read, tell stories, and/or sing songs to your child?

- 0 1 2 3 4 5 6 7

17. ♦ Does your child have health insurance coverage?

- Yes
 No

If yes, which type of health insurance do you use when you take your child for medical care (please check all that apply)?

- Medicaid
 CHIP
 Tri-Care
 Private
 Other (please specify) _____

M2. Where do you usually take your child for medical care?

- Doctor's/Nurse Practitioner's Office
 Hospital Emergency Room
 Hospital Outpatient
 Federally Qualified Health Center (FQHC)
 Retail Store or Minute Clinic
 Other: _____

M3. Does your child have a usual source of dental care? Yes No

Instructions for the MIECHV INFANT BIRTH Form

When to complete this form: At the time of Enrolling the Index Child into the MIECHV program.

The following MIECHV Reporting Data Points have been incorporated into the ETO Infant Birth form:

Item Instructions

Item	Guidelines
M1. If Yes, Is child continuing to get any breast milk?	Is the index child currently getting any breast milk? If yes, same question is asked again, until child is weaned.
M1. If No, Date child stopped getting breast milk	<p>If child is completely weaned: after having no breast milk at all for <i>at least 2 weeks</i> – what was the date the child stopped getting breast milk? If exact date is not known or given, use these guidelines for different times of the month given (for example, parent says child stopped getting breast milk “the middle of last month”):</p> <p>Beginning of the month – Use month, 5th day and year Middle of the month – Use month, 15th day and year End of the month – Use month, 25th day and year</p> <p><i>MM/DD/20YY</i></p>
M2. Where do you usually take your child for medical care?	The particular medical professional, doctor’s office, clinic, health center, or other place where the parent would take the child if he/she were sick or in need of advice about their health.
M3. Does your child have a usual source of dental care?	HRSA does ask that this data item be reported at every age for every child. Does the child have a dental home where the child’s oral health care is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist?

N2
Addendum to NFP PHQ-9 Form

To be completed within 3 months of infant's birth

Name of Home Visitor: _____

NFP ID # of Mother: _____

Name of Mother: _____

1. PHQ-9 completed (with *mother*)?

Yes, completed → **Date tool completed:** / / 20 → *Go to Question 1a.*

1a. If Yes, result of PHQ-9:

- Score of 10 or higher → *Go to Question 1b.*
- Score of 9 or lower

1b. If a Score of 10 or higher, did you give referral information?

- Yes → *Complete M2B-MIECHV Referral Tracking & Follow-up Form*
- No, client refused a referral and/or services
- No, an earlier referral is still in process
- No, the client is not ready for a referral
- No, a referral is not needed at this time
- No, other reason

No, not completed → *Go to Question 1c.*

1c. If No, reason why PHQ-9 not completed:

- Concern previously identified
- Other

Instructions for the
N2
Addendum to: NFP PHQ-9 Form

When to complete this form: Within 3 months of child’s birth.

Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this family.
PHQ-9 completed?	Was the PHQ-9 completed to screen for depression? If it was, enter the date that the PHQ-9 was completed. If it was completed, go to Question 1a. DO NOT send the PHQ-9 to the state. See Appendix A for PHQ-9 Tool and Scoring Guidelines
If Yes, Result of PHQ-9	If the PHQ-9 was completed, indicate if the score on the PHQ-9 was either 10 or higher or 9 or lower. If the score was 10 or higher, go to Question 1b.
If a Score of 10 or higher, did you give referral information?	Was a referral made? If not, indicate the reason why. <i>If Referral was made, use M2B-Referral Tracking & Follow-up Form</i>
If No, reason why PHQ-9 not completed	If the PHQ-9 was not completed, indicate if the reason was either because Concern previously identified or any Other reason.

N3
NFP Baby's Age 3 Months
Index Child

Name of Home Visitor: _____

NFP ID # of Mother: _____

Name of Mother: _____

Name of Child: _____

1. How often do you place your infant to sleep on their back?

- Always
- Sometimes
- Never

2. How often do you bed-share with your infant?

- Always
- Sometimes
- Never

3. How often does your infant sleep with soft bedding?

- Always
- Sometimes
- Never

4. During a typical week, how many days do you (and/or a family member) read, tell stories and/or sing songs to your child?

- 0 – Not at all 1 2 3 4 5 6 7 – Every day

Instructions for the
N3
NFP BABY'S AGE 3 MONTHS Form

When to complete this form: When Child is between 2 - 4 months old.

Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this family.
How often do you place your infant to sleep on their back?	Indicate if the Parent places their infant to sleep on their back: Always, Sometimes or Never?
How often do you bed-share with your infant?	Indicate if the Parent shares a bed with their infant: Always, Sometimes or Never?
How often does your infant sleep with soft bedding?	Indicate if the infant sleeps with soft bedding: Always, Sometimes or Never?
During a typical week, how many days do you (and/or a family member) read, tell stories and/or sing songs to your child?	Indicate how many days in a typical week does the parent or other family member read, tell stories and/or sing songs to the child.

