Attachment C

Initial Contact Form

1. Last Name: *	5. Form Date: *	6. Worker: *
2. First Name: *		
3. Other Name: (e.g., maiden)		
4. Birth Date: *		
7. Lives in target area?	8. Primary Language:	9. Would you like to

7. Lives in target area?	8. Primary Language:	9. Would you like to become pregnant in the
⊖ Yes	⊖ English	next year?
○ No	⊖ Spanish	⊖ Yes
O Unknown	Other:	○ No
		⊖ Unsure

Demographics Optional. As reported by client.

10. Gender:	11. Ethnicity	/:	12. Race: (Check all the	at		
⊖ Female	⊖ Hispanic/	Latinx	apply)			
⊖ Male	🔿 Not Hispa	anic/Latinx	☐ White			
○ Non-binary		to self-identify	Black/African-American			
			🗌 Asian			
			Pacific Islander			
			American Indian/Ala Native	ska		
			Declined to self-ider	ntifv		
			Other:			
13a. Type of referral/rec	cruitment source:	13c. Outside	Referrer:			
Outreach (Street / Do	or-to-Door)	O Prenatal C	are 🛛 🔿 Social Serv	ice		
○ Outside Referral to M	ICHC	Provider	Agency			
○ Group Session Attend	lance	\bigcirc Primary Ca				
 Unrecorded 		Physician	O Public Heal			
O Other:		O Dental Pro	vider Nurse / LHI	D		
		O Pediatricia	n 🔿 School			
		O Birthing Ho				
13b. If street outreach,	specify location:	⊖ Family Pla	•			
		Provider	○ Managed C Plan	are		
		\bigcirc Health Hor				
		○ Mental Heat	Deced	-		
		Behavioral Health	Organizatio	n		

○ Other Health

Specify:

Care Provider,

- Faith Based
 Organization
- Relative / Friend
- Other MICHC
 Program
- Other Client

	⊖ Self
	O Other Service, Specify:
14. Primary Presenting Need:	
15. Action Taken: (Check all that apply)	
Provided information and/or referral (complete Encounter Form and fill out Referrals)	
 Completed Screening Assessment (continue to and complete Screening Assessment Form) 	
 Will schedule follow-up for Screening Assessment (complete Screening Assessment Form at a later date) 	

Screening/Assessment Form

Client Name:	1. Intake Date: *	2. Worker: *
 3a. Living Arrangement: Lives alone or with child/children Lives with speuse/partner 	 4. Highest Grade Completed: Less than 8th 8.11 	6a. Currently is working for pay? ○ Yes ○ No
 Lives with spouse/partner Lives with parent(s) Lives with partner's parent (s) or other related adults Lives with other unrelated adults Lives in foster/group home Homeless/no permanent residence 	 8-11 High school graduate GED Vocational school after HS Some college Associates degree Bachelor's degree or higher 	 No Unknown 6b. Current job is: (Check all that apply) Full-time Part-time Temporary
 Refused/Unknown Other: 3b. Is homeless or has no permanent residence? Yes No Unknown 	 5. Currently enrolled in education/training program? Yes No Unknown 	

 7. Receiving any of the following benefits? (Check all that apply) TANF Emergency Assistance SSI/SSD Food stamps WIC 	 8. Total number of people in household: 9. Average total monthly income of household: \$ Unknown 10. Average total monthly value of benefits: \$ Unknown 	
11a. Usual source of medical care:	12a. Currently has a dental provider?	13a. Currently has health insurance coverage?
○ Doctor/clinician's office	⊖ Yes	⊖ Yes
\bigcirc Hospital outpatient clinic	⊖ No	⊖ No
 Federally qualified health center (FQHC) 	O Unknown	O Unknown
 Emergency department 	12b. Had dental visit in the past 6-8 months?	13b. Type of health insurance:
 Urgent care None 	⊖ Yes	(Check all that apply)
○ None○ Unknown	○ No	Medicaid/Medicaid
O Other:	 Unknown 	Managed Care ☐ Child Health Plus
11b. Had well-visit (non- sick visit) in the past year?	12c. Has any dental problems?	 Private Insurance FPEP or FPBP (family planning only)
Sick visit) in the past year?	\bigcirc No	Unknown
⊖ Yes		Other:
NoUnknown		

Reproductive History

14. Number of previous pregnancies: (Include current pregnancy, if applicable)	 17a. Currently pregnant? * Yes No Unknown 	 18c. If yes, types of birth control used: (Check all that apply) Abstinence Birth control pill
15. Date of last delivery: (if applicable)	17b. If so, expected date of delivery:	 Birth control pill Cervical cap (FemCap) Female condom Spermicide Withdrawal/Other
16a. Number of previous live births:	18a. If not currently pregnant, would like to become pregnant in the next 12 months?	 Birth control implant (Implanon/Nexplanon) Birth control vaginal ring (NuvaRing) Condom
 16b. Any previous babies born below normal weight? (Less than 5 lbs 8 oz) Yes No 	 Yes No Unknown Unsure 18b. If no, currently taking 	 Condom Emergency contraception (morning after pill) Tubal ligation (female sterilization) Rhythm method/natural
 No Unknown 16c. Any previous 	steps to prevent a pregnancy?	family planning/FAM (fertility amenorrhea method)
 inc. Any previous premature births? (36 weeks or less) Yes No 	YesNoUnknown	 Birth control patch (Ortho Evra) Birth control shot (Depo-Provera) Diaphragm
 Unknown 16d. Any previous still births or fetal deaths? 		 Diaphragina IUD (Mirena, Paragard) Vasectomy (male sterilization)
YesNoUnknown		

General Health & Well-Being

19. Taking folic acid supplements? (Or prenatal vitamins, if	21a. Does potential client use tobacco products or vapes?	22a. Have they traveled recently (approx. past 3-6 months)?
pregnant)	⊖ Yes	⊖ Yes
⊖ Yes	⊖ No	⊖ No
⊖ No	🔿 Unknown	🔿 Unknown
	21b. Does anyone in the	22b. If yes, where?
20. Any concerns about a healthy weight?	household use tobacco productst or vapes?	
⊖ Yes	⊖ Yes	
⊖ No	⊖ No	
⊖ Unknown	⊖ Unknown	

