ATTACHMENT 1
CLASSROOM/HOME VISITOR SAMPLING FORM FROM Early Head Start STAFF

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| **NOTE:** For each selected center, a member of the Baby FACES study team will request a list of all Early Head Start (EHS) classrooms from EHS staff (typically the On-Site Coordinator). The attached classroom sampling form (table 1) is an example of the information required for classroom sampling. Staff will request a list of all EHS home visitors in the program. Table 2 in the attached form is an example of the information required for selecting home visitors. EHS staff may provide this information in various formats such as print outs from an administrative record system or photocopies of hard copy list or records. Therefore, EHS staff will not physically fill out the attached classroom sampling form. The study team member will data enter the information into a computer. |



BABY FACES 2018

CLASSROOM/HOME VISITOR SAMPLING FORM

|  |  |
| --- | --- |
| **Program:** [EHS Program] | **OSC:** [OSC Name] |
| **Center:** [Center Name] | **OSC Phone:** [Phone #] |
|  | **F.E.S.**   |
| **Center Phone:** [Phone #] | *(Please Print Your Name)* |

INSTRUCTIONS: Please enter into the sampling website the information below for each classroom in this center that contains EHS funded children.

Table 1.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **CLASSROOMS** |  |  |  |  |
|  |  | **Selected Classrooms Only** |
|  | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** |
|  | **Lead Teacher****First Name Last Name** | **Classroom Type***(Select Only One)*Part Day AM, Part Day PM, Full Day,Dual Session | **Number of EHS children enrolled**  | **What is the age (in months) of the youngest child in this classroom?** | **What is the age (in months) of the oldest child in this classroom?** | **Check box if selected** | **Check box if any Spanish instruction** | **Class Start Time** | **Class End Time** |
| **1** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **2** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **3** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **4** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **5** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **6** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **7** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **8** |  |  |  |  |  | 🞎 | 🞎 |  |  |
| **9** |  |  |  |  |  | 🞎 | 🞎 |  |  |

INSTRUCTIONS: Please enter into the sampling website the information below for each home visitor caseload that contains EHS funded children.

Table 2.

|  |  |
| --- | --- |
|  | **HOME VISITORS** |
|  | **A** | **B** | **C** | **D** | **E** | **F** |
|  | **Home VisitorFirst Name Last Name** | **Indicate if HV serves children only (C), pregnant women only (P),or a mix (M)** | **Number of EHS families enrolled** | **Check box if HV selected for Staff Survey** | **Check box if HV caseload selected (SCR)** | **Center affiliation (Center 1, Center 2 or N/A)** |
| **1** |  |  |  | 🞎 | 🞎 |  |
| **2** |  |  |  | 🞎 | 🞎 |  |
| **3** |  |  |  | 🞎 | 🞎 |  |
| **4** |  |  |  | 🞎 | 🞎 |  |
| **5** |  |  |  | 🞎 | 🞎 |  |
| **6** |  |  |  | 🞎 | 🞎 |  |
| **7** |  |  |  | 🞎 | 🞎 |  |
| **8** |  |  |  | 🞎 | 🞎 |  |
| **9** |  |  |  | 🞎 | 🞎 |  |

This collection of information is voluntary and will be used to describe the characteristics of children and families served by Early Head Start, and the characteristics and features of programs and staff that serve them. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB number for this information collection is 0970and the expiration date is XX/XX/XXXX. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to [Contact Name]; [Contact