Healthy Start Demographic Form | April 2024

OMB Control No. XXXX-XXXX, Expiration Date MM/DD/YYYY

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

Name of Participant/Individual: _____ Date of Birth:_____

Name of Interviewer: _____

Names and dates of birth are included above for grantee tracking purposes only and should not be submitted to HRSA.

Public Burden Statement: The purpose of this information collection is to obtain performance data for the following: HRSA grantees and cooperative agreement recipients, program operations, and reporting requirements. In addition, these data will facilitate the ability to demonstrate alignment between MCHB discretionary programs and the Healthy Start Program to quantify outcomes across MCHB. 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 XXXX-XXXX and it is valid until MM/DD/YYYY. Public reporting burden for this collection of information is estimated to average 0.17 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

GENERAL INSTRUCTIONS

- This demographic form must be completed with all participants enrolled in Healthy Start for preconception, prenatal, postpartum, or parenting/interconception services; an enrolled father or partner; an "other adult" who is not enrolled in the program but has primary responsibility for/custody of an enrolled child; or an individual attending group-based health education sponsored/provided by the Healthy Start program.
- This form must be administered by a trained case worker or other Healthy Start grantee staff member to ensure consistency in responses across participants. It should not be self-administered or administered by staff who have not received training.
- Every form should include the individual's Unique ID# (UID) in Question G1. Each person's UID should remain the same across phases and years of participation in the program and should be in the format noted in Question G1.
- Regardless of which reproductive phase a person is in, every individual should complete this form according to their own experiences.

See next page for additional instructions.

When to complete this form:

- **For enrolled case management/care coordination (CM/CC) participants** (an individual who is enrolling, or is already enrolled in Healthy Start for case management/care coordination services):
  - Complete this form when an individual first enrolls in the Healthy Start program. Every enrolled CM/CC participant must have a completed Demographic form to count toward the number of individuals served by a program.
- **For individuals attending group-based health education only** (an individual not enrolled in Healthy Start case management/care coordination services but attending group-based health education sponsored/provided by Healthy Start)
  - Complete this form when the individual first attends group-based health education. Every group-based health education participant must have a completed Demographic form to count toward the number of individuals served by a program.
- **For "other adults"** (individuals not enrolled in Healthy Start or attending group-based health education who have primary responsibility for/custody of an enrolled child):
  - Complete this form with the caregiver when the child is first enrolled into the program.

How to update/re-screen this form:

- This form should only be updated/re-screened if an individual's participant type (G2) and/or response(s) to Questions 3-9 have changed. To perform an update:
  1. Select "Updated form" in Question G3.
  2. Complete "Date of update" field in Question G3 by entering the date the form is being updated.
  3. Update participant type (G2) and/or responses to Questions 3-9, as applicable.
  4. Do not update/re-screen Questions 1-2.

[GENERAL INFORMATION to be completed by Healthy Start staff:]

G1. This individual's Unique ID#: _____

[Enter as One Number: Grantee Org. Code + PP + Client's Unique ID (e.g., 123PP45678)]

G2. Who is being screened?

(Select one)

- € **CM/CC participant** (an individual who is enrolling, or is already enrolled in the Healthy Start program for case management/care coordination services)
- € **Group-based health education participant** (an individual who is not enrolled in case management/care coordination, but attending group-based health education only)
- € **Other adult** (a person who is not enrolled in the Healthy Start program or attending group-based health education, but has primary responsibility for/custody of an enrolled child)
  - ***Specify relationship to child*** *(select one)**:***
    - € **Grandparent**
    - € **Family member**
    - € **Foster parent**
    - € **Other legal guardian**

G3. This form is an…

(Select one)

- € **Initial form** (this is the first time the individual is completing the form)
  - ⇨ ***Date of initial form completion:*** _____ *(mm/dd/yyyy)*
- € **Updated form** (the individual has completed this form before and is being screened again)
  - ⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*

(ADMINISTRATIVE) *Check the box below if this form is a correction to a copy already uploaded to the Healthy Start Monitoring and Evaluation Data System (HSMED). Otherwise, leave this box blank.*

- € This form is a correction.

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[Staff – Please read the following statement to the participant:]

The purpose of this form is to examine how well the Healthy Start program is meeting its goals of helping families improve their health, the health of their babies, and get the health care they need. This questionnaire should take about 10 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.

Participant General Information

1. Are you currently…?

(Select all that apply)

- € **Preconceptive** (no prior pregnancies, no prior children, not pregnant)
- € **Pregnant or expecting**
- € **Postpartum** (delivered less than 6 months prior to today)
- € **Parenting an infant less than 6 months of age**
- € **Parenting a child 6-11 months of age**
- € **Parenting a child 12-18 months of age**
- € **None of the above**
- € **Declined to answer**

2. What is your age?

(Select one)

- € **_____ years**
- € **Declined to answer**

3. How do you currently describe yourself?

(Select one)

- € **Female**
- € **Male**
- € **Transgender Woman/Transgender Female/Transfeminine**
- € **Transgender Man/Transgender Male/Transmasculine**
- € **I use a different term; please specify: _____**
- € **Declined to answer**

4. What sex were you assigned at birth, on your original birth certificate?

(Select one)

- € **Female**
- € **Male**
- € **Declined to answer**

5. Are you of Hispanic, Latino/a, or Spanish origin?

(Select all that apply)