23a. Any prenatal visits?	25a. From whom receives financial support related to pregnancy?	26. Has physician indicated any concerns about pregnancy weight gain?
∩ No	(e.g. buying supplies for the	prognancy worght gamm
○ Unknown	baby; paying for doctors' visits)	○ Yes ○ No
23b. If yes, date of first prenatal visit:	☐ Baby's parent	
	Partner (not baby's parent)	27a. Has physician indicated any other
	☐ Parents	concerns about
23c. Number of prenatal	 ☐ Other relatives	pregnancy?
visits:	Friends	⊖ Yes
	□ No one	⊖ No
	Other:	
24. Plan to feed with breast		27b. If yes, specify
milk?	25b. From whom receives	physician's concerns:
⊖ Yes	social support related to	
○ No	pregnancy?	
Unknown	(e.g. going to doctors' visits, transportation, helping with chores)	28. Selected a method of birth control to discuss with physician?
	☐ Baby's parent	⊖ Yes
	Partner (not baby's parent)	⊖ No
	Parents	
	Other relatives	
	Friends	
	☐ No one	
	Other:	

Client with Children Under Twelve Months

29. Does baby have health insurance?	32. Currently feed breast milk?	ding with	fi	4a. From whom nancial support elf/child?	
⊖ Yes	\bigcirc Breast milk on	у		e.g. child support	navmonte
⊖ No	\bigcirc Breastmilk and		•	uying supplies fo	
⊖ Unknown	formula/solids			iving cash)	,
30. Does baby have a	○ No			Baby's parent	
primary medical provider?	33a. Was child ev	ver fed	Γ] Partner (not ba	by's
	breast milk?			parent)	
⊖ Yes	⊖ Yes			Parents	
○ No				Other relatives	
				Friends	
31. Child(ren)'s usual				No one	
source of medical care:	33b. If yes, numb months fed breas		Ľ	Other:	
 Doctor/clinician's office 	months red breas	st milk:			
○ Hospital outpatient clinic		Months)
 Federally qualified health center (FQHC) 	33c. Number of n only breast milk:	nonths fe	ed s	4b. From whom ocial support fo elf/child?	
 Emergency department 	only breast mik.			e.g. child care,	
⊖ Urgent care		Months	· ·	ansportation, hel	ping with
⊖ None				hores)	
🔿 Unknown			Г	Baby's parent	
⊖ Other:			Г] Partner (not ba	bv's
			L	parent)	, , , , , , , , , , , , , , , , , , ,
			Г	Parents	
			Γ	Other relatives	
			Γ	Friends	
			Г	No one	
			Г	Other:	
35. In the past 2 weeks, how o put to bed:		Always	Usuall	y Sometimes	Never
On Back		0	0	0	0

35. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
Alone	0	0	\bigcirc	0
In Crib	0	0	0	0

Alcohol Use (AUDIT-C)

 36. How often do you have a drink containing alcohol? Never (0) Monthly or less (1) 2-4 times a month (2) 2-3 times a week (3) 4 or more times a week (4) 	 37. How many standard drinks containing alcohol do you have on a typical day? 2 or less (0) 3 or 4 (1) 5 or 6 (2) 7 to 9 (3) 10 or more (4) 	 38. How often do you have six or more drinks on one occasion? Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)
39. Screening Result?	40. Was client referred?	41. If another evidence
⊖ Positive	⊖ Yes	based screening tool was used, what was it?
○ Negative	⊖ No	
⊖ Refused		

Substance Abuse (NIDA)

42. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	0	0	0	0	\bigcirc
Tobacco Products	\bigcirc	\bigcirc	0	0	0

https://michc.azurewebsites.net/Pages/ScreeningAssessmentForm?print=1

42. In the past year, H have you used the fo		Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Prescription Drugs for Medical Reasons	Non-	\bigcirc	\bigcirc	0	0	0
Illegal Drugs		0	\bigcirc	\bigcirc	0	0
43. In your lifetime, wh substances have you		-	44. Se Resu	creening It?		5. Was client ferred?
 Cannabis Cocaine Prescription stimulants Methamphetamine Inhalants 	☐ Halluc	ng pills inogens opioids iption s	⊖ Ne	ositive egative ofused	ev so	Yes No If another vidence based creening tool was sed, what was it?

Domestic Violence (HITS)

47. How often does yo partner?	Not at our all Score 1	Rarely Score 2	Sometimes Score 3	Fairly often Score 4	Frequently Score 5
Physically hurt you	0	0	0	0	0
Talk down to you	0	\bigcirc	0	0	0
Threaten you with harm	0	\bigcirc	\bigcirc	0	0
Scream or curse at you	0	0	\bigcirc	0	0
 48. If any of the above items are not answered, why? Does not want to disclose Safety concerns 	49. Does CHW have any concern about violence/coercion in the home not captured by these questions?	is Ri I O O	 Screening Screening Positive Negative Refused 	refe	Was client erred? Yes No If another dence based eening tool was
 No partner Other: 	○ No				ed, what was it?

Depression (PHQ-9)

53. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly every day Score 3
_ittle interest or pleasure in doing hings	\bigcirc	0	0	0

53. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly every day Score 3
Feeling down, depressed, or hopeless	0	0	0	0
Trouble falling asleep or staying asleep, or sleeping too much	\bigcirc	0	0	0
Feeling tired or having little energy	\bigcirc	\bigcirc	0	0
Poor appetite or overeating	\bigcirc	\bigcirc	0	0
Feeling bad about yourself - or that you are a failure or have let your family down	0	0	0	0
Trouble concentrating on things, such as reading the newspaper or watching TV	0	0	0	0
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	0	0	0	0
Thought that you would be better off dead or of hurting yourself in some way	0	0	0	0
54. If you checked off any of the above items, how difficult have these problems	ems	55. Screen Result?		6. Was client eferred?
made it for you to work, take care of at home or get along with other peop	-	⊖ Positive	C) Yes
○ Not difficult at all		○ Negative	-) No
 Somewhat difficult 		 Refused 	5	7. If another
○ Very difficult			-	vidence based
 Extremely difficult 				creening tool was sed, what was it?

