Healthy Start Mandatory Parent/Child Form | Jan 2023

OMB Control No. 0915-0338, Expiration Date xx/xx/xxxx

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

Name of Primary Participant: _____ DOB:_____

Name of Enrolled Child: _____ DOB:_____

Name(s) & Date(s) of _____ DOB:_____

Birth of Other Linked _____ DOB:_____

Primary Participant(s): _____ DOB:_____

Name of Interviewer: _____

Names and dates of birth are included above for grantee tracking purposes only and should not be submitted to HRSA. 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, an enrolled father with an enrolled child, or other non-enrolled adult who has primary responsibility for/custody of an enrolled child. Complete only one form per enrolled child.

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 02/28/2023. 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.

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.
- This Parent/Child Form is to be completed with primary participants who have an infant or child ("enrolled child" or EC) younger than 18 months enrolled in Healthy Start (HS); the primary participant should also first complete an initial or updated Background Information Form. This form should be completed as soon as possible after a child's birth into HS, or at the time of child's enrollment into HS.
- One Parent/Child form should be completed by the primary participant for each (live) child enrolled in HS.
- Every form should include the primary participant's Unique ID# (UID). Each person's UID should remain the same across phases and years, and should be in the format described in Questions G2 and G3. The UIDs of the primary participant, the enrolled child, and any other linked primary participant(s) must all appear together on this form so that the ID#s can be linked in the database.
- The primary participant completes the 'child' section of this form. There are also two questions at the end for enrolled mothers only.
- If an enrolled woman completing this form is pregnant, then she should also complete the Prenatal Form.
- Items in italics are questions for or statements to the participant. Instructions to staff may be [bracketed].

INSTRUCTIONS: FORM UPDATES

Form Update

- When a child turns 6 months or the child exits the program, complete:
  - *General Information:* Question G7 (and G8, if exiting)

  And rescreen the following questions/sections:

  - *General Information:* Questions G4 and G10
  - *Infant Health Care:* All Questions (Q10-Q14a)
  - *Infant Feeding:* All Questions (Q15-Q18)
  - *Infant Sleep:* For infants less than 12 months old only – All Questions (Q19-Q20a)
  - *Home Life:* All Questions (Q21-Q22)
  - *Enrolled Women's Pregnancy Health:* For enrolled women only - Question 23
- For other updates: To update a specific question(s) or section(s), such as when a participant stops breastfeeding or other major changes, complete Question G7, "Other update," and revise the relevant question(s) and/or section(s).
  - If the update reflected on the Parent/Child form is related to a major life event or significant change in health status for the primary participant (enrolled woman, enrolled man, or other adult with primary custody of the enrolled child), the primary participant's Background Information form should be updated following the procedures outlined in the Background Information form instructions.
- If a loss of the child occurs, complete Question G7, "Other update," and revise Question G11.

Other Linked Primary Participant or Custodial Adult Updates

- To add an "other linked primary participant", complete Question G7, "Other update," and add the other linked primary participant's UID in Question G4.
- To change/remove an "other linked primary participant," email HealthyStartData@hrsa.gov using the subject line, "Technical Support Request for HSMED-II" with your requested change/removal.
- If the custodial adult changes, a new background form will need to be completed with the new unique ID for that new person in order to record changes across the enrolled child's time in HS.

Participant Re-Enrollment

To re-enroll a child who has exited the program, please do the following:

- Select "other update" in Question G7 of the Parent/Child Form and enter the date of the update/re-enrollment. For update reason, indicate "re-enrollment after exit"
- Remove the exit information from Question G8
- Complete other updates as instructed above based on the child's age or circumstance
- ***Note: The participant's PPUID should never change; use the same PPUID as when first enrolled.***

[GENERAL INFORMATION to be completed by staff before uploading data for this Parent/Child Form:]

G1. PRIMARY PARTICIPANT TYPE:

- € **Enrolled mother (primary person receiving support who is the mother of the enrolled child)**
- € **Enrolled father (primary person receiving support who is the father of the enrolled child)**
- € **Other non-enrolled adult with primary custody of/responsibility for the enrolled child, Specify_____**

G2. THIS PRIMARY PARTICIPANT'S UNIQUE ID#: **_____**
[Enter as One Number: Grantee Org Code + PP + Client's Unique ID (e.g., 123PP45678)]

G3. ENROLLED CHILD'S UNIQUE ID#: **_____**
[Enter as One Number: Grantee Org Code + EC + This Child's Unique ID# (e.g., 123EC45678)]