N4
Addendum to Clinical IPV Assessment Form
12 WEEKS

**Reminder: Only return this Addendum to state. Do not return Clinical IPV Assessment to state.

Name of Home Visitor: _____

NFP ID # of Mother: _____

Name of Mother: _____

1. Clinical IPV Assessment completed (with *mother*)?

Yes, completed → **Date Assessment completed:** / / 20 → *Go to Question 1a.*

1a. If Yes, result of Clinical IPV:

- Score indicates risk of IPV → *Go to Question 1b.*
- Score does not indicate risk of IPV

1b. If Score indicates risk of IPV, did you give referral information?

- Yes
- No, client refused a referral and/or services
- No, an earlier referral is still in process
- No, the client is not ready for a referral
- No, a referral is not needed at this time
- No, other reason

No, not completed → *Go to Question 1c.*

1c. If No, reason why Clinical IPV not completed:

- Concern previously identified
- Client not currently in a relationship
- Other

Instructions for the MIECHV

N4

Addendum to: CLINICAL IPV ASSESSMENT – 12 WEEKS Form

When to complete this form: When the Index Child is between 2 - 4 months old.

Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this family.
NFP ID # of Mother	The Mother's NFP ID #.
Name of Mother	The Mother who signed up to participate in the MIECHV Program.
Clinical IPV Assessment Completed (with <i>mother</i>)?	Was the Clinical IPV Assessment completed to screen for Domestic Violence? If it was, enter the date that the assessment was completed. If it was completed, go to Question 1a. DO NOT send the Clinical IPV Assessment to the state.
If Yes, Result of Clinical IPV	If the Clinical IPV Assessment was completed, indicate if the score indicates risk of IPV or does not indicate risk of IPV. If the score does indicate risk of IPV, go to Question 1b.
If a Score indicates risk of IPV, did you give referral information?	Was a referral made? If not, indicate the reason why.
If No, reason why Clinical IPV not completed	If the Clinical IPV Assessment was not completed, indicate if the reason was either because Concern previously identified, Client not currently in a relationship, or Other reason.

MIECHV Demographics Update

Client ID Client Name DOB

Date Nurse Home Visitor ID Nurse Home Visitor Name

Check one: Infancy 6 Months Infancy 12 Months Toddler 18 Months Toddler 24 Months

Personal/Family

1. ♦ Marital Status:

- Married (legal or common law)
- Single - never married
- Widowed
- Divorced
- Separated
- Not Married – living with partner

2. ♦ How often do you usually see or talk to the baby's biological father?

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

3. ♦ During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?

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

4. ♦ With whom do you live? (check only one from options 1 – 5)

- Live with others (check all that apply)
 - Client's mother
 - Father of Child (FoC)
 - Current husband/partner (not FoC)
 - Other family members
 - Infant/child
 - Other adults
- Live alone (or with infant/child)
- Live in a group home/shelter
- Confined to an institutional facility (residential treatment facility, incarcerated)
- Homeless
 - Homeless and sharing housing (skip to 6)
 - Homeless and living in emergency or transitional shelter (skip to 6)
 - Other (skip to 6)

MIECHV Demographics Update

5. ♦ If you are not homeless, where do you currently live?
- Owns or shares own home, condominium, or apartment Rents
 - own home, condominium, or apartment
 - Lives in public housing
 - Lives with parent or family member Other
 -
6. ♦ Which members of your family are in the Military – active or reserve? (check all that apply)
- Self (client)
 - Client's spouse
 - Client's parent(s)
 - Father of child (FoC)
 - None

M1. *At 12 and 24 months only:* Which members of your family are currently serving or **formerly** served in the military – active or reserve? (*Check all that apply.*)

- Index Parent
- Index Parent's Spouse
- Index Parent's Parents
- Father of the Child
- Mother of the Child
- None

MIECHV Demographics Update

Education and Income

7. ♦ Are you currently enrolled in middle or high school?
- Yes – middle school (6th – 8th grade)
 - Yes – high school or GED program (includes alternative and technical programs)
 - Not enrolled
8. ♦ Have you completed high school or a GED or vocational/certification program?
- Yes - completed high school
 - Yes - completed GED
 - Yes - completed vocational/certification program
 - No. If no, what is the last grade you have completed? grade (skip to 12)
9. ♦ If you have completed high school/GED, are you currently enrolled in any kind of school, vocational, certification or educational program?
- Yes
 - Full Time – 12 semester hours or equivalent
 - Part Time
 - 7 – 11 semester hours or equivalent
 - 6 or less semester hours or equivalent
 - No (skip to 11)
10. ♦ What type of educational program are you currently enrolled in?
- Post-high school vocational/certification/technical training
 - College
11. ♦ Have you completed education other than high school/GED (mark the highest level)?
- Vocational/certification/technical training program (beyond high school)
 - Some college (no degree)
 - Associate's degree
 - Bachelor's degree
 - Master's degree
 - Professional degree (e.g.: LLB, LD, MD, DDS)
 - Doctorate degree (e.g.: PhD, EdD)
 - No
12. ♦ Do you **have a** plan to enroll in any additional kind of school, vocational, certification or educational program?
- Yes
 - No

M2. *At 12 and 24 months only:* When you think about your most recent experience in school or classes, how would you rate your own learning and achievement level?