Issues

58. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	⊖ No	🔿 No	🔿 No	⊖ No
	O Unknown			
Substance use	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
			\bigcirc No	
		0 110	() no	
Physical disability/health	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
problems	○ No	⊖ No	\bigcirc No	⊖ No
		0	<u> </u>	0
Depression	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	⊖ No	\bigcirc No	O No
		0	0	0
Other mental illness/disability	⊖ Yes	○ Yes	⊖ Yes	⊖ Yes
	○ No	⊖ No	O No	O No
		U No	() no	0 110
Domestic violence	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
				⊖ Tes ⊖ No
Marital or relationship	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
difficulties				
		() No	() Νο	() No

58. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Health concerns for yourself				
		○ Yes○ No	○ Yes○ No	○ Yes○ Ne
	○ No	⊖ No	⊖ No	⊖ No
Financial difficulties	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
			\bigcirc No	
	_			
	O Unknown			
Unemployment (self or	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
partner)	\bigcirc No		 No 	
Homelessness/inadequate	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
housing	○ No	○ No	O No	◯ No
		_	-	-
Legal problems	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	-	-	-	-
		⊖ No	⊖ No	⊖ No
Social isolation	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	⊖ No	○ No	⊖ No
		0	0	0
Stress or emotional				
difficulties	⊖ Yes	⊖ Yes	\bigcirc Yes	\bigcirc Yes
	⊖ No	⊖ No	⊖ No	🔿 No

58. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Inadequate food, clothing, or	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
household items	○ No	⊖ No	◯ No	⊖ No
		0	0	0
Smoking	◯ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	○ No	○ No	⊖ No
		0	0	0
Problems with teeth or gums	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
(e.g. pain, bleeding)		 No 		
			U NO	0 110
Parenting	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	○ No	⊖ No	⊖ No
		0	0	0
Prenatal/postpartum health	◯ Yes	⊖ Yes	⊖ Yes	⊖ Yes
issues	⊖ No	○ No	◯ No	⊖ No
		0	0	0
Health concerns for your	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
child	○ No	○ No	◯ No	⊖ No
		0	C	C
Concerns about your child's	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
development	○ No	⊖ No	⊖ No	⊖ No
		<u> </u>	<u> </u>	0

58. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Accessing dental care	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	⊖ No	🔿 No	🔿 No	🔿 No
	O Unknown			

Information

 59. Would like more information about? (Check all that apply) Family planning/contraception Pregnancy testing Safe sex Exercise, opportunities to exercise Nutrition, access to healthy foods HIV testing STD testing Job search/placement assistance Adult basic education or GED preparation ESL (English as a Second Language) Vocational or job skills training Alcohol Basic needs (housing, food, etc) Depression Domestic Violence Health Insurance 	Pregnant or Parenting Child care programs Parenting skills Lead assessment/testing Child development Safe sleep Environmental health/safety Car seat use Healthy pregnancy Feeding with breast milk and child nutrition Hmunizations Accessing dental care Birth Plan / Preterm Birth Infant / New Born Care Postpartum Care Prental Care
 Basic needs (housing, food, etc) Depression Domestic Violence 	Postpartum Care

Child Information & Pregnancy Outcomes Form

Pregnancy

3a. Did birthing person/client receive prenatal care?	4. Did birthing person/client visit dentist during pregnancy?	6. Number of births:
⊖ Yes	⊖ Yes	
⊖ No	○ No	
⊖ Unknown	O Unknown	
3b. Date began receiving prenatal care?	5. Did birthing person/client smoke during pregnancy?	
	⊖ Yes	
	⊖ No	
	O Unknown	

Children

7. Last Name: *	13. Was a live birth?	18. Gender:	
	⊖ Yes	⊖ Female	
8. First Name: *	⊖ No	⊖ Male	
	14. Type of Delivery:	○ Non-binary	
	⊖ Vaginal	19. Ethnicity:	
9. Birth Date: *	⊖ Cesarean	○ Hispanic/Latinx	
	15. Was in an intensive care unit?	 Not Hispanic/Latinx Declined to self-identify 	
 10. First Birth? Yes No 11. Gestational Age: (In whole weeks) Weeks 12. Birth Weight: Lbs Oz 	 care unit? Yes No 16. Was infant alive at hospital discharge? Yes No 17. Was infant receiving breast milk at discharge? Yes Yes No 	 20. Race: (Check all that apply) White Black/African-American Asian Pacific Islander American Indian/Alaska Native Declined to self-identify Unknown Other: 	
* Children missing required field	s will not be saved.	21. Date of death (if applicable):	

Medical

22a. Has Insurance Coverage?	23. Post-partum visit scheduled?
⊖ Yes	⊖ Yes
⊖ No	○ No
⊖ Unknown	⊖ Unknown
22b. Insurance Type: (Check all that apply)	24. Has birthing person/client selected a
Medicaid/Medicaid Managed Care	contraceptive method to discuss with their doctor?
Child Health Plus	
Private Insurance	○ No
Unknown	⊖ Unknown
Other:	

ASQ Form

1. Infant: *	2. Worker: *	3. Date: *
4. Interval:	5. Infant is currently	6. Parent declined further
○ 2 Months	receiving services:	screening:
⊖ 4 Months	⊖ Yes	⊖ Yes
○ 6 Months	⊖ No	⊖ No
○ 9 Months		
○ 12 Months		
○ 18 Months		
 at least 18 Months under 24 Months 		
 at least 24 Months under 36 Months 		
 at least 36 Months under 48 Months 		
 at least 48 Months under 60 Months 		
7. Was a referral made?:	8. Referral not needed at this time:	9. Monitoring prior to referral:
⊖ Yes	this time.	Teleffal.
⊖ No	\bigcirc Yes	⊖ Yes
	⊖ No	⊖ No
10. If another evidence based screening tool was used, what was it?		
Communication:		

Gross Motor:
Fine Motor:
Dasklam Calvinau
Problem Solving:
Personal / Social:

Encounter Form

Client Name:	1. Encounter Date: *	2. Worker: *	
3. Length of Visit: Hrs Mins	 4a. Type of Contact: In-person Phone E-mail Text Videoconferencing 4b. If in-person, where did it occur? Client home Other: 	 5. Who was present at visit? (Check all that apply) Client Client's partner Client's parent(s) Client's child(ren) Other: 	

