State of Oklahoma
Office of Management and Enterprise Services
Central Purchasing Division

Solicitation

1. Solicitation #: 3400001190

2. Solicitation Issue Date: Sept. 5, 2013

3. Brief Description of Requirement:

This is a Re-Bid for :

MIECHV Parents as Teachers (PAT) Home Visitation Program
Contract for the implementation of home visitation services using the Parents as Teachers model in Muskogee County in an effort to expand the continuum of home visitation services within the county.

Please reference Section G regarding deadline for questions and also guidelines for proposal submissions

4. Response Due Date[1]: October 1, 2013 **Time**: 3:00 PM CST/CDT

5. Issued By and RETURN SEALED BID TO:

Personal or Common Carrier Delivery:

Office of Management and Enterprise Services
Central Purchasing Division
Will Rogers Building
2401 N. Lincoln Blvd, Suite 116,
Oklahoma City, OK 73105

U.S. Postal Delivery:

Office of Management and Enterprise Services
Central Purchasing Division
P.O. Box 528803,
Oklahoma City, Oklahoma 73152-8803

6. Solicitation Type (check one below)**:**

- ☐ Invitation to Bid
- ☑ Request for Proposal
- ☐ Request for Quote

7. Requesting Agency: Oklahoma Department of Health

8. Contracting Officer:

Name: Kathy Hallum
Phone: (405) 521-3835
Email: kathy.hallum@omes.ok.gov

[1] Amendments to solicitation may change the Response Due Date (read CP GENERAL PROVISIONS, section 3, "Solicitation Amendments")

State of Oklahoma
Office of Management and Enterprise Services
Central Purchasing Division

Responding Bidder Information

*"Certification for Competitive Bid and Contract" **MUST** be submitted along with the response to the Solicitation.*

1. **RE: Solicitation #** 3400001190

2. **Bidder General Information:**

FEI / SSN : _____ VEN ID: _____

Company Name: _____

3. **Bidder Contact Information:**

Address: _____

City: _____ State: ____ Zip Code: _____

Contact Name: _____

Contact Title: _____

Phone #: _____ FAX#: _____

Email: _____ Website: _____

4. **Oklahoma Sales Tax Permit[2]:**

☐ YES – Permit #: _____

☐ NO – Exempt pursuant to Oklahoma Laws or Rules

5. **Registration with the Oklahoma Secretary of State:**

☐ YES - Filing Number: _____

☐ NO - Prior to the contract award, the successful bidder will be required to register with the Secretary of State or must attach a signed statement that provides specific details supporting the exemption the supplier is claiming (www.sos.ok.gov or 405-521-3911).

6. **Workers' Compensation Insurance Coverage:**

Bidder is required to provide with the bid a certificate of insurance showing proof of compliance with the Oklahoma Workers' Compensation Act.

☐ YES – include a certificate of insurance with the bid

☐ NO - attach a signed statement that provides specific details supporting the exemption you are claiming from the Workers' Compensation Act (Note: Pursuant to Attorney General Opinion #07-8, the exemption from 85 O.S. 2011, § 311 applies only to employers who are natural persons, such as sole proprietors, and does not apply to employers who are entities created by law, including but not limited to corporations, partnerships and limited liability companies.)[3]

_____ _____

Authorized Signature Date

_____ _____

Printed Name Title

[2] For frequently asked questions concerning Oklahoma Sales Tax Permit, see http://www.tax.ok.gov/faq/faqbussales.html

[3] **For frequently asked questions concerning workers' compensation insurance, see** http://www.ok.gov/oid/faqs.html#c221

State of Oklahoma
Office of Management and Enterprise Services
Central Purchasing Division

Certification for Competitive Bid and/or Contract (Non-Collusion Certification)

NOTE: *A certification shall be included with any competitive bid and/or contract exceeding $5,000.00 submitted to the State for goods or services.*

Solicitation or Purchase Order #: 3400001190

Supplier Legal Name: _____

SECTION I [74 O.S. § 85.22]:

A. For purposes of competitive bid,

1. I am the duly authorized agent of the above named bidder submitting the competitive bid herewith, for the purpose of certifying the facts pertaining to the existence of collusion among bidders and between bidders and state officials or employees, as well as facts pertaining to the giving or offering of things of value to government personnel in return for special consideration in the letting of any contract pursuant to said bid;
2. I am fully aware of the facts and circumstances surrounding the making of the bid to which this statement is attached and have been personally and directly involved in the proceedings leading to the submission of such bid; and
3. Neither the bidder nor anyone subject to the bidder's direction or control has been a party:
    a. to any collusion among bidders in restraint of freedom of competition by agreement to bid at a fixed price or to refrain from bidding,
    b. to any collusion with any state official or employee as to quantity, quality or price in the prospective contract, or as to any other terms of such prospective contract, nor
    c. in any discussions between bidders and any state official concerning exchange of money or other thing of value for special consideration in the letting of a contract.

