Demographics: Family Intake

***Indicates Required**

***Time periods for completion**
o At Enrollment

***Family (Case) Identifier:** _____ (Must match Caregiver(s) / child(ren))

***Total number of people in the household:** _____ (Number 1,2,3, 4, etc.)

***Annual Household Income**
- o Less than or equal to $6,000
- o $20,001 to $30,000
- o $6,001 to $12,000
- o $30,001 to $40,000
- o $12,001 to $20,000
- o Over $40,000
- o Refused to Respond

Household Receives Disability Benefits (any Caregiver in home) (optional)
- o Yes
- o No

***Users of tobacco products**
- o Yes, Primary Caregiver
- o Yes, Other Caregiver
- o Yes, both
- o No
- ***Tobacco use location (only if Yes above)**
  - o In Home
  - o Outside Home
  - o Both

***Have, or have child with, low student achievement (any Caregiver and/or child in the home)**
- o Yes, Caregiver
- o Yes, Child
- o Yes, Both
- o No

***Have a child with developmental delays or disabilities (any child in home)**
- o Yes
- o No

***Family member is serving, or formerly served, in the US armed forces (any family member living in the home)**
- o Yes
- o No

***Household has a history of child abuse or neglect or has had interactions with child welfare services (any Caregiver and/or child in the home)**
- o Yes
- o No
- o Refused to Respond

***Please indicate the primary referral source for this family? (This question is required starting on October 1, 2020)**
- o Court System (Judge)
- o Children and Youth
- o Doctor Office
- o Department of Corrections
- o Early Intervention (EI)
- o Early Learning Resource Center (ELRC)
- o Hospital
- o Managed Care Organization
  - ***Which Care Organization?**
    - o Aetna Better Health
    - o AmeriHealth Caritas PA
    - o Gateway Health
    - o Geisinger
    - o HealthChoices Physical Health
    - o Health Partners Plan
    - o Highmark Wholecare
    - o Keystone First - Southeast Zone
    - o United Healthcare Community Plan of PA
    - o UPMC for You, Inc.
- o Other Home Visiting or Family Support Program
- o Self-Referral
- o Word of Mouth **If Word of Mouth, was the referral from any of the following? (If applicable)**
  - o Current Participant in Services
  - o Prior Participant in Services
- o Other
  - ***Please Specify:** _____

Enrollment: Caregiver Intake

*Indicates Required

***Time periods for completion**
o At Enrollment

***Client Identifier** *(Caregiver)*: _____ (Unique number to identify Caregiver)
***Family Identifier** *(Case)*: _____ (Must Match Family/Child(s))
***First Name:** _____
Middle Name: _____
***Last Name:** _____
Suffix: o None | o Jr. | o Sr. | o I | o II | o III | o IV | o V | o VI | o VII|

*** Under the program type (i.e. MIECHV, FC, etc.) selected for this family is the Primary Caregiver enrolled in an evidence-based home visiting program and/or other family support program(s) (e.g. a parenting class, non-evidence-based home visiting, etc.)?**
o Evidence-Based Home Visiting (EBHV)
o Family Support Program (FSP)
o Both

***Evidence-based Home Visiting Program (Select One) (Based on the HOMVEE List)**
o Attachment and Biobehavioral Catch-Up Intervention (ABC)
o Child First (CF)
o Early Head Start - Home Based Option (EHS)
o Early Start (New Zealand) (ESNZ)
o Family Check-up (FCU)
o Family Connects (FCS)
o Family Spirit (FS)
o Health Access Nurturing Development Services Program (HANDS)
o Healthy Beginnings (HB)
o Healthy Families America (HFA)
o Home Instruction for Parents of Preschool Youngsters (HIPPY)
o Maternal Early Childhood Sustained Home-Visiting Program (MECSH)
o Maternal Infant Health Program (MIHP)
o Minding the Baby (MIB)
o Nurse-Family Partnership (NFP)
o Parents as Teachers (PAT)
o Play and Learning Strategies Infant Only (PALS)
o Promoting First Relationships – Home Visiting Intervention Model
o Safe Care Augmented (SCA)