G4. OTHER PARTICIPANTS' (IF APPLICABLE) UNIQUE ID NUMBERS THAT SHOULD BE LINKED TO THIS ENROLLED CHILD (ENTER UP TO 3 & USE FORMAT INDICATED IN QUESTION G2):

- € **Other Linked PP ID#: _____**
- € **Other Linked PP ID#: _____**
- € **Other Linked PP ID#: _____**
- € **Or, no other participants are linked to the enrolled child**

G5. DATES OF ENROLLMENT IN HEALTHY START:

- ⇨ **Primary Participant_____ [Staff: Leave blank if not enrolled]**
- ⇨ **Enrolled Child _____**

G6. INITIAL COMPLETION OF THIS FORM BY PRIMARY PARTICIPANT:

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

[Staff: This is the date that the form (all applicable parts) has been completed in its entirety. Men complete through the Child sections (pg. 11); women complete to the end.]

G7. THIS FORM HAS BEEN UPDATED WITH THE PRIMARY PARTICIPANT FOLLOWING ITS INITIAL COMPLETION BASED ON [select below as applicable]:

- € **Enrolled infant turns 6 months**
  - ⇨ ***Date updated:*** **_____**
- € **Other update (e.g., annual reporting occurs with no phase change, added/removed other linked primary participant, mother stops breastfeeding or has had a postpartum visit since the initial form completion, other major changes)**
  - ⇨ ***Date updated:*** **_____**
  - ⇨ ***Specify change/reason for update:*** **_____**

G8. UPDATE THIS FORM WHEN THIS CHILD EXITS HS:

⇨ **Date of child's exit from HS services: _____**

⇨ **Reason for exit: _____**

G9. CHILD IS:

- € **Female**
- € **Male**

G10. 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**

G11. 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)**
- € **Not applicable**

[Staff: 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.]
   - € 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
     - o If enrolled more than 30 days following birth, please indicate child's age (in months) at enrollment: _____months

2. ***Is this child of Hispanic or Latino/a origin?***
   [Select one.]
   - € 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.]
   - € American Indian or Alaska Native
   - € Asian
   - € 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 (based on response to Question 7)
   - € Declined to answer (based on response to Question 7)

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
   - € 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.]

- € 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?

[Select all that apply.]

	Insurance Type	Check if currently have
a.	Private health insurance from my job or the job of my husband or partner	€
b.	Private health insurance from my parents	€
c.	Private health insurance from the <State> Health Insurance Marketplace or <state website> or HealthCare.gov	€
d.	Medicaid (Title XIX) (required: state Medicaid name_____)	€
e.	CHIP (Title XXI)	€
f.	Subsidized ACA plan (also called 'subsidized premium or subsidized coverage through the Affordable Care Act')	€
g.	TRICARE or other military health care	€
h.	*Indian Health Service or tribal **[also check 'I do not have health insurance for this child now' below if the participant does not have other insurance type]**	€
i.	Other health insurance, Please tell us:_____	€
j.	I do not have health insurance for this child now	€
k.	Don't know	€
l.	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. If a participant uses IHS, please check both the IHS and the 'I do not have health insurance coverage for this child now' boxes, if the participant does not have other insurance. This will enable HS to track IHS 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? _____ (months)

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

- The first week visit (3 to 5 days old)
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old

14a. [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.]

- € 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.]

- € 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

[Staff: If mother is currently breastfeeding, be sure to update Questions G7, 17, and 18 once she has stopped to note status change and capture the total amount of time the child was breastfed.]

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.]
- € 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]**

20a. ***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 of 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 this child's second primary parent as:

- € Involved and supportive of me and the child
- € Involved with the child but not supportive of me
- € Involved and supportive of me but not the child
- € Not involved with the child, but supportive of me and the child
- € Not regularly involved/supportive in either mine or the child's life
- € There is no second parent
- € Don't know
- € Declined to answer

End of Child Questions

[Staff: Note the following directions based on participant type:

- **Enrolled men and non-enrolled persons with custody of an enrolled child: This form is now complete.**
- **Enrolled women: Continue on to the next section.]**

ENROLLED WOMAN'S PREGNANCY HEALTH

[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
- € 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, Specify reason:_____
- € 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 questions G7 and 23 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.

	Tobacco or Nicotine Products	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
a.	E-cigarettes or other electronic nicotine products							
b.	Hookah							
c.	Chewing tobacco, snuff, snus, or dip							
d.	Cigars, cigarillos, or little filtered cigars							

The Healthy Start Mandatory Parent/Child Form is Complete