B. I certify, if awarded the contract, whether competitively bid or not, neither the contractor nor anyone subject to the contractor's direction or control has paid, given or donated or agreed to pay, give or donate to any officer or employee of the State of Oklahoma any money or other thing of value, either directly or indirectly, in procuring this contract herein.

SECTION II [74 O.S. § 85.42]:

For the purpose of a contract for services, the supplier also certifies that no person who has been involved in any manner in the development of this contract while employed by the State of Oklahoma shall be employed by the supplier to fulfill any of the services provided for under said contract.

The undersigned, duly authorized agent for the above named supplier, by signing below acknowledges this certification statement is executed for the purposes of:

☐ the competitive bid attached herewith and contract, if awarded to said supplier;

OR

☐ the contract attached herewith, which was not competitively bid and awarded by the agency pursuant to applicable Oklahoma statutes.

Supplier Authorized Signature	Certified This Date
Printed Name	Title
Phone Number	Email
Fax Number	

TABLE OF CONTENTS

A. GENERAL PROVISIONS

A.1. Definitions

As used herein, the following terms shall have the following meaning unless the context clearly indicates otherwise:

A.1.1. "Acquisition" means items, products, materials, supplies, services, and equipment a state agency acquires by purchase, lease purchase, lease with option to purchase, or rental pursuant to the Oklahoma Central Purchasing Act;

A.1.2. "Bid" means an offer in the form of a bid, proposal, or quote a bidder submits in response to a solicitation;

A.1.3. "Bidder" means an individual or business entity that submits a bid in response to a solicitation;

A.1.4. "Solicitation" means a request or invitation by the State Purchasing Director or a state agency for a supplier to submit a priced offer to sell acquisitions to the state. A solicitation may be an invitation to bid, request for proposal, or a request for quotation; and

A.1.5. "Supplier" or "vendor" means an individual or business entity that sells or desires to sell acquisitions to state agencies.

A.2. Bid Submission

A.2.1. Submitted bids shall be in strict conformity with the instructions to bidders and shall be submitted with a completed Responding Bidder Information, OMES-FORM-CP-076, and any other forms required by the solicitation.

A.2.2. Bids shall be submitted to the Central Purchasing Division in a single envelope, package, or container and shall be sealed, unless otherwise detailed in the solicitation. The name and address of the bidder shall be inserted in the upper left corner of the single envelope, package, or container. SOLICITATION NUMBER AND SOLICITATION RESPONSE DUE DATE AND TIME MUST APPEAR ON THE FACE OF THE SINGLE ENVELOPE, PACKAGE, OR CONTAINER.

A.2.3. The required certification statement, "Certification for Competitive Bid and/or Contract (Non-Collusion Certification)", OMES-FORM-CP-004, must be made out in the name of the bidder and must be properly executed by an authorized person, with full knowledge and acceptance of all its provisions.

A.2.4. All bids shall be legible and completed in ink or with electronic printer or other similar office equipment. Any corrections to bids shall be identified and initialed in ink by the bidder. Penciled bids and penciled corrections shall NOT be accepted and will be rejected as non-responsive. In addition to a hard copy submittal, the bidder will also be required to submit an electronic copy. Electronic responses must be submitted in the identical format contained in the solicitation (for example Microsoft Word, Microsoft Excel, but not Adobe PDF). In the event the hard copy of the price worksheets and electronic copy of the price worksheets do not agree, the electronic copy will prevail.

A.2.5. All bids submitted shall be subject to the Oklahoma Central Purchasing Act, Central Purchasing Rules, and other statutory regulations as applicable, these General Provisions, any Special Provisions, solicitation specifications, required certification statement, and all other terms and conditions listed or attached herein—all of which are made part of this solicitation.

A.3. Solicitation Amendments

A.3.1. If an "Amendment of Solicitation", OMES-FORM-CP-011, is issued, the bidder shall acknowledge receipt of any/all amendment(s) to solicitations by signing and returning the solicitation amendment(s). Amendment acknowledgement(s) may be submitted with the bid or may be forwarded separately. If forwarded separately, amendment acknowledgement(s) must contain the solicitation number and response due date and time on the front of the envelope. The Central Purchasing Division must receive the amendment acknowledgement(s) by the response due date and time specified for receipt of bids for the bid to be deemed responsive. Failure to acknowledge solicitation amendments may be grounds for rejection.

A.3.2. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in the solicitation. All amendments to the solicitation shall be made in writing by the Central Purchasing Division.

A.3.3. It is the Bidder's responsibility to check the OMES/Central Purchasing Division website frequently for any possible amendments that may be issued. The Central Purchasing Division is not responsible for a bidder's failure to download any amendment documents required to complete a solicitation.