- High
- Average
- Low
- Unknown

MIECHV Demographics Update

13. ♦ Have you worked at all at a paid job since the birth of your infant?

- Yes
 No (skip to 15)

14. ♦ How many months have you worked since the birth of your infant?

months

15. ♦ Are you currently working?

- Yes
 Full-time: 37+ hours per week
 Part-time
 20 – 36 hours per week
 10 – 19 hours per week
 less than 10 hours per week
- No
 Unemployed and seeking employment
 Not employed (student, homemaker, other)

16. ♦ Which of the following categories best describes your total yearly household income and types of benefits you receive? Include your income and any other income you may have received. For the purpose of this question, the household should include only you and your child. Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).

Sources of household income include (please check all that apply)

- Salary/wages from employment
 Social Security/Disability
 TANF
 Alimony
 Child Support
 Rent from tenants
 Cash Assistance from friends/relatives
 Unemployment
 Other income (please specify) _____

- Less than or equal to \$6,000
 \$6,001 - \$9,000
 \$9,001 - \$12,000
 \$12,001 - \$16,000
 \$16,001 - \$20,000
 \$20,001 - \$30,000
 Over \$30,000
 Client is dependent on parent/guardian

MIECHV Demographics Update

M3. *At 6 and 18 months only.* Last **month**, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? *All information will be kept private and will not affect any services you are now getting.*

- \$250 or less
- \$251 - \$500
- \$501 - \$750
- \$751 - \$1,000
- \$1,001 - \$1,250
- \$1,251 - \$1,500
- \$1,501 - \$1,750
- \$1,751 - \$2,000
- \$2,001 - \$2,250
- \$2,251 - \$2,500
- \$2,501 - \$2,750
- \$2,751 - \$3,000
- \$3,001 or more
- Don't Know

M4. Number of Adults in Household: _____ M5. Number of Children in Household: _____

17. ♦ Do you (client) qualify for TANF, Medicaid, WIC or Foodstamps?

- Yes
- No

MIECHV Demographics Update

Birth Control and Additional Pregnancies

18. ♦ In the last 6 months, have you been using any form of birth control to prevent another pregnancy?

- Yes
- No. If no, do any of the following apply? (Check all that apply and skip to 21)
- Female partner
 - Tubal ligation or hysterectomy
 - Partner has a vasectomy
 - Practicing abstinence
 - Plan to become pregnant
 - Currently pregnant

19. Thinking about all the times you've had sexual intercourse in the last six months, about how often did you use birth control?

- Some of the time
- About half the time
- Most of the time
- Every time

20. Please tell me all the different types of birth control you have used in the last six months. Mark all that apply.

- Male condom (rubbers)
- Natural family planning (rhythm method)
- Spermicides/jelly/foam/cream/suppositories/vcf
- Diaphragm/Cervical cap/Sponge
- Withdrawing (pulling out before coming)
- Birth control pills
- Patch
- Cervical ring
- Quarterly birth control shot (Depo-Provera)
- Monthly birth control shot (Lunelle)
- IUD
- Emergency contraception
- Female Condom
- Birth Control Implant
- Other

21. Please tell me all the different types of birth control you plan to use in the next six months. (Please check all that apply).

- Male condom (rubbers)
- Natural family planning (rhythm method)
- Spermicides/jelly/foam/cream/suppositories/vcf
- Diaphragm/Cervical cap/Sponge
- Withdrawing (pulling out before coming)
- Birth control pills
- Patch

MIECHV Demographics Update

- Cervical ring
- Quarterly birth control shot (Depo-Provera)
- Monthly birth control shot (Lunelle)
- IUD
- Emergency contraception
- Female Condom
- Birth Control Implant
- Other
- None

22. ♦ Since you had [child's name], have you been pregnant?

