

Healthy Start Mandatory Parent/Child Form | Jan 2020

OMB Control No. 0915-0338, Expiration Date XX/XX/202X

INFORMATION IN THIS GRAY BOX IS FOR GRANTEE USE ONLY—DO NOT UPLOAD

Name of Primary Participant: _____ DOB: _____

Name of Enrolled Child: _____ DOB: _____

Name of Accompanying Adult: _____ DOB: _____

Name of Interviewer: _____

NAMES AND DATES OF BIRTH ARE INCLUDED ABOVE FOR GRANTEE TRACKING PURPOSES ONLY AND SHOULD NOT BE SUBMITTED TO HRSA. EACH PERSON'S UNIQUE ID# SHOULD REMAIN THE SAME ACROSS PHASES AND YEARS, AND SHOULD INCLUDE THE GRANTEE'S ORG CODE PLUS A UNIQUE NUMBER. EVERY MANDATORY FORM SHOULD INCLUDE THE PRIMARY PARTICIPANT'S UNIQUE ID#. THE PRIMARY PARTICIPANT FOR THIS FORM IS AN ENROLLED WOMAN (REPRODUCTIVE AGE FEMALE) WITH AN ENROLLED CHILD WHO IS RECEIVING POSTPARTUM OR PARENTING/INTERCONCEPTION HEALTH SERVICES; OR THE PRIMARY PARTICIPANT MAY BE AN ENROLLED FATHER WHO HAS PRIMARY CUSTODY/RESPONSIBILITY FOR AN ENROLLED CHILD; OR ANOTHER ADULT WHO HAS PRIMARY CUSTODY OF AN ENROLLED CHILD. THE ACCOMPANYING ADULT PARTICIPANT IS THE PRIMARY PARTICIPANT'S SPOUSE OR PARTNER, AND/OR THE ENROLLED CHILD'S CO-PARENT. THE UNIQUE IDs OF THE ENROLLED WOMAN, THE ENROLLED CHILD, AND ANY ACCOMPANYING ADULT SHOULD ALL BE PROVIDED BELOW AS APPLICABLE, SO THAT THESE CAN BE LINKED IN THE ELECTRONIC DATABASE.

Public Burden Statement: The purpose of this data collection is to obtain consistent information across all grantees about Healthy Start and its outcomes. 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 control number for this information collection is 0915-0338 and it is valid until XX/XX/202X. This information collection is voluntary. Public reporting burden for this collection of information is estimated to average 0.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

- THIS MANDATORY PARENT/CHILD FORM IS TO BE COMPLETED WITH PRIMARY PARTICIPANTS WHO HAVE AN INFANT OR CHILD YOUNGER THAN 18 MONTHS ENROLLED IN HEALTHY START.
- FOR AN ENROLLED CHILD, THE PRIMARY PARTICIPANT IS THE ENROLLED MOTHER OR THE ADULT WHO HAS PRIMARY CUSTODY OF THE CHILD, INCLUDING THE FATHER OR ANOTHER ADULT.
- PRIMARY PARTICIPANTS WHO HAVE AN INFANT OR CHILD ENROLLED IN HS WILL ALSO HAVE COMPLETED EITHER AN INITIAL OR UPDATED BACKGROUND INFORMATION FORM PRIOR TO COMPLETING THIS PARENT/CHILD FORM.
- ONE PARENT/CHILD FORM SHOULD BE COMPLETED FOR EACH ENROLLED CHILD.
- THE PRIMARY PARTICIPANT COMPLETES THE 'CHILD' SECTION OF THIS FORM. THERE ARE ALSO TWO QUESTIONS AT THE END FOR ENROLLED WOMEN ONLY. ENROLLED FATHERS DO NOT COMPLETE THIS SECTION, WHICH PERTAINS TO THE WOMAN'S PREGNANCY WITH THIS CHILD.
- THIS FORM IS COMPLETED ONLY WITH PRIMARY PARTICIPANTS WHO DO NOT HAVE A (LIVE) CHILD ENROLLED IN HS. ACCOMPANYING ADULTS DO NOT COMPLETE THIS FORM, NOR DO PRIMARY PARTICIPANTS WHO DO NOT HAVE A (LIVE) CHILD ENROLLED IN HS.

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- THIS FORM IS UPDATED WITH THE PRIMARY PARTICIPANT WHEN THE INFANT TURNS 6 MONTHS, IF THERE IS A CHANGE IN PRIMARY PARTICIPANT/CUSTODIAL PARENT, AND/OR WHEN THE INFANT/CHILD EXITS THE PROGRAM.
- THE UNIQUE ID#s OF THE PRIMARY PARTICIPANT, ENROLLED CHILD AND ACCOMPANYING ADULT MUST ALL APPEAR TOGETHER ON THIS FORM SO THAT THE ID#s CAN BE LINKED IN THE DATABASE.