Activities (Check all that apply)

Health Care:	Family Functioning:
Provide general health information	Address issues re: violence in the home
Provide family planning/optimal birth	Discuss family relations
spacing info	Discuss substance use issues
Provide child health information	Discuss mental health issues
Provide dental health information	Teach, foster communication skills
Provide nutrition/food preparation information	Concrete Activities:

Provide safe sex or STD information	Arrange for transportation
Provide information of health providers or services	Provide or arrange for food, clothes, diapers, or household goods
Provide advocacy/support or accompany to	Address legal needs
medical providers and services	Provide info and/or assistance with housing
Provide information on smoking cessation	☐ Translation
Completed / Reviewed Birth Plan	Provide advocacy/support and/or
Prenatal/New Parent:	accompany to non-medical providers or services
Provide education/info re: prenatal	Discuss child support issues
care/pregnancy	Discuss visitation issues
Discuss feelings about baby	Discuss parental rights issues
Provide labor and delivery support	Arrange appointment for health care
Address infant basic care needs (sleeping, bathing, etc)	services
Provide safe sleep information	Program Activities:
Provide infant feeding information and	Complete forms
support	\Box Assess needs, develop or review family
Provide breastfeeding information and ownered	service plan
support	Crisis Intervention:
Provide information/equipment relating to child safety (car seats, child proofing	\Box Help reactive problems and hendle prices
homes, etc.)	Help resolve problems and handle crises
Discuss alcohol impacts during pregnancy	Other Activities:
Discuss Shaken Baby Syndrome	Other:
Provide support to parents re: stresses of parenting	
☐ Infant weight check	
\Box Car seat check	
☐ Crib check/crib for kids	
Self-Sufficiency:	
Teach to use public transportation or	
provide maps or directions	
Teach how to use calendar or appointment book	
Address needs for child care	

Client Medical Visits

Type of Visit *	Date of Visit *	Reason for Visit	Weeks Pregnant (if applicable)
Specify:			

Type of Visit Codes:

- 5. Urgent Care 1. Annual OBGYN 6. Dental visit exam 99. Other
- 2. Prenatal visit
- 3. Postpartum visit
- 4. Routine physical

Baby Medical Visits

Type of Visit *	Date of Visit *	Reason for Visit	Child's Age (in months)	Lead screening done at this visit?
Specify:				○ Yes○ No○ Unknown
Specify:				○ Yes ○ No ○ Unknown
Specify:				○ Yes ○ No ○ Unknown
Specify:				○ Yes○ No○ Unknown
Specify:				○ Yes○ No○ Unknown
* Records missin	g required fields wi	ll not be saved.		

Type of Visit Codes:

- 1. Well-baby visit
- 2. Urgent Care
- 3. Non-well baby visit
- 4. Dental
- 99. Other

Type of Immunization(s) *	Date *	Child's Age (in months)	
* Records missing required fields will not be saved.			

Type of Immunization Codes:			
1. Hepatitis B	9. Varicella		
2. Rotavirus	10. Hepatitis A		
3. Diphtheria, tetanus, &	11. Meningococcal		
acellular pertussis	12. Tetanus, diphtheria, &		
4. Haemophilus influenzae	acellular pertussis		
type b	13. Human papillomavirus		
5. Pneumococcal conjugate	14. Meningococcal B		
6. Inactivated poliovirus	15. Pneumococcal		
7. Influenza	polysaccharide		
8. Measles, mumps, rubella	16. COVID-19		

Referrals

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
* Records missing	required fields will not	be saved.		

Service Codes:

Health Care

- 1. Adult primary care
- 2. Child primary care
- 3. Dental services
- 4. Early Intervention
- 5. Family Planning
- 6. Immunization

Home Visiting

- 28. Early Head Start
- 29. Head Start
- 30. Healthy Families New York
- 31. Healthy Start
- 32. Home Instruction for Parents of Preschool Youngsters

- 7. Lead Testing
- 8. Mental Health Services
- 9. Postpartum Care
- 10. Prenatal Care
- 11. Other, Specify

Family & Social Support Referrals

- 12. Breastfeeding
- 13. Car Seat
- 14. Childcare
- 15. Child Development
- 16. Child Support
- 17. Clothing / Baby Care Items
- 18. Domestic Violence
- 19. Educational Attainment
- 20. Employment / Vocational Services
- 21. Environmental Health / Safety
- 22. English as a Second Langauge (ESL)
- 23. Family Resource Center
- 24. Food Pantry
- 25. Furniture
- 26. Health Insurance
- 27. HEAP

- 33. Nurse-Family Partnership
- 34. Parent Child Home Program
- 35. Parents as Teachers
- 36. Public Health Nurse / LHD
- 37. Other Home Visiting Program, Specify

Other Services

- 38. Housing
- 39. Immigration Services
- 40. Legal Services
- 41. Nutrition, General
- 42. Safe Sleep
- 43. Smoking Cessation
- 44. SNAP (Food Stamps)
- 45. Substance Use
- 46. Support Groups
- 47. TANF/DSS Cash Assistance
- 48. Translation
- 49. Transportation
- 50. WIC
- 51. Other, Specify

Family Member Codes:

- 1. Client
- 2. Client's partner
- 3. Other biological parent of
- enrolled child (non-partner)
- 4. Enrolled child

- 5. Other child
- 6. Other relative
- 7. Non-relative

Update Form

Client Name:	1. Form Date: *	2. Worker: *
3a. Living Arrangement:	4a. Currently has health	5. Receiving any of the
 Lives alone or with child/children Lives with spouse/partner Lives with parent(s) Lives with partner's parent (s) or other related adults Lives with other unrelated 	 insurance coverage? Yes No Unknown 4b. Type of health insurance: (Check all that apply) 	following benefits? (Check all that apply) TANF Emergency Assistance SSI/SSD Food stamps WIC
adults Lives in foster/group home Homeless/no permanent residence Refused/Unknown Other: 3b. Is homeless or has no	 Medicaid/Medicaid Managed Care Child Health Plus Private Insurance FPEP or FPBP (family planning only) Unknown Other: 	
 permanent residence? Yes No Unknown 	 4c. Any period of no health insurance coverage since last update? Yes No Unknown 	