- Yes (Complete table below)
- No (skip to 24)

Subsequent Pregnancy after Index Child
<p>a. Which pregnancy after index child?</p> <ul style="list-style-type: none"> <input type="checkbox"/> First pregnancy <input type="checkbox"/> Second pregnancy <input type="checkbox"/> Third pregnancy <p>b. When did the pregnancy begin?</p> <p style="margin-left: 20px;"><input style="width: 40px; height: 20px;" type="text"/> mo. <input style="width: 40px; height: 20px;" type="text"/> yr.</p> <p>c. What have you been told is your due date (EDD)? <input style="width: 40px; height: 20px;" type="text"/> EDD</p> <p>d. Was this pregnancy planned?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>e. What was the outcome?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Still pregnant <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Stillbirth <input type="checkbox"/> Live birth

MIECHV Demographics Update

23. For the live birth reported in Question 22, please complete the following information: -

Client's Subsequent Child	
a.	DOB <input type="text"/>
b.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
c.	Birthweight <input type="text"/> grams or <input type="text"/> lbs. <input type="text"/> oz.
d.	Did (<u>name</u>) have to spend any time in the NICU or a special nursery because of problems? <input type="checkbox"/> Yes. For how many days prior to being discharged? <input type="text"/> days <input type="checkbox"/> No
e.	Gestational age at birth: <input type="text"/> weeks

24. ♦ In the past 6 months, have you (client) obtained care at the hospital emergency room for any reason?

Yes

If yes, what was the purpose of the visit (please check all that apply)?

Injury – Accidental, how many times? times

Injury – Intentional self inflicted, how many times? times

Injury – Intentional other inflicted, how many times? times

Injury – Declined, how many times? times

Ingestion – Accidental, how many times? times

Ingestion – Intentional self inflicted, how many times? times

Ingestion – Intentional other inflicted, how many times? times

Ingestion – Declined, how many times? times

Respiratory infection, how many times? times

Fever, how many times? times

Other (please specify) _____, how many times? times

No

MIECHV Demographics Update

25. ♦ In the past 6 months, have you (client) obtained care at the urgent care center for any reason?

Yes

If yes, what was the purpose of the visit (please check all that apply)?

Injury – Accidental, how many times? times

Injury – Intentional self inflicted, how many times? times

Injury – Intentional other inflicted, how many times? times

Injury – Declined, how many times? times

Ingestion – Accidental, how many times? times

Ingestion – Intentional self inflicted, how many times? times

Ingestion – Intentional other inflicted, how many times? times

Ingestion – Declined, how many times? times

Respiratory infection, how many times? times

Fever, how many times? times

Other (please specify) _____, how many times? times

No

26. ♦ Do you (client) have health insurance coverage?

Yes (If yes, which type of health insurance do you use when you go for medical care; please check all that apply)

Medicaid

CHIP

Tri-Care

Private

Other (please specify) _____

No

M6. *At 12 and 24 months only:* Do you have a history of substance abuse or need substance abuse treatment?

Yes

No

Unknown

M7. *At 12 and 24 months only:* Do you use tobacco products?

Yes

No

M8. *At 12 and 24 months only:* Have you had a history of child abuse or neglect and/or involvement with child welfare services either as a child or as an adult?

Yes

No

Unknown

M9. *At 12 and 24 months only:* Has a doctor or health professional ever told you that your child/any of your children has any developmental delay or developmental disability?

Yes

No

Unknown

**Instructions for the
MIECHV DEMOGRAPHICS UPDATE – 6 MONTHS Form**

When to complete this form: When Child is between 5 - 7 months old.

The following MIECHV Reporting Data Point has been incorporated into the ETO Demographics Update form and is the **only MIECHV question that needs to be answered at 6 months:**

Item Instructions

Item	Guidelines
<p>M3. Last month, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? All information will be kept private and will not affect any services you are now getting.</p>	<p>Reassure parent that income information will not be used to determine eligibility in any programs or affect any services they are now getting. <i>Based on self-report</i>, what was the total household income, before taxes, last month? <u>For 2-parent households, include both parents' income and benefits. If household income/benefit source includes someone other than parents, include that also.</u></p> <p>Include all of these Income Sources: Paycheck or money from a job Benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) Money from a business, fees, dividends, or rental income Child support or alimony Social security, workers' compensation, disability, veteran benefits or pensions Unemployment benefits</p>
<p>M4. Number of adults in household</p>	<p>Total number of adults living in household. Include any adults who stay in the household at least 4 nights a week.</p>
<p>M5. Number of children in household</p>	<p>Total number of children living in household. Includes Index child and any other children, ages Birth – 18 yrs old, who stay in the household at least 4 nights a week.</p>

For Children who Screened at Risk for Developmental Delay

MIECHV REFERRAL TRACKING & FOLLOW-UP – INDEX CHILD

Please send this form to the State MONTHLY with updates
(due by the 15th of the following month)

Name of Home Visitor: _____

NFP Child ID #: _____

Name of Index Child: _____

Name of Index Parent: _____

	INITIAL REFERRAL CONTACT	FOLLOW-UP		
Type of Service	Date EI Referral Contacted	Date of EI Evaluation	If EI Evaluation NOT completed within 45 days of initial referral contact -- REASON:	Enrolled in EI?
1) Early Intervention Services	/ / 20	/ / 20	<input type="checkbox"/> Parent refused the EI referral or did not take action <input type="checkbox"/> Child is waiting for EI evaluation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1a) Early Intervention Services	/ / 20	/ / 20	<input type="checkbox"/> Parent refused the EI referral or did not take action <input type="checkbox"/> Child is waiting for EI Evaluation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