A.4. Bid Change

If the bidder needs to change a bid prior to the solicitation response due date, a new bid shall be submitted to the Central Purchasing Division with the following statement "This bid supersedes the bid previously submitted" in a single envelope, package, or container and shall be sealed, unless otherwise detailed in the solicitation. The name and address of the bidder shall be inserted in the upper left corner of the single envelope, package, or container. SOLICITATION NUMBER AND SOLICITATION RESPONSE DUE DATE AND TIME MUST APPEAR ON THE FACE OF THE SINGLE ENVELOPE, PACKAGE, OR CONTAINER.

A.5. Certification Regarding Debarment, Suspension, and Other Responsibility Matters

By submitting a response to this solicitation:

A.5.1. The prospective primary participant and any subcontractor certifies to the best of their knowledge and belief, that they and their principals or participants:

A.5.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal, State or local department or agency;

A.5.1.2. Have not within a three-year period preceding this proposal been convicted of or pled guilty or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract; or for violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

A.5.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph A.5.1.2. of this certification; and

A.5.1.4. Have not within a three-year period preceding this application/proposal had one or more public (Federal, State, or local) contracts terminated for cause or default.

A.5.2. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to its solicitation response.

A.6. Bid Opening

Sealed bids shall be opened by the Central Purchasing Division at the Will Rogers Building, 2401 N. Lincoln Blvd. First Floor, Suite 116, Oklahoma City, Oklahoma, 73105 at the time and date specified in the solicitation as Response Due Date and Time.

A.7. Open Bid / Open Record

Pursuant to the Oklahoma Public Open Records Act, a public bid opening does not make the bid(s) immediately accessible to the public. The procurement or contracting agency shall keep the bid(s) confidential, and provide prompt and reasonable access to the records only after a contract is awarded or the solicitation is cancelled. This practice protects the integrity of the competitive bid process and prevents excessive disruption to the procurement process. The interest of achieving the best value for the State of Oklahoma outweighs the interest of vendors immediately knowing the contents of competitor's bids. [51 O.S. § 24A.5(5)]

Additionally, financial or proprietary information submitted by a bidder may be designated by the Purchasing Director as confidential and the procurement entity may reject all requests to disclose information designated as confidential pursuant to 62 O.S. (2012) § 34.11.1(H)(2) and 74 O.S. (2011) § 85.10. Bidders claiming any portion of their bid as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and identify applicable law supporting their claim of confidentiality. The State Purchasing Director shall make the final decision as to whether the documentation or information is confidential pursuant to 74 O.S. § 85.10. Otherwise, documents and information a bidder submits as part of or in connection with a bid are public records and subject to disclosure after contract award or the solicitation is cancelled.

A.8. Late Bids

Bids received by the Central Purchasing Division after the response due date and time shall be deemed non-responsive and shall NOT be considered for any resultant award.

A.9. Legal Contract

A.9.1. Submitted bids are rendered as a legal offer and any bid, when accepted by the Central Purchasing Division, shall constitute a contract.

A.9.2. The Contract resulting from this solicitation may consist of the following documents in order of preference:

A.9.2.1. Purchase order, as amended by Change Order (if applicable);

A.9.2.2. Solicitation, as amended (if applicable); and

A.9.2.3. Successful bid (including required certifications), to the extent the bid does not conflict with the requirements of the solicitation or applicable law.

A.9.3. Any contract(s) awarded pursuant to the solicitation shall be legibly written or typed.

A.10. Pricing

A.10.1. Bids shall remain firm for a minimum of sixty (60) days from the solicitation closing date.

A.10.2. Bidders guarantee unit prices to be correct.

A.10.3. In accordance with 74 O.S. §85.40, ALL travel expenses to be incurred by the supplier in performance of the Contract shall be included in the total bid price/contract amount.

A.11. Manufacturers' Name and Approved Equivalents

Unless otherwise specified in the solicitation, manufacturers' names, brand names, information and/or catalog numbers listed in a specification are for information and not intended to limit competition. Bidder may offer any brand for which they are an authorized representative, and which meets or exceeds the specification for any item(s). However, if bids are based on equivalent products, indicate on the bid form the manufacturer's name and number. Bidder shall submit sketches, descriptive literature, and/or complete specifications with their bid. Reference to literature submitted with a previous bid will not satisfy this provision. The bidder shall also explain in detail the reason(s) why the proposed equivalent will meet the specifications and not be considered an exception thereto. Bids that do not comply with these requirements are subject to rejection.

A.12. Clarification of Solicitation

A.12.1. Clarification pertaining to the contents of this solicitation shall be directed in writing to the Central Purchasing Contracting Officer specified in the solicitation.