6a. Been pregnant since last follow-up? (Exclude pregnancy at program intake) Yes No Unknown 6b. If yes, currently pregnant? * Yes No Unknown 6c. If so, expected date of delivery:	 7a. If not currently pregnant, would like to become pregnant in the next 12 months? Yes No Unknown Unsure 7b. If no, have you been consistently using birth control since last follow-up? Yes No Unknown 	 7c. If yes, types of birth control used since the last follow-up: (Check all that apply) Abstinence Birth control pill Cervical cap (FemCap) Female condom Spermicide Withdrawal/Other Birth control implant (Implanon/Nexplanon) Birth control vaginal ring (NuvaRing) Condom Emergency contraception (morning after pill) Tubal ligation (female sterilization) Rhythm method/natural family planning/FAM (fertility amenorrhea method) Birth control shot (Depo-Provera) Diaphragm IUD (Mirena, Paragard) Vasectomy (male sterilization)
		sterilization)

General Health & Well Being

8. Taking folic acid supplements? (Or prenatal vitamins, if pregnant)	10a. Does potential client use tobacco products or vapes?	11a. Have they traveled recently (approx. past 3-6 months)?	
	⊖ Yes	⊖ Yes	
⊖ Yes	⊖ No	⊖ No	
⊖ No	🔿 Unknown	O Unknown	
 Unknown 9. Any concerns about a healthy weight? 	10b. Does anyone in the household use tobacco	11b. If yes, where?	
	productst or vapes?		
⊖ Yes	⊖ Yes		
⊖ No	⊖ No		
🔿 Unknown	🔿 Unknown		

12a. Any prenatal visits? O Yes	14a. From whom receives financial support related to pregnancy?	15. Has physician indicated any concerns about pregnancy weight gain?	
NoUnknown	(e.g. buying supplies for the baby; paying for doctors'	○ Yes	
12b. If yes, date of first prenatal visit:	visits) Baby's parent Partner (not baby's		
	 parent) Parents 	16a. Has physician indicated any other concerns about	
12c. Number of prenatal visits:	 ☐ Other relatives ☐ Friends	pregnancy?	
	 ☐ No one ☐ Other: 	 No Unknown 	
13. Plan to feed with breast milk?		16b. If yes, specify	
○ Yes○ No	14b. From whom receives social support related to	physician's concerns:	
 Unknown 	pregnancy? (e.g. going to doctors' visits, transportation, helping with chores)	17. Selected a method of birth control to discuss with physician?	
	Baby's parent	⊖ Yes	
	Partner (not baby's parent)	⊖ No	
	Parents		
	Other relatives		
	Friends		
	☐ No one		
	Other:		

Client with Children Under Twelve Months

18. Does baby have health insurance?	21. Currently fee breast milk?	ding with		23a. From whom receives financial support for
⊖ Yes	○ Breast milk onl	у		self/child?
⊖ No	○ Breastmilk and			(e.g. child support payments, buying supplies for the baby;
🔿 Unknown	formula/solids			giving cash)
19. Does baby have a primary medical provider?	○ No 22a. Was child ev	ver fed		 □ Baby's parent □ Partner (not baby's
	breast milk?			parent)
⊖ Yes				Parents
⊖ No				Other relatives
	O No			Friends
20. Child(ren)'s usual	O Unknown			🗌 No one
source of medical care:	22b. If yes, number of months fed breast milk:			 □ Other:
O Doctor/clinician's office		Months	3	
Hospital outpatient clinic Federally muslified beatth				23b. From whom receives
 Federally qualified health center (FQHC) 	22c. Number of n only breast milk:			social support for self/child?
 Emergency department 		Months		(e.g. child care,
○ Urgent care		Wontine		transportation, helping with
○ None				chores)
🔿 Unknown				Baby's parent
O Other:				Partner (not baby's parent)
				□ Parents
				☐ Other relatives
				☐ Friends
				☐ No one
				☐ Other:
24. In the past 2 weeks, how o put to bed:		Always	Usual	lly Sometimes Never
On Back		0	0	0 0

24. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
Alone	0	0	0	0
In Crib	0	0	0	0

Alcohol Use (AUDIT-C)

 25. How often do you have a drink containing alcohol? Never (0) Monthly or less (1) 2-4 times a month (2) 2-3 times a week (3) 4 or more times a week (4) 	 26. How many standard drinks containing alcohol do you have on a typical day? 2 or less (0) 3 or 4 (1) 5 or 6 (2) 7 to 9 (3) 10 or more (4) 	 27. How often do you have six or more drinks on one occasion? Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)
28. Screening Result?	29. Was client referred?	30. If another evidence
⊖ Positive	⊖ Yes	based screening tool was used, what was it?
○ Negative	⊖ No	
⊖ Refused		

Substance Abuse (NIDA)

		0			Dellerer
31. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	0	\bigcirc	0	0	0
Tobacco Products	0	\bigcirc	0	\bigcirc	\bigcirc
Prescription Drugs for Non- Medical Reasons	0	0	0	0	0
Illegal Drugs	0	0	0	0	0
2. In your lifetime, which of the substances have you ever used	-	33. S Resu	creening It?		4. Was client ferred?
Cocaine slee	atives or bing pills ucinogens	0	esitive egative	C) Yes) No

 Prescription Street opioids Prescription Methamphetamine Inhalants Other: 	Refused 35. If another evidence based screening tool was used, what was it?
--	--

Domestic Violence (HITS)

36. How often does yo partner?	Not at our all Score 1	Rarely Score 2	Sometimes Score 3	Fairly often Score 4	Frequently Score 5
Physically hurt you	0	0	0	0	0
Talk down to you	0	0	\bigcirc	0	0
Threaten you with harm	0	\bigcirc	\bigcirc	0	0
Scream or curse at you	0	0	\bigcirc	0	0
 37. If any of the above items are not answered, why? Does not want to disclose Safety concerns 	38. Does CHW have any concern about violence/coercion in the home not captured by these questions?	is Ri	 Screening Solution Positive Negative Refused 	refe 0 41. evi	Was client erred? Yes No If another dence based
 No partner Other: 	○ Yes○ No				eening tool was ed, what was it?