	INITIAL REFERRAL CONTACT	FOLLOW-UP		
Type of Service	Date Service Referral Contacted	Date Service Started/Received	If Service NOT received within 30 days of initial referral contact -- REASON:	
2) Another Community Service: <i>Type:</i> _____	/ / 20	/ / 20	<input type="checkbox"/> Parent refused the referral or did not take action <input type="checkbox"/> Child is waiting for service <input type="checkbox"/> Parent was unable to access service due to barriers (such as transportation, cost, time, child care, etc.) <input type="checkbox"/> Other: _____	
2a) Another Community Service: <i>Type:</i> _____	/ / 20	/ / 20	<input type="checkbox"/> Parent refused the referral or did not take action <input type="checkbox"/> Child is waiting for service <input type="checkbox"/> Parent was unable to access service due to barriers (such as transportation, cost, time, child care, etc.) <input type="checkbox"/> Other: _____	
3) Individualized developmental support from a home visitor	N/A	/ / 20	N/A	
3a) Individualized developmental support from a home visitor	N/A	/ / 20	N/A	

Instructions for the MIECHV

FOR CHILDREN WHO SCREENED AT RISK FOR DEVELOPMENTAL DELAY **REFERRAL TRACKING & FOLLOW-UP FORM - INDEX CHILD**

When to complete this form:

Initial Referral Contact Column: If as a result of a MIECHV-required ASQ-3 Developmental Screening, the child is identified as in the monitoring zone (lightly shaded or gray area) or below the cutoff (darkly shaded or black area) as at-risk of developmental delay, this form should be completed. The date referral contacts are made to needed services should be recorded ***any time they are made for the child***. This form should be sent to the state when any initial referral contact is made for the child.

Follow-up Columns: Following the initial contact with a referral service, when the child receives the Early Intervention (EI) Evaluation or other service, record the date that service is started or received. If the child has not received the service, continue to follow up as appropriate by encouraging the parent to access services for the child when ready or by checking on the referral. During this time of follow up with the parent, send the referral tracking form monthly to the state when updates are made. A reminder email will be sent monthly to your program from the state requesting the updated form.

Referral Guidelines: A referral to services can be made directly by calling Early Intervention or a community service agency and requesting services for the parent or by giving the parent a list of resources to call for assistance related to enhancing the child's development.

Referral Definitions:

1) Early Intervention Services:

Referrals made to Early Intervention (EI) Services for further evaluation and services. Benchmark will measure the percent of children who receive an EI evaluation within 45 calendar days of the referral. The 45 days begins when contact is made with EI services.

1a) Additional Referrals to Early Intervention Services:

If there is more than one referral for EI services over time, the second referral can be recorded here.

2) Another Community Service:

Referrals include those made to a different community service, other than Early Intervention, that provide support to enhance a child's development. Examples may include referrals to health or mental health services, speech, occupational or physical therapy services, parent-child groups, parent classes or early literacy supports. Benchmark will measure the percent of children who receive services within 30 calendar days of the referral. The 30 days begins when contact is made with the community service.

2a) Additional Referrals to Another Community Service:

If there are more than one referral for other community services, the second referral can be recorded here.

3) Individualized developmental support from a home visitor:

For when the home visitor provides individualized developmental support directly to the child. This would include follow up activities to work on developmental skills identified in the monitoring zones, including additional screening. This should be done for any child who screens in the monitoring or at-risk zone for an ASQ domain.

3a) Additional Individualized developmental support from a home visitor:

If the child receives this service more than once, the second occurrence can be recorded here.

Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this index parent.
NFP Child ID#	The Child's NFP ID #.
Initial Referral Contact Column: Early Intervention Services	
Date EI Referral Contacted	When a referral to EI is made, date the referral contact was made. <i>MM/DD/20YY</i>
Follow-up Columns:	
Date of EI Evaluation	Date of Early Intervention Evaluation. <i>MM/DD/20YY</i>
If EI Evaluation not completed within 45 days of initial referral contact —REASON:	If the child did not receive the EI Evaluation within 45 calendar days of referral contact, the reason they did not. Write in Other reason, if applicable.
Enrolled in EI?	Was child enrolled in EI as a result of the evaluation? Check Yes or No.
Initial Referral Contact Column: Another Community Service	
Another Community Service	If referral was made to another community service, other than EI, list type of Community Service.
Date Service Referral Contacted	When a referral to another community service is made, date the referral contact was made. <i>MM/DD/20YY</i>
Follow-up Columns:	
Date Service Started/Received	Date service started or was received. <i>MM/DD/20YY</i>
If service was not received within 30 days of initial referral contact —REASON:	If the child did not receive the other community service within 30 calendar days of referral contact, the reason they did not. Write in Other reason, if applicable.
Follow-up Column: Individualized developmental support from a home visitor	
Date Service Started/Received	Date that the home visitor provided support to child. <i>MM/DD/20YY</i>

MIECHV Demographics Update

Client ID Client Name DOB

Date Nurse Home Visitor ID Nurse Home Visitor Name

Check one: Infancy 6 Months Infancy 12 Months Toddler 18 Months Toddler 24 Months

Personal/Family

1. ♦ Marital Status:

- Married (legal or common law)
- Single - never married
- Widowed
- Divorced
- Separated
- Not Married – living with partner

2. ♦ How often do you usually see or talk to the baby's biological father?