A.12.2. If a bidder fails to notify the State of an error, ambiguity, conflict, discrepancy, omission or other error in the SOLICITATION, known to the bidder, or that reasonably should have been known by the bidder, the bidder shall submit a bid at its own risk; and if awarded the contract, the bidder shall not be entitled to additional compensation, relief, or time, by reason of the error or its later correction. If a bidder takes exception to any requirement or specification contained in the SOLICITATION, these exceptions must be clearly and prominently stated in their response.

A.12.3. Bidders who believe proposal requirements or specifications are unnecessarily restrictive or limit competition may submit a written request for administrative review to the State prior to the closing date.

A.13. Rejection of Bid

The State reserves the right to reject any bids that do not comply with the requirements and specifications of the solicitation. A bid may be rejected when the bidder imposes terms or conditions that would modify requirements of the solicitation or limit the bidder's liability to the State. Other possible reasons for rejection of bids are listed in OAC 580:16-7-32.

A.14. Award of Contract

A.14.1. The State Purchasing Director may award the Contract to more than one bidder by awarding the Contract(s) by item or groups of items, or may award the Contract on an ALL OR NONE basis, whichever is deemed by the State Purchasing Director to be in the best interest of the State of Oklahoma.

A.14.2. Contract awards will be made to the lowest and best bidder(s) unless the solicitation specifies that best value criteria is being used.

A.14.3. In order to receive an award or payments from the State of Oklahoma, suppliers must be registered. The vendor registration process can be completed electronically through the OMES website at the following link: https://www.ok.gov/dcs/vendors/index.php .

A.15. Contract Modification

A.15.1. The Contract is issued under the authority of the State Purchasing Director who signs the Contract. The Contract may be modified only through a written Contract Modification, signed by the State Purchasing Director.

A.15.2. Any change to the Contract, including but not limited to the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by a person who is not specifically authorized by the Central Purchasing Division in writing, or made unilaterally by the supplier, is a breach of the Contract. Unless otherwise specified by applicable law or rules, such changes, including unauthorized written Contract Modifications, shall be void and without effect, and the supplier shall not be entitled to any claim under this Contract based on those changes. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in the resultant Contract.

A.16. Delivery, Inspection and Acceptance

A.16.1. Unless otherwise specified in the solicitation or awarding documents, all deliveries shall be F.O.B. Destination. The bidder(s) awarded the Contract shall prepay all packaging, handling, shipping and delivery charges and firm

prices quoted in the bid shall include all such charges. All products and/or services to be delivered pursuant to the Contract shall be subject to final inspection and acceptance by the State at destination. "Destination" shall mean delivered to the receiving dock or other point specified in the purchase order. The State assumes no responsibility for goods until accepted by the State at the receiving point in good condition. Title and risk of loss or damage to all items shall be the responsibility of the supplier until accepted by the receiving agency. The supplier(s) awarded the Contract shall be responsible for filing, processing, and collecting any and all damage claims accruing prior to acceptance.

A.16.2. Supplier(s) awarded the Contract shall be required to deliver products and services as bid on or before the required date. Deviations, substitutions or changes in products and services shall not be made unless expressly authorized in writing by the Central Purchasing Division.

A.17. Invoicing and Payment

A.17.1. Pursuant to 74 O.S. §85.44(B), invoices will be paid in arrears after products have been delivered or services provided.

A.17.2. Interest on late payments made by the State of Oklahoma is governed by 62 O.S. §34.71 and 62 O.S. §34.72.

A.18. Tax Exemption

State agency acquisitions are exempt from sales taxes and federal excise taxes. Bidders shall not include these taxes in price quotes.

A.19. Audit and Records Clause

A.19.1. As used in this clause, “records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form. In accepting any Contract with the State, the successful bidder(s) agree any pertinent State or Federal agency will have the right to examine and audit all records relevant to execution and performance of the resultant Contract.

A.19.2. The successful bidder(s) awarded the Contract(s) is required to retain records relative to the Contract for the duration of the Contract and for a period of seven (7) years following completion and/or termination of the Contract. If an audit, litigation, or other action involving such records is started before the end of the seven (7) year period, the records are required to be maintained for two (2) years from the date that all issues arising out of the action are resolved, or until the end of the seven (7) year retention period, whichever is later.

A.20. Non-Appropriation Clause

The terms of any Contract resulting from the solicitation and any Purchase Order issued for multiple years under the Contract are contingent upon sufficient appropriations being made by the Legislature or other appropriate government entity. Notwithstanding any language to the contrary in the solicitation, purchase order, or any other Contract document, the procuring agency may terminate its obligations under the Contract if sufficient appropriations are not made by the Legislature or other appropriate governing entity to pay amounts due for multiple year agreements. The Requesting (procuring) Agency's decisions as to whether sufficient appropriations are available shall be accepted by the supplier and shall be final and binding.