***If enrolled in EBHV, which program type is supporting the evidence-based home visiting model selected? (Select One)**

OCDEL FUNDING (These Changes will be implemented August 15th, 2022)
- o CHILDREN'S TRUST FUND (CTF)
- o COMMUNITY BASED CHILD ABUSE PREVENTION - AMERICAN RESCUE PLAN (CBCAP ARP)
- o COMMUNITY BASED CHILD ABUSE PREVENTION (CBCAP)
- o FAMILY CENTER (FC)
- o FAMILY SUPPORT (FS)
- o HEALTH ENTERPRISE ZONE (HEZ)
- o MIECHV (MIECHV)
- o OCDEL NFP (OCDEL NFP)
- o PROMOTING SAFE AND STABLE FAMILIES (PSSF)

Other Non OCDEL Funding
- o DOH – Title V
- o OCYF & CCY
  - o CCYA – Needs Based Budget
  - o CCYA – Family First
  - o CCYA – Other (_____)
  - o OCYF – Other (_____)
- o Medical Assistance (MA)
- o Managed Care Organization – Home Visiting
- o Other Local Funding – County
- o Other Local Funding – Other (_____)
- o United Way

***Date of EBHV enrollment:** __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***If the Primary Caregiver is enrolled in Family Support Program, please enter the program, the Supporting Program and the date of enrollment for each one.**

- o 24/7 Dad
- o 27/7 Dad AM & PM
- o ACT / ACT Raising Safe Kids
- o Active Parenting 4th Edition
- o Active Parenting for Teens
- o Circle of Programs
- o Circles
- o Doctor Dad
- o Families in Recovery
- o Father in 15
- o Foundations of Fatherhood
- o Growing Great Kids
- o Incredible Years
- o Inside Out Dad
- o Logic Model
- o Make Parenting a Pleasure
- o Moving Beyond Depression
- o Nurse Legal Partnership
- o Nurturing Dads
- o Nurturing Parenting
- o ParentChild+
- o Parent Café
- o Parent Child Home Program (PCHP)
- o Parenting Inside Out
- o Positive Solutions for Families
- o SAFE
- o Safe Care (Non-Augmented)
- o Smart Parent Safe and Healthy Kids (SPHK)
- o Strengthening Families Program
- o Systematic Training for Effective Parenting (STEP)
- o The Father Project
- o The Refugee Family Strengthening Program
- o The Incredible Years
- o Triple P
- o Video Interaction Project

Family Support Program Type 1*: _____ (Choose from List Above)

Which FS program type is supporting the Family Support Program 1? (Select one) *

OCDEL FUNDING (These Changes will be implemented August 15th, 2022)

- o CHILDREN'S TRUST FUND (CTF)
- o COMMUNITY BASED CHILD ABUSE PREVENTION - AMERICAN RESCUE PLAN (CBCAP ARP)
- o COMMUNITY BASED CHILD ABUSE PREVENTION (CBCAP)
- o FAMILY CENTER (FC)
- o FAMILY SUPPORT (FS)
- o HEALTH ENTERPRISE ZONE (HEZ)
- o MIECHV (MIECHV)
- o OCDEL NFP (OCDEL NFP)
- o PROMOTING SAFE AND STABLE FAMILIES (PSSF)

Other Non OCDEL Funding

- o DOH – Title V
- o OCYF & CCY
  - o CCYA – Needs Based Budget
  - o CCYA – Family First
  - o CCYA – Other (_____)
  - o OCYF – Other (_____)
- o Medical Assistance (MA)
- o Managed Care Organization – Home Visiting
- o Other Local Funding – County
- o Other Local Funding – Other (_____)
- o United Way

***Date of FSP 1 enrollment:** __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Can add up to 4 Family Support Programs if Necessary**