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

3. ♦ During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?

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

4. ♦ With whom do you live? (check only one from options 1 – 5)

- Live with others (check all that apply)
 - Client's mother
 - Father of Child (FoC)
 - Current husband/partner (not FoC)
 - Other family members
 - Infant/child
 - Other adults
- Live alone (or with infant/child)
- Live in a group home/shelter
- Confined to an institutional facility (residential treatment facility, incarcerated)
- Homeless
 - Homeless and sharing housing (skip to 6)
 - Homeless and living in emergency or transitional shelter (skip to 6)
 - Other (skip to 6)

MIECHV Demographics Update

5. ♦ If you are not homeless, where do you currently live?
- Owns or shares own home, condominium, or apartment Rents
 - own home, condominium, or apartment
 - Lives in public housing
 - Lives with parent or family member Other
 -
6. ♦ Which members of your family are in the Military – active or reserve? (check all that apply)
- Self (client)
 - Client's spouse
 - Client's parent(s)
 - Father of child (FoC)
 - None

M1. *At 12 and 24 months only:* Which members of your family are currently serving or **formerly** served in the military – active or reserve? (*Check all that apply.*)

- Index Parent
- Index Parent's Spouse
- Index Parent's Parents
- Father of the Child
- Mother of the Child
- None

MIECHV Demographics Update

Education and Income

7. ♦ Are you currently enrolled in middle or high school?
- Yes – middle school (6th – 8th grade)
 - Yes – high school or GED program (includes alternative and technical programs)
 - Not enrolled
8. ♦ Have you completed high school or a GED or vocational/certification program?
- Yes - completed high school
 - Yes - completed GED
 - Yes - completed vocational/certification program
 - No. If no, what is the last grade you have completed? grade (skip to 12)
9. ♦ If you have completed high school/GED, are you currently enrolled in any kind of school, vocational, certification or educational program?
- Yes
 - Full Time – 12 semester hours or equivalent
 - Part Time
 - 7 – 11 semester hours or equivalent
 - 6 or less semester hours or equivalent
 - No (skip to 11)
10. ♦ What type of educational program are you currently enrolled in?
- Post-high school vocational/certification/technical training
 - College
11. ♦ Have you completed education other than high school/GED (mark the highest level)?
- Vocational/certification/technical training program (beyond high school)
 - Some college (no degree)
 - Associate's degree
 - Bachelor's degree
 - Master's degree
 - Professional degree (e.g.: LLB, LD, MD, DDS)
 - Doctorate degree (e.g.: PhD, EdD)
 - No
12. ♦ Do you **have a** plan to enroll in any additional kind of school, vocational, certification or educational program?
- Yes
 - No

M2. *At 12 and 24 months only:* When you think about your most recent experience in school or classes, how would you rate your own learning and achievement level?

- High
- Average
- Low
- Unknown

MIECHV Demographics Update

13. ♦ Have you worked at all at a paid job since the birth of your infant?

- Yes
 No (skip to 15)

14. ♦ How many months have you worked since the birth of your infant?

months

15. ♦ Are you currently working?

- Yes
 Full-time: 37+ hours per week
 Part-time
 20 – 36 hours per week
 10 – 19 hours per week
 less than 10 hours per week
 No
 Unemployed and seeking employment
 Not employed (student, homemaker, other)

16. ♦ Which of the following categories best describes your total yearly household income and types of benefits you receive? Include your income and any other income you may have received. For the purpose of this question, the household should include only you and your child. Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).

Sources of household income include (please check all that apply)

- Salary/wages from employment
 Social Security/Disability
 TANF
 Alimony
 Child Support
 Rent from tenants
 Cash Assistance from friends/relatives
 Unemployment
 Other income (please specify) _____

- Less than or equal to \$6,000
 \$6,001 - \$9,000
 \$9,001 - \$12,000
 \$12,001 - \$16,000
 \$16,001 - \$20,000
 \$20,001 - \$30,000
 Over \$30,000
 Client is dependent on parent/guardian

MIECHV Demographics Update

M3. *At 6 and 18 months only.* Last **month**, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? *All information will be kept private and will not affect any services you are now getting.*

- \$250 or less
- \$251 - \$500
- \$501 - \$750
- \$751 - \$1,000
- \$1,001 - \$1,250
- \$1,251 - \$1,500
- \$1,501 - \$1,750
- \$1,751 - \$2,000
- \$2,001 - \$2,250
- \$2,251 - \$2,500
- \$2,501 - \$2,750
- \$2,751 - \$3,000
- \$3,001 or more
- Don't Know

M4. Number of Adults in Household: _____ M5. Number of Children in Household: _____

17. ♦ Do you (client) qualify for TANF, Medicaid, WIC or Foodstamps?

