ATTACHMENT 17: COMMUNITY SERVICE PROVIDER SURVEY

5/29/2012

Community Service Providers Survey – Baseline

Nominated by the Participating Home Visiting Program

The U.S. Department of Health and Human Services has contracted with MDRC to evaluate the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program.

The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is designed to build knowledge for policymakers and practitioners about the effectiveness of MIECHV.

Your answers will be kept confidential. Only the research team will have access to this information. Your answers will not be shared with anyone at your program or any other agencies. In our research reports, the information you provide will not be attributed by name to you or your individual program.

One objective of MIHOPE is to learn about the availability of community services and the coordination between home visiting programs and community service providers.

We have contacted you because [HV PROGRAM SITE] nominated your program as one to which it refers families for [SERVICE]. We are requesting that you complete this questionnaire to help us describe service availability and coordination from the perspective of your agency.

- The questionnaire should take about 6 minutes to complete.

- If you are unsure how to answer a question, please give the best answer you can rather than leaving it blank.

- In this questionnaire the term "program" means a specific set of services offered within your agency, and the term "agency" means an organization that may offer one or more programs.

- We would appreciate your response by 5 p.m. on DD/MM/YYYY.

- If you have questions at any time during the study, please call Alexander Vazquez at MDRC toll-free at 1-877-311-6372 or email Alexander.vazquez@mdrc.org.

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1. Please provide your agency's street address, that is, the address of the place where clients receive services, even if that is different from your agencies mailing address or main offices.
   Street Address
   City and state
   Zip Code

2. Please rate the availability of [SERVICE] in your community.

   ☐ [SERVICE] is almost always available to families who need it.
   ☐ [SERVICE] is usually available to families who need it.
   ☐ [SERVICE] is sometimes available to families who need it.
   ☐ [SERVICE] is difficult to obtain for families who need it.
   ☐ [SERVICE] is not available in our community.

3. About how often does your agency receive referrals from [HV PROGRAM SITE]?

   ☐ No referrals
   ☐ Less than monthly
   ☐ Once or twice a month
   ☐ Every week or almost every week
   ☐ Every day or almost every day

   ☐ Don't know

4. About how many families were referred from [HV PROGRAM SITE] in the past three months?

   ☐ No referrals
   ☐ 1 to 3 referrals
   ☐ 4 to 10 referrals
   ☐ 11 to 20 referrals
   ☐ More than 20 referrals
   ☐ Don't know

5. About what proportion of families referred by [HV PROGRAM SITE] is eligible for your services?

   ☐ All or almost all
   ☐ More than half
   ☐ About a third
   ☐ Very few
   ☐ Don't know

6. Does your program maintain a waiting list for [SERVICE]?

   ☐ No [SKIP TO 7]
   ☐ Yes
   ☐ Sometimes
   ☐ Don't Know
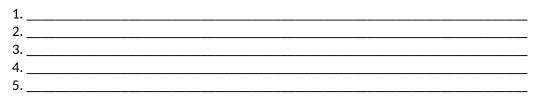
7. How long do families usually have to wait for services?

      ☐ Less than a week
      ☐ Less than a month
      ☐ 1 to 3 months
      ☐ More than 3 months

8. Does your agency charge fees for [SERVICE]?

      ☐ No [SKIP TO 11]
      ☐ Yes

9. Are fees on a sliding scale based on income?

      ☐ No
      ☐ Yes

10. Do you accept private insurance?

      ☐ No
      ☐ Yes
      ☐ Not applicable because the service is not typically covered by health insurance.

11. Do you accept public insurance such as Medicaid or SCHIP?

      ☐ No
      ☐ Yes
      ☐ Not applicable because the service is not typically covered by health insurance.

12. Is your service location within a 10-minute walk of public transportation?

      ☐ No
      ☐ Yes

13. Are services offered outside of standard working hours, such as early mornings, evenings, or weekends?

      ☐ No
      ☐ Yes

14. Are services offered in languages other than English if needed, either directly or through an interpreter?

      ☐ No
      ☐ Yes

15. How long do clients typically receive services from your program?

□ Clients receive one-time services in a single session.
□ Up to 1 week
□ Between 1 week and 1 month
□ Between 1 and 3 months
□ Between 3 and 6 months
□ More than 6 months
□ Don't know

16. Over the past three months, what activities were you involved in with [HV PROGRAM SITE]?
CHECK ALL THAT APPLY.

□ Met for joint planning
□ Submitted a joint grant proposal
□ Participated in joint training
□ Provided training to staff from [HV PROGRAM SITE]
□ Shared costs
□ Developed joint program materials
□ Contracted for specific services
□ Shared information about specific families

17. Over the past three months, how often did your program have contact with [HV PROGAM SITE]
about referred families or other issues listed above in Question 16?

□ No contact
□ Every day or almost every day
□ Every week or almost every week
□ Once or twice a month
□ Less than monthly

18. Do you have a Memorandum of Understanding (MOU) or other service agreement with [HV
PROGRAM SITE]?

□ No
□ Yes
□ Don't know

19. Do you have a designated point of contact at [HV PROGRAM SITE]?

□ No
□ Yes
□ Don't know

20. Are there other service providers in the community that offer [SERVICE]?

□ No [SKIP TO 21]
□ Yes

21. Listed below are the names of [service] providers in the community. [Space for 1-5 below to match the web version]. Are there any other service providers in the community that provide [SERVICE]?

      1. _____

      2. _____

      3. _____

      4. _____

      5. _____

What is the average cost of your program per client [complete any that apply]:

Weekly:

Monthly:

Total per client: