Demographics: Family Update

*Indicates Required

***Time periods for completion**

o Between June 1st and June 30th each calendar year
o Between September 1st and September 30th each calendar year

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

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

***Annual Household Income at Update**

- 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) at Update

- o Yes
- o No

***Users of tobacco products at Update**

- o Yes, Primary Caregiver
- o Yes, Other Caregiver
- o Yes, both
- o No

***Tobacco use location at Update (only if yes above) at Update**

- o In Home
- o Outside Home
- o Both

***Have, or have child with, low student achievement (any Caregiver and/or child in the home) at Update**

- o Yes, Caregiver
- o Yes, Child
- o Yes, Both
- o No

***Have a child with developmental delays or disabilities (any child in home) at Update**

- o Yes
- o No

***Family member is serving, or formerly served, in the US armed forces (any family member living in the home) at Update**

- 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) at Update**

- 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 Department of Corrections
- o Doctor Office
- 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**: _____

Demographics: Caregiver Update

*Indicates Required

***Time periods for completion**
o Between June 1st and June 30th each calendar year
o Between September 1st and September 30th each calendar year
o As needed if a change occurs (10th of the following month after being notified of the change)

***Are there any changes to the demographics for the Caregiver (6/30 and 9/30)?**
o Yes (Continue updating the information below)
o No (End)

*** Pregnancy Status at Update (Do not update Pregnancy Status for NFP Clients if Second Child is not going to be receiving services)**
o Currently pregnant
o Not currently pregnant

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

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

*** If currently Pregnant Number of Children Expected from Current Pregnancy at Update** (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

*** Legal Marital Status at Update (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 Update (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 Update**
o Student/trainee
o Not a student/trainee

*** Employment Status at Update**

o Full-time (30+ hours per week)
o Part-time (Less than 30 hours per week)
o Not employed

*** Housing Status at Update**

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 Update**

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: _____)

***Caregiver Education (if enrolled without High School Diploma or Equivalent) at Update (Measure 15)**

Have you (Caregiver) enrolled in, maintained continuous enrollment in, or completed a high school degree or equivalent?

o Currently enrolled in high school and/or a GED Program
o Yes, they have obtained a high school diploma or equivalent prior to the update
o No, they have not obtained a high school diploma or equivalent

Enrollment and Demographics: Child Update

*Indicates Required

***Time periods for completion**
o Between June 1st and June 30th each calendar year
o Between September 1st and September 30th each calendar year
o As needed if a change occurs (10th of the following month after being notified of the change)

***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 |

***Primary Caregiver's Relationship to Child at Update**
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)

*** 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 Update**
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: _____)

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