- Yes
- No

MIECHV Demographics Update

Birth Control and Additional Pregnancies

18. ♦ In the last 6 months, have you been using any form of birth control to prevent another pregnancy?

- Yes
- No. If no, do any of the following apply? (Check all that apply and skip to 21)
- Female partner
 - Tubal ligation or hysterectomy
 - Partner has a vasectomy
 - Practicing abstinence
 - Plan to become pregnant
 - Currently pregnant

19. Thinking about all the times you've had sexual intercourse in the last six months, about how often did you use birth control?

- Some of the time
- About half the time
- Most of the time
- Every time

20. Please tell me all the different types of birth control you have used in the last six months. Mark all that apply.

- Male condom (rubbers)
- Natural family planning (rhythm method)
- Spermicides/jelly/foam/cream/suppositories/vcf
- Diaphragm/Cervical cap/Sponge
- Withdrawing (pulling out before coming)
- Birth control pills
- Patch
- Cervical ring
- Quarterly birth control shot (Depo-Provera)
- Monthly birth control shot (Lunelle)
- IUD
- Emergency contraception
- Female Condom
- Birth Control Implant
- Other

21. Please tell me all the different types of birth control you plan to use in the next six months. (Please check all that apply).

- Male condom (rubbers)
- Natural family planning (rhythm method)
- Spermicides/jelly/foam/cream/suppositories/vcf
- Diaphragm/Cervical cap/Sponge
- Withdrawing (pulling out before coming)
- Birth control pills
- Patch

MIECHV Demographics Update

- Cervical ring
- Quarterly birth control shot (Depo-Provera)
- Monthly birth control shot (Lunelle)
- IUD
- Emergency contraception
- Female Condom
- Birth Control Implant
- Other
- None

22. ♦ Since you had [child's name], have you been pregnant?

- Yes (Complete table below)
- No (skip to 24)

Subsequent Pregnancy after Index Child
<p>a. Which pregnancy after index child?</p> <ul style="list-style-type: none"> <input type="checkbox"/> First pregnancy <input type="checkbox"/> Second pregnancy <input type="checkbox"/> Third pregnancy <p>b. When did the pregnancy begin?</p> <p style="margin-left: 20px;"><input style="width: 40px; height: 20px;" type="text"/> mo. <input style="width: 40px; height: 20px;" type="text"/> yr.</p> <p>c. What have you been told is your due date (EDD)? <input style="width: 40px; height: 20px;" type="text"/> EDD</p> <p>d. Was this pregnancy planned?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>e. What was the outcome?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Still pregnant <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Stillbirth <input type="checkbox"/> Live birth

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23. For the live birth reported in Question 22, please complete the following information: -

Client's Subsequent Child	
a.	DOB <input type="text"/>
b.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
c.	Birthweight <input type="text"/> grams or <input type="text"/> lbs. <input type="text"/> oz.
d.	Did (<u>name</u>) have to spend any time in the NICU or a special nursery because of problems? <input type="checkbox"/> Yes. For how many days prior to being discharged? <input type="text"/> days <input type="checkbox"/> No
e.	Gestational age at birth: <input type="text"/> weeks

24. ♦ In the past 6 months, have you (client) obtained care at the hospital emergency room for any reason?

Yes

If yes, what was the purpose of the visit (please check all that apply)?

Injury – Accidental, how many times? times

Injury – Intentional self inflicted, how many times? times

Injury – Intentional other inflicted, how many times? times

Injury – Declined, how many times? times

Ingestion – Accidental, how many times? times

Ingestion – Intentional self inflicted, how many times? times

Ingestion – Intentional other inflicted, how many times? times

Ingestion – Declined, how many times? times

Respiratory infection, how many times? times

Fever, how many times? times

Other (please specify) _____, how many times? times

No

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25. ♦ In the past 6 months, have you (client) obtained care at the urgent care center for any reason?

Yes

If yes, what was the purpose of the visit (please check all that apply)?

Injury – Accidental, how many times? times

Injury – Intentional self inflicted, how many times? times

Injury – Intentional other inflicted, how many times? times

Injury – Declined, how many times? times

Ingestion – Accidental, how many times? times

Ingestion – Intentional self inflicted, how many times? times

Ingestion – Intentional other inflicted, how many times? times

Ingestion – Declined, how many times? times

Respiratory infection, how many times? times

Fever, how many times? times

Other (please specify) _____, how many times? times

No

26. ♦ Do you (client) have health insurance coverage?