GENERAL INFORMATION to be completed by staff before uploading data for this parent/child form:

1. PRIMARY PARTICIPANT UNIQUE ID#: _____

- [Enter as One Number: Grantee Org Code + PP + Unique ID]

2. ACCOMPANYING ADULT (IF APPLICABLE) UNIQUE ID#: _____

- [Enter as One Number: Grantee Org Code + AA + Unique ID]
- Or indicate no AA

3. DATES OF ENROLLMENT IN HEALTHY START:

- o Primary Participant _____
- o Enrolled Child _____
- o Accompanying Adult _____

4. INITIAL COMPLETION OF THIS FORM BY PRIMARY PARTICIPANT:

- o Date of initial completion of this Parent/Child form: _____

5. THIS FORM HAS BEEN UPDATED WITH THE PRIMARY PARTICIPANT FOLLOWING ITS INITIAL COMPLETION BASED ON [select below as applicable]:

- o Enrolled infant turns 6 months
 - Date updated: _____
- o Change in the child's custody has occurred (new primary caregiver reports on own activities)
 - Date updated: _____
- o Other update (eg, annual reporting occurs with no phase change, other changes)
 - Date updated: _____
 - Specify change/reason for update: _____

6. UPDATE THIS FORM WHEN THIS CHILD EXITS HS:

- o Date of child's exit from HS services: _____
- o Reason for exit: _____

7. PRIMARY PARTICIPANT TYPE:

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- Enrolled woman (primary person receiving support is/identifies as a female)
- Enrolled father (primary parent receiving support is/identifies as a male)
- Other adult with primary custody of child, Specify _____

8. ENROLLED CHILD UNIQUE ID#: _____

- [Enter as One Number: Grantee Org Code + EC + Unique ID THIS Child's Unique ID#:

9. CHILD IS:

- Female
- Male

10. BASED ON DATE OF BIRTH IN BOX ABOVE, CHILD IS CURRENTLY:

- Less than 6 months old
- 6 through 12 months old
- 13-18 months old

11. THIS CHILD WAS ENROLLED IN HS BUT THEN DIED:

- Within 0 to 27 days of life (neonatal): _____
- 28 to 364 days after birth (infant): _____
- 12 months or older (post-infancy): _____

ADDITIONAL INSTRUCTIONS

- This form must be administered by a trained case worker or other Healthy Start grantee staff member, to ensure consistency in responding across participants and grantees when questions or misunderstandings arise. It should not be self-administered or administered by untrained staff.
- If the custodial or accompanying adult changes, a new background form will need to be completed with new unique ID for that new person in order to record changes across the enrolled child's time in HS.
- If an enrolled woman completing this form is also pregnant, then she should also complete the mandatory Prenatal Form.
- Items in *italics* are questions for or statements to the participant. Instructions to staff may be [bracketed].

Please read the following statement to the participant:

Thank you for participating in the Healthy Start program. The purpose of these forms is to examine how well the Healthy Start program is meeting its goals of helping families improve their health and the health of their babies. This questionnaire should take about 25 minutes to complete. Any information you provide will be kept confidential. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits.

THE CHILD: Setting the Stage

In this questionnaire, we will ask questions about your enrolled child. Enrolled women will also respond to a few questions at the end about their health around the time of the child's birth.

[Staff, if participant has more than one enrolled child under 18 months of age, say:]

We will complete a separate form for each of your babies/children. Since you have more than one child who is less than 18 months enrolled in Healthy Start, we ask you to focus only on one child at a time. We will then complete a separate questionnaire for each of your babies under 18 months old.

Enrolled Child General Information

This section focuses on this child and his/her health.

First, I'd like to start with some general background questions about your child.

1. Was your child:

Select one of the options below.

- Receiving HS services before birth (i.e., 'born into the program')
- Part of a family enrolled for services within 30 days following child's birth
- Part of a family enrolled for services more than 30 days following child's birth
 - If enrolled more than 30 days following birth, please indicate child's age at enrollment

2. Is this child of Hispanic or Latino/a origin?

Select one only.

- Yes, of Hispanic or Latino/a origin
- No, Not of Hispanic or Latino/a origin
- Don't Know
- Declined to answer

3. What is this child's race?

Select all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Don't know
- Declined to answer

4. Which ONE racial classification below do you think best describes your child's racial background?

Select ONE only.

- American Indian or Alaska Native
- Asian

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- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- More than one race/biracial/multiracial
- Other: _____
- Don't know
- Declined to answer

Infant Health at Birth

Next, we're going to ask you some questions about this child's health when he/she was born.