A.21. Choice of Law

Any claims, disputes, or litigation relating to the solicitation, or the execution, interpretation, performance, or enforcement of the Contract shall be governed by the laws of the State of Oklahoma.

A.22. Choice of Venue

Venue for any action, claim, dispute or litigation relating in any way to the Contract shall be in Oklahoma County, Oklahoma.

A.23. Termination for Cause

A.23.1. The supplier may terminate the Contract for default or other just cause with a 30-day written request and upon written approval from the Central Purchasing Division. The State may terminate the Contract for default or any other just cause upon a 30-day written notification to the supplier.

A.23.2. The State may terminate the Contract immediately, without a 30-day written notice to the supplier, when violations are found to be an impediment to the function of an agency and detrimental to its cause, when conditions preclude the 30-day notice, or when the State Purchasing Director determines that an administrative error occurred prior to Contract performance.

A.23.3. If the Contract is terminated, the State shall be liable only for payment for products and/or services delivered and accepted.

A.24. Termination for Convenience

A.24.1. The State may terminate the Contract, in whole or in part, for convenience if the State Purchasing Director determines that termination is in the State's best interest. The State Purchasing Director shall terminate the Contract by delivering to the supplier a Notice of Termination for Convenience specifying the terms and effective date of Contract termination. The Contract termination date shall be a minimum of 60 days from the date the Notice of Termination for Convenience is issued by the State Purchasing Director.

A.24.2. If the Contract is terminated, the State shall be liable only for products and/or services delivered and accepted, and for costs and expenses (exclusive of profit) reasonably incurred prior to the date upon which the Notice of Termination for Convenience was received by the supplier.

A.25. Insurance

The successful bidder(s) awarded the Contract shall obtain and retain insurance, including workers' compensation, automobile insurance, medical malpractice, and general liability, as applicable, or as required by State or Federal law, prior to commencement of any work in connection with the Contract. The supplier awarded the Contract shall timely renew the policies to be carried pursuant to this section throughout the term of the Contract and shall provide the Central Purchasing Division and the procuring agency with evidence of such insurance and renewals.

A.26. Employment Relationship

The Contract does not create an employment relationship. Individuals performing services required by this Contract are not employees of the State of Oklahoma or the procuring agency. The supplier's employees shall not be considered employees of the State of Oklahoma nor of the procuring agency for any purpose, and accordingly shall not be eligible for rights or benefits accruing to state employees.

A.27. Compliance with the Oklahoma Taxpayer and Citizen Protection Act of 2007

By submitting a bid for services, the bidder certifies that they, and any proposed subcontractors, are in compliance with 25 O.S. §1313 and participate in the Status Verification System. The Status Verification System is defined in 25 O.S. §1312 and includes but is not limited to the free Employment Verification Program (E-Verify) through the Department of Homeland Security and available at www.dhs.gov/E-Verify .

A.28. Compliance with Applicable Laws

The products and services supplied under the Contract shall comply with all applicable Federal, State, and local laws, and the supplier shall maintain all applicable licenses and permit requirements.

A.29. Special Provisions

Special Provisions set forth in SECTION B apply with the same force and effect as these General Provisions. However, conflicts or inconsistencies shall be resolved in favor of the Special Provisions.

B. SPECIAL PROVISIONS

B.1. Accountability/Quality Assurance/Continuous Quality Improvement

B.1.1. Contractors must comply with:

- The Maternal, Infant and Early Childhood Home Visiting (MIECHV) Parents as Teachers (PAT) Program Procedures Manual;
- The MIECHV PAT Financial Procedures Manual;
- The MIECHV PAT Program Evaluation Procedures Manual;
- The PAT Curriculum; and
- The PAT requirements associated with the PAT best practices as well as the PAT affiliation process.

B.1.2. In addition, Contractors must cooperate with the Community Action Project of Tulsa as they conduct the Early Development Instrument (EDI) within school districts located in Muskogee County.

B.1.3. All MIECHV related manuals and their subsequent revised editions will be provided to the Contractors at the beginning of each contract period. Contractors failing to comply with state law, MIECHV Grant requirements, PAT affiliation requirements, and PAT User requirements and/or any duties listed in this RFP will be considered out of compliance.

- Training: Included in the MIECHV PAT Program Procedures Manual will be the associated training requirements and the year's training calendar. Every effort will be made to provide training in an efficient and cost-effective manner. When deemed appropriate, trainings will be provided by satellite or online.
- Evaluation: In order to assure that the required quantity and quality of services are being provided, Contractors will gather data from individual clients and utilize the data for program evaluation. It is paramount that data be accurately entered within the required timeframe.
- Site Visits: Contractors must participate in at least one site visit per year conducted by the OSDH Office of Child Abuse Prevention. In addition, Contractors may have to participate in PAT site visits as prescribed by the PAT affiliation process.