Yes (If yes, which type of health insurance do you use when you go for medical care; please check all that apply)

Medicaid

CHIP

Tri-Care

Private

Other (please specify) _____

No

M6. *At 12 and 24 months only:* Do you have a history of substance abuse or need substance abuse treatment?

Yes

No

Unknown

M7. *At 12 and 24 months only:* Do you use tobacco products?

Yes

No

M8. *At 12 and 24 months only:* Have you had a history of child abuse or neglect and/or involvement with child welfare services either as a child or as an adult?

Yes

No

Unknown

M9. *At 12 and 24 months only:* Has a doctor or health professional ever told you that your child/any of your children has any developmental delay or developmental disability?

Yes

No

Unknown

Instructions for the **MIECHV DEMOGRAPHICS UPDATE – 12 MONTHS Form**

When to complete this form: When the Child is between 11 - 13 months old.

The following MIECHV Reporting Data Points have been incorporated into the ETO Demographics Update form and **are the only MIECHV questions that needs to be answered at 12 months:**

Item Instructions

Item	Guidelines
M1. Which Members of your family are currently serving or formerly served in the Military – active or reserve? (Check all that apply)	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , families that include individuals who are serving or formerly served in the Armed Forces.
M2. When you think about your <u>most recent experience</u> in school or classes, how would you rate your own learning and achievement level?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , mother’s self-perception of their achievement level during their <i>most recent experience</i> in school or classes.
M6. Do you have a history of substance abuse or need substance abuse treatment?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , a mother who has a history of substance abuse or who has been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.
M7. Do you use tobacco products?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , mothers who use tobacco products in the home or who have been identified as using tobacco through a substance abuse screening administered during intake. Include use of smokeless tobacco and electronic cigarettes.
M8. Have you had a history of child abuse or neglect and/or involvement with child welfare services either as a child or as an adult?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , a Client who has a history of abuse or neglect and/or has had involvement with child welfare services either as a child or as an adult.
M9. Has a doctor or health professional ever told you that your child/any of your children has any developmental delay or developmental disability?	<i>Based on self-report</i> or home visitor’s observation, enrollees who have a child or children suspected of having a developmental delay or disability.

**Instructions for the
MIECHV DEMOGRAPHICS UPDATE – 18 MONTHS Form**

When to complete this form: When Child is between 17 - 19 months old.

The following MIECHV Reporting Data Point has been incorporated into the ETO Demographics Update form and is the **only MIECHV question that needs to be answered at 18 months:**

Item Instructions

Item	Guidelines
<p>M3. Last month, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? All information will be kept private and will not affect any services you are now getting.</p>	<p>Reassure parent that income information will not be used to determine eligibility in any programs or affect any services they are now getting. <i>Based on self-report</i>, what was the total household income, before taxes, last month? <u>For 2-parent households, include both parents' income and benefits. If household income/benefit source includes someone other than parents, include that also.</u></p> <p>Include all of these Income Sources: Paycheck or money from a job Benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) Money from a business, fees, dividends, or rental income Child support or alimony Social security, workers' compensation, disability, veteran benefits or pensions Unemployment benefits</p>
<p>M4. Number of adults in household</p>	<p>Total number of adults living in household. Include any adults who stay in the household at least 4 nights a week.</p>
<p>M5. Number of children in household</p>	<p>Total number of children living in household. Includes Index child and any other children, ages Birth – 18 yrs old, who stay in the household at least 4 nights a week.</p>

**Instructions for the
MIECHV DEMOGRAPHICS UPDATE – 24 MONTHS Form**

When to complete this form: When the Child is between 23 - 25 months old.

The following MIECHV Reporting Data Points have been incorporated into the ETO Demographics Update form and **are the only MIECHV questions that needs to be answered at 24 months:**

Item Instructions

Item	Guidelines
M1. Which Members of your family are currently serving or formerly served in the Military – active or reserve? (Check all that apply)	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , families that include individuals who are serving or formerly served in the Armed Forces.
M2. When you think about your <u>most recent experience</u> in school or classes, how would you rate your own learning and achievement level?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , mother’s self-perception of their achievement level during their <i>most recent experience</i> in school or classes.
M6. Do you have a history of substance abuse or need substance abuse treatment?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , a mother who has a history of substance abuse or who has been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.
M7. Do you use tobacco products?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , mothers who use tobacco products in the home or who have been identified as using tobacco through a substance abuse screening administered during intake. Include use of smokeless tobacco and electronic cigarettes.
M8. Have you had a history of child abuse or neglect and/or involvement with child welfare services either as a child or as an adult?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , a Client who has a history of abuse or neglect and/or has had involvement with child welfare services either as a child or as an adult.
M9. Has a doctor or health professional ever told you that your child/any of your children has any developmental delay or developmental disability?	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> or home visitor’s observation, enrollees who have a child or children suspected of having a developmental delay or disability.