5. **How many weeks pregnant were you [was the mother] when he/she was born?**

[STAFF: Please enter number of weeks. If participant does not know number of weeks, help them calculate backwards from the baby's original due date to determine weeks gestation at birth.]

- _____ weeks
- Don't know
- Declined to answer

6. **[Staff, was this child preterm (earlier than 37 weeks of pregnancy)?]**

- Yes
- No
- Unable to determine

7. **How much did he/she weigh at birth?**

- _____ pounds, _____ ounces [OR grams _____]
- Don't know
- Declined to answer

8. **[Staff: Please check appropriate box below for baby's birthweight]:**

- Very low birthweight (Less than 3 pounds 5 ounces or 1500 grams)
- Low birthweight (At least 3 pounds 5 ounces but less than 5 pounds 8 ounces or 2500 grams)
- Normal weight range (5 pounds 8 ounces to 9 pounds 4 ounces)
- High birthweight (More than 9 pounds 4 ounces or 4500 grams)
- Don't know
- Declined to answer

9. **Was this child the only baby you were [the mother was] pregnant with at the time, or was it a multiple birth, such as twins, triplets, or more?**

- Singleton (from a pregnancy involving just one baby)
- Twins
- Triplets or more

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- Don't know
- Declined to answer

Infant Health Care

These next few questions are about your child's health care.

10. Is there a place you or another caregiver USUALLY take this child when he or she is sick or you need advice about his or her health?

- Yes
- No
- Don't know
- Declined to answer

11. Where does this child USUALLY go first?

Select one only.

- Doctor's Office
- Hospital Emergency Room
- Hospital Outpatient Department
- Clinic or Health Center
- Retail Store Clinic or "Minute Clinic"
- School (Nurse's Office, Athletic Trainer's Office)
- Some other place _____
- Don't Know
- Declined to answer

[Staff: If participant says 'urgent care,' mark this as 'some other place' and write in 'urgent care.' If participant does not know what a 'Minute Clinic' is, explain that it is a walk-in clinic at a local pharmacy or store.]

12. DURING THE PAST 12 MONTHS, was this child EVER covered by ANY kind of health insurance or health coverage plan?

- Yes, this child was covered all 12 months
- Yes, but this child had a gap in coverage
- No
- Don't know
- Declined to answer

13. What kind of health insurance is your child covered by now?

Please select all that apply.

Insurance Type	Check if Currently have
Private health insurance from my job or the	<input type="checkbox"/>

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job of my husband or partner	
Private health insurance from my parents	€
Private health insurance from the <State> Health Insurance Marketplace or <state website> or HealthCare.gov	€
Medicaid (Title XIX) (required: state Medicaid name_____)	€
CHIP (Title XXI)	€
Subsidized ACA plan (also called 'subsidized premium or subsidized coverage through the Affordable Care Act')	€
TRICARE or other military health care	€
*Indian Health Service or tribal [also check 'no health insurance' below]	€
Other health insurance, Please tell us:_____	€
I do not have health insurance for this child now	€
Don't know	€
Declined to answer	€

[*Staff note: If the participant uses Indian Health Service, please indicate above. We understand that Indian Health Service does not constitute insurance, and so if a participant uses IHS, please check both the IHS and the 'no health insurance coverage' boxes, so that IHS can be tracked as a separate item in addition to being counted as 'no health insurance coverage'.]

14. How old was this child at his/her last well-child check-up? _____

[Staff: below is the AAP-recommended schedule of well visits for the first 18 months of life.]

- First week of
- 1 month old
- 2 months old
- 4 months old

- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old

[Staff: Compare the child's current age with age at his/her most recent well-visit, and determine: was this child's last well-child visit within the time frame recommended for this child's age (e.g., a 10 month old baby has had her 9 month visit)]?

- Yes
- No
- Unable to determine

Infant Feeding

The next few questions are about breastfeeding.

15. Did you [or the biological mother] EVER breast feed or pump breast milk to feed this child after delivery, even for a short period of time?

Select one response only.

- Yes
- No
- Don't know
- Declined to answer

16. Is this child currently being breastfed or fed pumped milk?

- Yes
- No
- Don't know
- Declined to answer

17. How many months [up till current date] was this child breastfed or fed pumped milk?

- Not at all
- Less than 1 month
- ____ Months (for mothers still breastfeeding, indicate how many months so far)
- Don't know
- Declined to answer

18. [Staff: Was this child breastfed or fed pumped milk for first 6 months of life?]

Select one response only.