FSP 2: _____ Funding Type: _____ Enrollment Date: __ __ / __ __ / __ __ __ __

FSP 3: _____ Funding Type: _____ Enrollment Date: __ __ / __ __ / __ __ __ __

FSP 4: _____ Funding Type: _____ Enrollment Date: __ __ / __ __ / __ __ __ __

Demographics: Caregiver Intake
*Indicates Required

***Time periods for completion**
o At Enrollment
o Within 15 Days of Enrollment

***Client Identifier** *(Caregiver)*: _____ (Unique number to identify Caregiver)
***Family Identifier** *(Case)*: _____ (Must Match Family/Child(s))

***Caregiver Address**
* Street Address: _____
* City: _____
* Zip: _____
* County: _____

*** Date of Birth** __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Gender**
o Male
o Female
o Gender Non-Binary (includes enrolled participants who do not identify as either male or female, which may include participants who identify as gender non-binary and/or genderqueer)

***Enrolled Prenatally?**
o Yes
o No

***Pregnancy Status at Enrollment**
o Currently pregnant
o Not currently pregnant

*** If Currently Pregnant Number of weeks pregnant**
_____ (Number: 6, 10, 18, etc.)

*** If Currently Pregnant Estimated Date of Delivery**
__ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

*** If currently Pregnant Number of Children Expected from Current Pregnancy** (Used to Calculate Enrollment)
o 1 o 3
o 2 o 4

***History of substance abuse**
o Yes, Opioids
o Yes, Other: _____
o No
o Refused to Respond

***Current Substance Use / Needs Substance Abuse Treatment**
o Yes, Opioids
o Yes, Other: _____
o No
o Refused to Respond

***If the Caregiver is pregnant and is currently using substances has a Plan of Safe Care been developed for the family?**
o Yes
o No
o Unknown

***Has the Caregiver self-identified that they have a disability? (*Required beginning on April 1, 2021)**
o Yes
o No
o Refused to respond

*** Race**
(Select all that apply)
o American Indian or Alaska Native
o Native Hawaiian or Other Pacific Islander
o Asian
o White
o Black or African-American
o Refused to Respond

*** Ethnicity**
o Not Hispanic or Latino
o Hispanic or Latino
o Refused to Respond

*** Legal Marital Status at Enrollment (Current official legal status, meaning if Currently Divorced but living with a partner this would be entered as Divorced, as this is the current identified legal status)**
o Never Married
o Not Married but Living Together with Partner
o Married
o Separated/Divorced/Widowed

*** Educational Attainment at Enrollment (highest level)**
o Less than HS diploma (Not currently enrolled in school, did not receive GED or a High School diploma)
o Currently enrolled in middle school
o Currently enrolled in high school
o Currently enrolled in GED program
o HS Diploma / GED
o Some college/training
o Technical training or certification
o Associate's degree
o Bachelor's degree or Higher
o Other: _____

*** Educational Status at Enrollment**
o Student/trainee
o Not a student/trainee

*** Employment Status at Enrollment**
o Full-time (30+ hours per week)
o Part-time (Less than 30 hours per week)
o Not employed

*** Housing Status at Enrollment**
o Not Homeless
- o Owns or shares own home, condominium, or apartment
- o Rents or shares own home or apartment
- o Lives in public housing
- o Lives with parent or family member
- o Some other arrangement

o Homeless
o Homeless and sharing housing
- o Homeless and living in an emergency or transitional shelter
- o Some other arrangement

*** Health Insurance Status at Enrollment**
o No Insurance Coverage
- o Not eligible
- o Caregiver applied for coverage, application is pending
- o Private Pay (Pay out of Pocket)
- o Other (please specify: _____)

o Medicaid or CHIP
- ***Which Care Organization?**
  - o AmeriHealth Caritas PA
  - o Geisinger Health Plan Family
  - o Health Partners
  - o UPMC
  - o Other (please specify: _____)

o Medicare
o Tri-Care
o Private (Such as employer sponsored healthcare plans, i.e. Aetna, BlueCross)
o Other (please specify: _____)