Depression (PHQ-9)

2. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly every day Score 3
ittle interest or pleasure in doing hings	0	0	0	0

42. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly every day Score 3
Feeling down, depressed, or hopeless	0	0	0	0
Trouble falling asleep or staying asleep, or sleeping too much	\bigcirc	0	0	0
Feeling tired or having little energy	\bigcirc	\bigcirc	0	0
Poor appetite or overeating	\bigcirc	\bigcirc	0	0
Feeling bad about yourself - or that you are a failure or have let your family down	0	0	0	0
Trouble concentrating on things, such as reading the newspaper or watching TV	0	0	0	0
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	0	0	0	0
Thought that you would be better off dead or of hurting yourself in some way	0	0	0	0
43. If you checked off any of the above items, how difficult have these problems		44. Screen Result?	•	5. Was client eferred?
made it for you to work, take care of at home or get along with other peop	-	 Positive Negative 	0) Yes
 Not difficult at all Somewhat difficult Very difficult Extremely difficult 		 Negative Refused 	4 e S	No No No Notifience based Creening tool was Sed, what was it?

Issues

47. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	⊖ No	🔿 No	🔿 No	🔿 No
Substance use	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
		U No	\bigcirc no	
Physical disability/health	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
problems	○ No	⊖ No	\bigcirc No	O No
		0	0	0
Depression	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
			\bigcirc No	
Other mental illness/disability		⊖ Yes		
		0	⊖ Yes	⊖ Yes
	○ No○ Unknown	🔿 No	⊖ No	⊖ No
Domestic violence				
	⊖ Yes	○ Yes		⊖ Yes
	○ No○ Unknown	⊖ No	⊖ No	⊖ No
Marital or relationship	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
difficulties				

	Currently	Would like	Was information	Was client
47. Issue	experiencing?	assistance?	given?	referred?
Health concerns for yourself	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	⊖ No	O No	⊖ No
		0 110	\bigcirc No	\bigcirc No
Financial difficulties				
			○ Yes	
	○ No	⊖ No	⊖ No	⊖ No
Unemployment (self or	0.14	0.14	0.14	- N
partner)	⊖ Yes		⊖ Yes	⊖ Yes
	○ No	⊖ No	⊖ No	⊖ No
	 Unknown 			
Homelessness/inadequate	0.14	0.14	0.14	0.14
housing	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	⊖ No	⊖ No	⊖ No
Legal problems	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	-		-	-
	○ No	⊖ No	⊖ No	⊖ No
Social isolation	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	○ No	⊖ No	
		0 110	0 110	0 110
Stress or emotional difficulties	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
amouluos	⊖ No	🔿 No	⊖ No	⊖ No
	O Unknown			

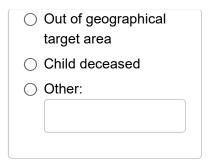
47. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Inadequate food, clothing, or	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
household items	\bigcirc No	 No 	O No	
		U No	U No	0 110
Smoking	◯ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	○ No	No	○ No
		0		0
Problems with teeth or gums	⊖ Yes	○ Yes	⊖ Yes	⊖ Yes
(e.g. pain, bleeding)	⊖ No	⊖ No	◯ No	⊖ No
		0	0	0
Parenting	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	○ No	◯ No	⊖ No
		C	0	C
Prenatal/postpartum health	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
issues	○ No	○ No	No	○ No
		0	0	C
Health concerns for your	◯ Yes	⊖ Yes	⊖ Yes	⊖ Yes
child	○ No	◯ No	◯ No	◯ No
		0		C
Concerns about your child's	◯ Yes	⊖ Yes	⊖ Yes	⊖ Yes
development	○ No	◯ No	◯ No	⊖ No
	 Unknown 	-	-	-

47. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Accessing dental care	YesNoUnknown	○ Yes○ No	○ Yes○ No	○ Yes ○ No

Information

48. Would like more information about?	Pregnant or Parenting
 (Check all that apply) Family planning/contraception Pregnancy testing 	 Child care programs Parenting skills Lead assessment/testing
 Safe sex Exercise, opportunities to exercise Nutrition, access to healthy foods HIV testing STD testing Job search/placement assistance Adult basic education or GED preparation ESL (English as a Second Language) Vocational or job skills training Alcohol Basic needs (housing, food, etc) Depression Domestic Violence Health Insurance Illicit Drug Use Preventative Care / Primary Care 	 Child development Safe sleep Environmental health/safety Car seat use Healthy pregnancy Feeding with breast milk and child nutrition Immunizations Accessing dental care Birth Plan / Preterm Birth Infant / New Born Care Postpartum Care Prental Care
Smoking	

Client Name:	1. Discharge Date: *	2. Worker: *
3. Discharge Reason:	4a. Living Arrangement:	5a. Currently has health insurance coverage?
 Client has met their goals 	 Lives alone or with child/children 	 Yes
Program unable to	○ Lives with	⊖ No
locate or make contact	spouse/partner	O Unknown
 Participant non- compliant or unresponsive 	 Lives with parent(s) Lives with partner's parent(s) or other related 	5b. Type of health insurance:
 Participant refused 	adults	(Check all that apply)
 Transferred/referred to another MICHC 	 Lives with other unrelated adults 	Medicaid/Medicaid Managed Care
program Transferred/referred to	 Lives in foster/group home 	Child Health Plus
a prevention/home visiting program	 Homeless/no permanent residence 	FPEP or FPBP (family planning only)
 Client deceased 	◯ Refused/Unknown	
 Client unavailable due to school or employment 	O Other:	☐ Other:
 CHW left, client refused new CHW 	4b. Is homeless or has no permanent residence?	5c. Any period of no
 Safety issues for worker 	⊖ Yes	health insurance coverage since last update?
O Program terminated	⊖ No	⊖ Yes
due to mental health		⊖ No
issues Family or other household member objects to program		O Unknown