- Yes
- Not yet. Child is currently less than 6 months old and is currently being breastfed.
- No, child was not breastfed for the first 6 months of life
- Don't know
- Unable to determine

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[STAFF: IF MOTHER IS CURRENTLY BREASTFEEDING, BE SURE TO UPDATE QUESTIONS 17 AND 18 ONCE SHE HAS STOPPED SO THAT THE TOTAL AMOUNT OF TIME IS CAPTURED.]

Infant Sleep

[For children 12 MONTHS AND OLDER, check 'not applicable' in each box and move to next section.]

[For babies LESS THAN 12 MONTHS old, say:]

Next we're going to ask some questions about sleeping.

Good sleep habits are important to your baby's physical health and emotional well-being. An important part of safe sleep is the place where your baby sleeps and his or her sleeping position, the kind of crib or bed, and type of mattress.

19. In which one position do you most often lay your baby down to sleep now?

Select ONE answer.

- On his or her side
- On his or her back
- On his or her stomach
- Not applicable [child is 12 months or older]

20. In the past 2 weeks, how often has your baby slept alone in his or her own crib or bed? [Note: That is, the baby is the only person in the crib or bed; the baby's crib or bed may be in the parent(s) room]

- Always
- Often
- Sometimes
- Rarely
- Never
- Not applicable [child is 12 months or older]

19a. Is your baby's crib free of pillows, extra bedding, stuffed animals?

- Yes
- No
- Don't know
- Declined to answer
- Not applicable [child 12 months or older]

Home Life

Next, we have a couple questions about your child's home life. These are the last questions that focus on the child. After that, we will ask enrolled women a few additional questions about the pregnancy.

21. During the past week, how many days did you or other family members read or look at books with your (this) child? [Staff: Reading includes books with words or pictures and/or textures for the baby to see and feel but NOT books read by an audio tape, record, CD, or computer.]

- Did not read to the baby in the past week
- 1-2 days in the past week
- 3 days in the past week
- 4-7 days in the past week
- Don't know
- Declined to answer

22. Next, we have a question about home relationships that the baby/child experiences. Would you describe your partner or the father of this child as:

- Involved and supportive of me and the child
- Involved with child but not supportive of me
- Involved and supportive of me but not the child
- Not regularly involved/supportive in either mine or the child's life
- Don't know
- Declined to answer

End of Child Questions

ENROLLED WOMAN PREGNANCY HEALTH

[Staff: ENROLLED FATHERS AND OTHER ADULTS WITH PRIMARY CUSTODIAL RESPONSIBILITY FOR THE CHILD DO NOT COMPLETE THIS SECTION.]

[Staff, continue with enrolled woman and say:]

In this final section, I'd like to ask a couple questions about your pregnancy with this child.

23. The next question is about the postpartum care you may have received following your most recent delivery. Recently, doctors have been talking about what they now call 'the fourth trimester,' and this includes ongoing contact with an obstetric care provider (e.g., OB/GYN, nurse midwife) during the 12 weeks following labor and delivery. Postpartum care is important to ensure your ongoing health. Did you receive postpartum care from an obstetric care provider following your most recent delivery?

Select all that apply.

- Yes, within the first 3 weeks following delivery
- Yes, between 4 weeks and 6 weeks following delivery
- Yes, between 7 weeks and 8 weeks following delivery

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- Yes, between 9 and 12 weeks following delivery [Note: if participant responds, “Yes, after 12 weeks,” explain that it is not considered a postpartum checkup after 12 weeks]
- Not yet, but one is already scheduled for the following date: _____
- Not yet, but let’s work on making an appointment
- No, I did not have a postpartum visit with an obstetric care provider within 12 weeks of the birth of my most recent child
- Don’t know
- Declined to answer

[STAFF: IF MOTHER IS WITHIN 12 WEEKS OF DELIVERY BUT HAS NOT YET HAD A POSTPARTUM VISIT, PLEASE UPDATE QUESTION 23 AS APPROPRIATE ONCE SHE HAS EITHER HAD HER POSTPARTUM VISIT OR IS PAST 12 WEEKS POSTPARTUM.]

These next two questions ask about tobacco and nicotine use during the last three months of your pregnancy with this child.

24. In the last 3 months of your pregnancy with this child, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I didn’t smoke then
- Don’t know
- Declined to answer

25. During the last 3 months of your pregnancy with this child, on average, how often did you use other tobacco or nicotine products?

E-cigarettes (electronic cigarettes) and other electronic nicotine vaping products (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.
 A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

	More than once a day	Once a day	2-6 days a week	1 day a week or less	Not at all	Don't Know	Declined to Answer
E-cigarettes or other electronic nicotine products							
Hookah							
Chewing tobacco, snuff, snus,							

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or dip							
Cigars, cigarillos, or little filtered cigars							

The Healthy Start Mandatory Parent/Child Form is Complete