Enrollment and Demographics: Child Intake

*Indicates Required

***Time periods for completion**
o Enrollment
o Within 15 Days of Enrollment
o First visit after birth

***Child Identifier** *(Child)*: _____ (Unique number to identify Caregiver)
***Family Identifier** *(Case)*: _____ (Must Match Family/Child(s))

***Child's First Name:** _____
Child's Middle Name: _____
*** Child's Last Name:** _____
Child's Suffix: o None | o Jr. | o Sr. | o I | o II | o III | o IV | o V | o VI | o VII |

*** Child's Date of Birth** __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Child's Gender (For Child Gender you may use the gender assigned at birth for the Child unless the caregiver requests to use the non-binary option, then select that as the response)**
o Male
o Female
o Gender Non-Binary (includes enrolled participants who do not identify as either male or female, which may include participants who identify as gender non-binary and/or genderqueer)

***EBHV Program** _____
* Date of EBHV enrollment __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Family Support Program 1** _____
*Family Support Enrollment Date 1 __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Family Support Program 2** _____
*Family Support Enrollment Date 2 __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Family Support Program 3** _____
*Family Support Enrollment Date 3 __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Family Support Program 4** _____
*Family Support Enrollment Date 4 __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

***Primary Caregiver's Relationship to Child**
o Biological Mother
o Other Female Caregiver
  o Biological Grandmother
  o Adoptive Female Caregiver
  o Other Female Caregiver _____ (Required)
o Biological Father
o Other Male Caregiver
  o Biological Grandfather
  o Adoptive Male Caregiver
  o Other Male Caregiver _____ (Required)

If Gender nonbinary is selected for the Caregiver, the following options are available
o Biological Parent
o Biological Grandparent
o Adoptive Caregiver
o Other Caregiver _____ (Required)

***If Caregiver was enrolled during the Pregnancy with this child.**
***Is this child a result of the pregnancy status?**
o Yes (Continue)
o No (End)

***What was the child's birth weight?**
_____ (Pounds - Number) and
_____ (Ounces - Number)

***What was the child's gestational age at birth?**
_____ (Weeks – Number 36, etc.)
_____ (Days – Number 0 through 6)

***Was the child born affected by prenatal substance exposure? (Includes alcohol)?**
o Yes (Continue)
o No (End)
o Unknown (End)

*** Child's Race**
(Select all that apply)
o American Indian or Alaska Native
o Native Hawaiian or Other Pacific Islander
o Asian
o White
o Black or African-American
o Refused to Respond

*** Child's Ethnicity**
o Not Hispanic or Latino
o Hispanic or Latino
o Refused to Respond

*** Primary Language Spoken at Home**
o English
o Spanish
o Other: *_____

***Has the Caregiver identified that the Child has a disability? (*Required beginning on April 1, 2021)**
o Yes
o No
o Refused to respond

*** Health Insurance Status at Enrollment**
o No Insurance Coverage
- o Not eligible
- o Caregiver applied for coverage, application is pending
- o Private Pay (Pay out of Pocket)
- o Other (please specify: _____)

o Medicaid or CHIP
- ***Which Care Organization?**
  - o AmeriHealth Caritas PA
  - o Geisinger Health Plan Family
  - o Health Partners Plan
  - o Other (please specify: _____)

o Medicare
o Tri-Care
o Private (Such as employer sponsored healthcare plans, i.e. Aetna, BlueCross)
o Other (please specify: _____)

***Usual Source of Medical Care**
o Doctor's/Nurse Practitioner's Office
o Hospital Emergency Room
o Hospital Outpatient
o Federally Qualified Health Center
o Retail Store or Minute Clinic
o None
o Other: _____

*** Usual Source of Dental Care**
o Have a Usual Source of Dental Care
o Do not have a Usual Source of Dental Care