B.2. Allowable and Unallowable Expenditures

B.2.1. All expenditures must be directly related to the program. *(Attachment A)*

B.3. Assignment and Delegation

B.3.1. The services to be performed under this subrecipient contract shall not be subrogated, in whole or in part, to any other person or entity without the prior written approval of the OSDH. If the Contractor cannot perform the services as identified in this contract, the Contractor will be responsible for subcontracting the services or making alternative arrangements for the provision of the services. The terms of this contract shall be included in any OSDH approved subcontract. The Contractor will be liable for all additional costs and expenses arising from such subcontract or substitution to cover performance. Approval by OSDH of a subcontract shall not relieve the Contractor of any responsibility for performance under this contract.

B.4. Audit Requirements

B.4.1. The Contractor shall determine which of the following is applicable to their organization:

B.4.1.1. Contractors expending federal funds from all funding sources, in excess of the threshold established in OMB Circular A-133, shall be required to have an independent audit. The independent audit must be conducted in accordance with Government Auditing Standards (GAS) and OMB Circular A-133 "Audits of States, Local Governments, and Non-Profit Organizations" as required to comply with the Single Audit Act of 1984, Amendments of 1996 (31 U.S.C. 7501 et seq.). Audit costs may not be charged to any OSDH contracts when no audit has been performed or has not been prepared in accordance with this requirement.

B.4.1.2. Contractors expending a total of $75,000 or more in state funds from all OSDH programs shall have an independent audit of its operations conducted in accordance with Government Auditing Standards (GAS). The audit shall include a Supplementary Schedule of OSDH Awards listing the revenues and expenditures by purchase order number.

B.4.2. The Contractor agrees to provide the OSDH with a copy of the applicable (A-133 or GAS) audit and a copy of the management letter for the fiscal year(s) of this contract or for the period in which the contract is awarded. The Contractor shall provide OSDH a copy of the applicable audit within nine months of the Contractor's fiscal year end. The audit should be mailed to: The Oklahoma Department of Health, Procurement Service, 1000 NE 10th Street, Suite 309, Oklahoma City, OK 73117.

B.5. Authority

B.5.1. On March 23rd, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010. The Act authorized the Health Resources and Service Administration (HRSA) and the Administration for Children and Families (ACF) to jointly administer the MIECHV Grants.

B.5.2. In June 2010, Governor Brad Henry designated the Oklahoma State Department of Health (OSDH) to serve as the lead agency for the MIECHV Grants. The OSDH Family Support and Prevention Service (FSPS) submitted proposals designed to build upon Oklahoma's comprehensive early childhood system by enhancing and expanding the continuum of home visitation services available to pregnant women and families with infants or young children in at-risk communities identified in the statewide needs assessment. Communities that were identified and selected to receive services were Kay, Garfield, Oklahoma, Muskogee, Comanche and Tulsa Counties.

B.5.3. Evidence-based home visiting models that were chosen for implementation include: Nurse-Family Partnership (NFP); Healthy Families America (HFA); and Parents as Teachers (PAT). For purposes of the RFP and as required by the MIECHV Grant, the Proposer will implement the PAT model with fidelity in Muskogee County.

B.5.4. Awards for each county, and each model within each county, will be handled through separate RFP solicitation processes.

B.6. Availability of Funds

B.6.1. For FFY2013, a total amount of $300,000.00 is available to implement at least one HFA home visiting program and at least one PAT home visiting program in Muskogee County. Every effort will be made to award one HFA contract and one PAT contract. HFA contracts will be solicited and awarded through a separate RFP process. The $300,000.00 available is the total amount to be awarded for both RFP's. However, OSDH reserves the right to award contracts for only one program/model should there be strong rationale to do so. For administrative purposes only, the amount estimated to be available for PAT awards in Muskogee county is $150,000.00. However, as stated above, the total amount available for both HFA and PAT is $300,000.00.

B.6.2. The OSDH will consider proposals for the minimum amount of $150,000.00 for the first, partial-year contract period and $150,000.00 per full contract year or a greater amount as proposed by the proposer.

B.6.3. Contract awards may equal less than the amount requested in the Proposer's proposal. If the award amount is less than requested, required service goals will be prorated to match the award amount.

B.6.4. The OSDH may reduce the contract funding amount if any of the following occur:

B.6.4.1. for failure to expend funds appropriately and at a rate that will make full use of the award;

B.6.4.2. for failure to provide services as set forth in the contract;

B.6.4.3. for failure to maintain required performance levels;

B.6.4.4. for failure to achieve or maintain grant goals; and/or

B.6.4.5. for unavailable funding.

B.6.5. Renewal amounts may be more or less than the original award. Renewal shall be contingent upon the needs of the OSDH, the Contractor's performance and available funding.