Reproductive History

6a. Been pregnant since last follow-up? (Exclude pregnancy at program intake)	7a. If not currently pregnant, would like to become pregnant in the next 12 months?	7c. If yes, types of birth control used since the last follow-up: (Check all that apply)
 Yes No Unknown 6b. If yes, currently pregnant? Yes No Unknown 6c. If so, expected date of delivery: 	 Yes No Unknown Unsure Tb. If no, have you been consistently using birth control since last follow-up? Yes No Unknown 	 Abstinence Birth control pill Cervical cap (FemCap) Female condom Spermicide Withdrawal/Other Birth control implant (Implanon/Nexplanon) Birth control vaginal ring (NuvaRing) Condom Emergency contraception (morning after pill) Tubal ligation (female sterilization) Rhythm method/natural family planning/FAM (fertility amenorrhea method) Birth control patch (Ortho Evra) Birth control shot (Depo- Provera) Diaphragm IUD (Mirena, Paragard) Vasectomy (male sterilization)

General Health & Well Being

8. Taking folic acid supplements? (Or prenatal vitamins, if	10a. Does potential client use tobacco products or vapes?	11a. Have they traveled recently (approx. past 3-6 months)?
pregnant)	⊖ Yes	⊖ Yes
⊖ Yes	⊖ No	⊖ No
⊖ No	🔿 Unknown	🔿 Unknown
 Unknown 9. Any concerns about a healthy weight? 	10b. Does anyone in the household use tobacco productst or vapes?	11b. If yes, where?
	⊖ Yes	
⊖ No	⊖ No	
O Unknown	O Unknown	

Currently Pregnant Client

12a. Any prenatal visits?	14a. From whom receives financial support related to pregnancy?	15. Has physician indicated any concerns about pregnancy weight gain?
⊖ No	(e.g. buying supplies for the	
 Unknown 	baby; paying for doctors'	⊖ Yes
	visits)	⊖ No
12b. If yes, date of first prenatal visit:	Baby's parent	
	☐ Partner (not baby's	16a. Has physician
	parent)	indicated any other
	\square Parents	concerns about
40 - Norscham of annual stal	\Box Other relatives	pregnancy?
12c. Number of prenatal visits:		
	☐ Friends	⊖ Yes
	No one	⊖ No
	Other:	
13. Plan to feed with breast		16b. If yes, specify
milk?		physician's concerns:
⊖ Yes	14b. From whom receives	
⊖ No	social support related to	
⊖ Unknown	pregnancy?	17. Selected a method of
	(e.g. going to doctors' visits, transportation, helping with	birth control to discuss
	chores)	with physician?
		0 Y
	Baby's parent	⊖ Yes
	Partner (not baby's	⊖ No
	parent)	
	Parents	
	Other relatives	
	Friends	
	☐ No one	
	Other:	

Client with Children Under Twelve Months

18. Does baby have health insurance?	21. Currently fee breast milk?	ding with		23a. From whom receives financial support for
⊖ Yes	○ Breast milk on	ly		self/child?
⊖ No	○ Breastmilk and	ł		(e.g. child support payments, buying supplies for the baby;
⊖ Unknown	formula/solids			giving cash)
19. Does baby have a primary medical provider?	○ No 22a. Was child e	ver fed		 Baby's parent Partner (not baby's
	breast milk?	ver ieu		parent)
⊖ Yes	~ <i>.</i>			☐ Parents
⊖ No	⊖ Yes			 ☐ Other relatives
⊖ Unknown	○ No			 ∏ Friends
20. Child(ren)'s usual				□ No one
source of medical care:	22b. If yes, numb months fed brea			Other:
 Doctor/clinician's office 		Months		
○ Hospital outpatient clinic				23b. From whom receives
 Federally qualified health center (FQHC) 	22c. Number of r only breast milk:			social support for self/child?
○ Emergency department		Months		(e.g. child care,
⊖ Urgent care		wonths	5	transportation, helping with
⊖ None				chores)
				Baby's parent
O Other:				Partner (not baby's
				parent)
				Parents
				Other relatives
				Friends
				☐ No one
				Other:
24. In the past 2 weeks, how o put to bed:	often was child	Always	Usua	lly Sometimes Never
On Back		0	0	0 0

24. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
Alone	0	0	\bigcirc	0
In Crib	0	0	0	0

Alcohol Use (AUDIT-C)

 25. How often do you have a drink containing alcohol? Never (0) Monthly or less (1) 2-4 times a month (2) 2-3 times a week (3) 4 or more times a week (4) 	 26. How many standard drinks containing alcohol do you have on a typical day? 2 or less (0) 3 or 4 (1) 5 or 6 (2) 7 to 9 (3) 10 or more (4) 	 27. How often do you have six or more drinks on one occasion? Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)
28. Screening Result?	29. Was client referred?	30. If another evidence
⊖ Positive	⊖ Yes	based screening tool was used, what was it?
○ Negative	⊖ No	
⊖ Refused		

Substance Use (NIDA)

31. In the past year, how often have you used the following		Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	0	0	0	0	0
Tobacco Products	0	\bigcirc	\bigcirc	\bigcirc	\bigcirc
Prescription Drugs for Non- Medical Reasons	0	0	0	0	0
Illegal Drugs	0	0	0	0	0
2. In your lifetime, which of t ubstances have you ever use	-	33. S Resu	creening It?		4. Was client ferred?
Cocaine sle	datives or eping pills Ilucinogens	0	ositive egative	C	Yes No

 Prescription Street opioids Refused stimulants Prescription opioids Inhalants Other: 	35. If another evidence based screening tool was used, what was it?
--	--

Domestic Violence (HITS)

36. How often does yo partner?	Not at our all Score 1	Rarely Score 2	Sometimes Score 3	Fairly often Score 4	Frequently Score 5
Physically hurt you	0	0	0	0	0
Talk down to you	0	\bigcirc	0	0	0
Threaten you with harm		\bigcirc	\bigcirc	0	0
Scream or curse at you	0	0	\bigcirc	0	0
 37. If any of the above items are not answered, why? Does not want to disclose Safety concerns No partner Other: 	 38. Does CHW have any concern about violence/coercion in the home not captured by these questions? Yes No 	is Ri I O O	 D. Screening esult? Positive Negative Refused 	refe 41. evic	Was client erred? Yes No If another dence based eening tool was ed, what was it?