B.7. Capability

B.7.1. The Proposer will demonstrate program implementation capability to provide PAT home visiting services in Muskogee County using the following criteria:

B.7.1.1. The ability to provide home visitation services as described in this Request for Proposal (RFP);

B.7.1.2. The ability to provide services to the identified population as outlined in the RFP; and

B.7.1.3. Evidence of working partnerships with others whose cooperation assures the successful implementation of the PAT home visiting services.

B.8. Charitable Choice Providers

B.8.1. Providers who are members of the faith community are eligible to compete for contracts with the State of Oklahoma on the same basis as any other provider. Such providers shall not be required to alter their forms of internal governance, their religious character or remove religious art, icons, scripture, or other symbols. Such providers may not, however, discriminate against clients on the basis of their religion, religious beliefs, or clients' refusal to participate in religious practices. Organizations that receive direct financial assistance from OSDH under any OSDH program may not engage in inherently religious activities, such as worship, religious instruction, or proselytization, as part of the programs or services funded with direct financial assistance from OSDH. If an organization conducts such activities, the activities must be offered separately, in time or location, from the programs or services funded with direct financial assistance from OSDH and participation must be voluntary for beneficiaries of the programs or services funded with such assistance.

B.9. Contract Monitoring Plan

B.9.1. This contract will be monitored by the OSDH based on the completion of a Risk Assessment Process. As a part of the Risk Assessment Process, the Contractor will be required to complete a Contractor's questionnaire. Information related to Programmatic requirements, the contract specifications, and responses to the Contractor's questionnaire, will be utilized to complete the Risk Assessment Tool. The Risk Assessment Tool will be used to determine the level of risk associated with the Contract. A Contract Monitoring Plan and a Contract Administration Plan will be developed to define the activities and level of monitoring and administration that will be required during the contract period. Typical monitoring activities include site visits, review of contractually required reports, invoice review, invoice validation, and verification of licensure and/or insurance requirements, etc. The level of risk assigned to the contract shall determine the frequency and type of activity within a Contract Monitoring Plan and/or Contract Administration Plan. The Contract Monitoring and/or Contract Administration Plan may be updated periodically as determined by the OSDH throughout the contract period. Upon development of the Contract Monitoring Plan and Contract Administration Plan, the OSDH will provide a copy of each to the Contractor.

B.9.2. All communications related to this contract will be between the Contractor's contact person and the OSDH Contract Monitor. The OSDH Contract Monitor for this contract is:

B.9.2.1. Chris Fiesel, Family Support and Prevention Services

B.9.2.2. Office of Child Abuse Prevention

B.9.2.3. 1000 N.E. 10th Street

B.9.2.4. Oklahoma City, OK 73117-1299

B.9.2.5. Phone: (405) 271-7611

B.9.2.6. chrisf@health.ok.gov

B.10. Entire Agreement

B.10.1. Proposers, by submitting their response to this RFP, agree to comply with all terms and conditions contained herein. Upon award, the RFP document and the Proposer's response will become the contract. Proposer understands and agrees that any term and/or condition contained within this RFP is, or becomes, applicable to the Proposer's officers and/or employees. Proposer agrees to ensure that its officers and employees (collectively "Proposer") abide by the terms and/or conditions applicable to the Proposer.

B.10.2. No other understandings or representations, oral or otherwise, regarding the subject matter of this contract shall be deemed to exist or to bind any of the parties hereto.

B.11. Equal Opportunity Employer

B.11.1. The Contractor shall be an equal opportunity employer. The contractor shall not discriminate based on race, color, sex, age, disability, national origin, religion, or political opinion or affiliation. The Contract shall comply with all applicable state and federal civil rights laws, including the Civil Rights Act of 1964, as amended, Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990, as amended, and implementing regulations.

B.12. Equipment and Other Purchases

B.12.1. It is understood that no items of equipment, property or other capital purchases shall be reimbursed under the provisions of this contract. Equipment is defined as an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals $2,500 or more except for telecommunications and electronic information technology applications which has a threshold of $500.

B.13. Event of Default

B.13.1. In the event the Contractor fails to meet the terms and conditions of this contract or fails to provide services in accordance with the provisions of the contract, the OSDH at its sole discretion, may withhold payments claimed by the Contractor or may by written notice of default to the Contractor, cancel this contract. Cancellation due to default shall not be an exclusive remedy, but shall be in addition to any other rights and remedies provided for by law. In the event a Notice of Cancellation is issued, the Contractor shall have the right to request a review of such decision as provided by the rules and regulations promulgated by the State of Oklahoma Department of Central Services, Central Purchasing Division. This section is an exception to standard cancellation clause of thirty (30) days notice.