Depression (PHQ-9)

2. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly every day Score 3
ittle interest or pleasure in doing hings	0	0	0	0

42. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly s every day Score 3
Feeling down, depressed, or hopeless	0	0	0	0
Trouble falling asleep or staying asleep, or sleeping too much	0	0	0	0
Feeling tired or having little energy	\bigcirc	\bigcirc	0	0
Poor appetite or overeating	\bigcirc	\bigcirc	\bigcirc	0
Feeling bad about yourself - or that you are a failure or have let your family down	0	0	0	0
Trouble concentrating on things, such as reading the newspaper or watching TV	0	0	0	0
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	0	0	0	0
Thought that you would be better off dead or of hurting yourself in some way	0	0	0	0
I3. If you checked off any of the above tems, how difficult have these problemeds it for you to work, take core of	ems	44. Screen Result?	0	I5. Was client referred?
nade it for you to work, take care of at home or get along with other peop	-	 Positive Negative) Yes
 Not difficult at all Somewhat difficult Very difficult Extremely difficult 		 Negative Refused 	1	○ No I6. If another evidence based screening tool was used, what was it?

Issues

47. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	⊖ No	🔿 No	🔿 No	⊖ No
Substance use	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
		U NO	\bigcirc No	
Physical disability/health	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
problems	○ No	⊖ No	⊖ No	⊖ No
		0	0	0
Depression	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
			\bigcirc No	
Other mental illness/disability	⊖ Yes	⊖ Yes		
	0	0	⊖ Yes	⊖ Yes
	○ No○ Unknown	🔿 No	⊖ No	⊖ No
Domestic violence				
			⊖ Yes	
	○ No○ Unknown	⊖ No	⊖ No	⊖ No
Marital or relationship	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
difficulties				
				() No

47. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Health concerns for yourself	⊖ Yes	⊖ Yes	⊖ Yes	◯ Yes
		U NO	0 110	0 110
Financial difficulties	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
		U NO	0 110	0 110
Unemployment (self or	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
partner)				O No
Homelessness/inadequate	⊖ Yes	⊖ Yes) Yes	⊖ Yes
housing				
Legal problems	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
			0 110	
Social isolation	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	 No 	⊖ No	⊖ No
		0 No	0 110	0 110
Stress or emotional	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
difficulties				
	 Unknown 			

47. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Inadequate food, clothing, or	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
household items	⊖ No	⊖ No	◯ No	⊖ No
		0	0	0
Smoking	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	○ No	⊖ No	○ No	⊖ No
		0	0	0
Problems with teeth or gums	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
(e.g. pain, bleeding)				
		U No	U No	0 110
Parenting	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	⊖ No	○ No	◯ No	⊖ No
		0	0	0
Prenatal/postpartum health	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
issues	○ No	🔿 No	⊖ No	⊖ No
		-	-	-
Health concerns for your	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
child	○ No	○ No	○ No	◯ No
				C
Concerns about your child's	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
development	○ No	No	○ No	◯ No
		_	_	-

47. Issue	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Accessing dental care	⊖ Yes	⊖ Yes	⊖ Yes	⊖ Yes
	⊖ No	🔿 No	⊖ No	⊖ No
	O Unknown			

Outreach Event and Group Session Form

Date: *	Start Time:	End Time:
Title:	Workers: (Check all that apply) Madison, Lara	Location:
Event Type:		
If Coordinated Outreach:	Number of partners engaged:	Event Description:

Contacts

Last Name	First Name	Age (in years)	May Contact?	Preferred Contact

Last Name	First Name	Age (in years)	May Contact?	Preferred Contact

Referrals

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
Specify:			○ Yes ○ No	
Specify:			⊖ Yes ⊖ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			⊖ Yes ⊖ No	
Specify:			○ Yes ○ No	

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
Specify:			○ Yes ○ No	
* Records missing	required fields will not	be saved.		

Service Codes:

Health Care

- 1. Adult primary care
- 2. Child primary care
- 3. Dental services
- 4. Early Intervention
- 5. Family Planning
- 6. Immunization
- 7. Lead Testing
- 8. Mental Health Services
- 9. Postpartum Care
- 10. Prenatal Care
- 11. Other, Specify

Family & Social Support Referrals

- 12. Breastfeeding
- 13. Car Seat
- 14. Childcare
- 15. Child Development
- 16. Child Support
- 17. Clothing / Baby Care Items
- 18. Domestic Violence
- 19. Educational Attainment
- 20. Employment / Vocational Services
- 21. Environmental Health / Safety
- 22. English as a Second Langauge (ESL)
- 23. Family Resource Center
- 24. Food Pantry
- 25. Furniture
- 26. Health Insurance
- 27. HEAP

Home Visiting

- 28. Early Head Start
- 29. Head Start
- 30. Healthy Families New York
- 31. Healthy Start
- 32. Home Instruction for Parents of Preschool

Youngsters

- 33. Nurse-Family Partnership
- 34. Parent Child Home Program
- 35. Parents as Teachers
- 36. Public Health Nurse / LHD
- 37. Other Home Visiting Program, Specify

Other Services

- 38. Housing
- 39. Immigration Services
- 40. Legal Services
- 41. Nutrition, General
- 42. Safe Sleep
- 43. Smoking Cessation
- 44. SNAP (Food Stamps)
- 45. Substance Use
- 46. Support Groups
- 47. TANF/DSS Cash Assistance
- 48. Translation
- 49. Transportation
- 50. WIC
- 51. Other, Specify

4. Enrolled child

Family Member Codes:		
 Client Client's partner Other biological parent of enrolled child (non-partner) 	5. Other child 6. Other relative 7. Non-relative	

Information

Would like more information about? (Check all that apply) Family planning/contraception Pregnancy testing Safe sex Exercise, opportunities to exercise Nutrition, access to healthy foods HIV testing STD testing Job search/placement assistance Adult basic education or GED preparation ESL (English as a Second Language) Vocational or job skills training Alcohol Basic needs (housing, food, etc) Depression Domestic Violence Health Insurance Illicit Drug Use Preventative Care / Primary Care	Pregnant or Parenting Child care programs Parenting skills Lead assessment/testing Child development Safe sleep Environmental health/safety Car seat use Healthy pregnancy Feeding with breast milk and child nutrition Hmunizations Accessing dental care Birth Plan / Preterm Birth Infant / New Born Care Postpartum Care Prental Care

Training Form

Date: *	Training Type:	Topic:
Vorkers: (Check all that	t apply)	
] Madison, Lara		