B.14. Evidence of Insurability

B.14.1. The Contractor shall obtain and retain insurance, including workers' compensation, automobile insurance, medical malpractice, and general liability as applicable or as required by state or federal law and shall provide evidence of insurability (Certificate of Insurance), from the insurance carrier prior to commencement of any work in connection with the Contract.

B.14.2. The Contractor is also required to comply with applicable Federal and State occupational disease statutes. If occupational diseases are not covered under those statutes, they shall be covered under the employer's section of the insurance policy. The Contractor shall timely renew the policies to be carried pursuant to this section throughout the term of the Contract and shall provide OSDH Procurement Service with evidence of such insurance and renewals. Such policy shall require thirty days advance notice of cancellation be provided to OSDH Procurement Service.

B.14.3. If the Contractor does not carry Workers Compensation insurance because it considers their business to be that of an independent Contractor as defined by the Workers Compensation Act 85 O.S. § 1 et. seq. and not that of an employee, the Contractor must complete the OSDH Affidavit of Independent Contractor Status. (*Attachment B)*

B.15. Failure to Comply Statement

B.15.1. The Contractor shall be subject to all applicable state and federal laws, rules and regulations, and all amendments thereto. The Contractor agrees that should it be in noncompliance, the contract may be suspended or canceled in part or in whole. Compliance with the requirements shall be the responsibility of the Contractor without reliance on or direction by the OSDH.

B.16. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

B.16.1. Contractors shall comply with the requirements of the Federal Funding Accountability and Transparency Act of 2006 (FFATA) as set forth in 2 CFR part 170. A Data Universal Numbering System (DUNS) number is a requirement for all contracts of $25,000 or more. Contractors may be required to submit additional information to satisfy FFATA compliance. *(Attachment C)*

B.17. Financial Capability

B.17.1. The agency or organization shall affirm its financial capability and that it has sufficient capital to sustain ongoing program services for at least two months in the event of a temporary delay in the reimbursement of contract expenditures by signing, notarizing, and submitting the Financial Capability Affidavit. *(Attachment D)*

B.18. Internet Security

B.18.1. If the Contractor establishes a connection to the Internet other than through the OSDH network, the Contractor must obtain written approval of the security measures used with that connection from the Service Chief of the OSDH Information Technology Service. The Contractor shall provide all necessary access to the Contractor's site and equipment for OSDH personnel to review the security measures in place to ensure the computing safety of the OSDH and the Contractor.

B.19. Invoicing

B.19.1. A properly completed invoice must be submitted within 30 days of the end of the month in which services were delivered and include the following items:

B.19.1.1. name, address and FEI number of the Contractor

B.19.1.2. invoice date

B.19.1.3. period covered by invoice

B.19.1.4. purchase order number

B.19.1.5. any other data, reports, information or documentation required by other conditions of the contract

B.19.1.6. detail of the services provided and be in accordance with the terms and conditions of this agreement

B.19.2. For invoices involving payment for the Contractor's time, the invoice must be signed and contain the following statement:

B.19.2.1. By my signature I attest that this invoice is an accurate and true representation of my time in relation to the services provided to the OSDH.

B.19.3. The invoice shall be submitted to:

B.19.3.1. OKLAHOMA STATE DEPARTMENT OF HEALTH

B.19.3.2. Family Support and Prevention

B.19.3.3. MIECHV Program

B.19.3.4. 1000 NE 10TH Street

B.19.3.5. Oklahoma City, Oklahoma 73117-1299

B.19.3.6. Attn: Kathie Burnett

B.19.4. The State of Oklahoma has 45 days from presentation of a proper invoice to issue payment to the Contractor.

B.19.5. The OSDH may withhold or delay payment to any Contractor failing to provide required programmatic documentation and/or requested financial documentation.

B.19.6. The Contractor assures that all costs billed will be supported by documentation that will include, but is not limited to, copies of paid invoices, payroll records and time reports as required by the costs principles applicable to their organization. The Contractor further assures that all billings will be based on actual costs incurred and paid.

B.19.7. If the Contractor is unable to support any part of their claim to the OSDH and it is determined that such inability is attributed to misrepresentation of fact or fraud on the part of the Contractor, the Contractor shall be liable to OSDH for an amount equal to such unsupported part of the claim in addition to all costs, including legal, attributable to the reviewing and discovery of said part of claim. Liability under this paragraph shall be determined within two years of the discovery of such misrepresentation of fact or fraud by the Contractor.

B.20. Light Refreshments

B.20.1. Payments for purchase of light food and drink items used as refreshments in connection with meetings or similar type activities held/conducted for and in the interest of the general public shall be considered a valid operating expense to the extent that such purchases serve a public purpose. Service items such as disposable plates, flatware, stirrers, etc. are also reimbursable.

B.20.1.1. "Public purpose" means activities or functions conducted in the interest of the general public at large and the majority of attendees are non-OSDH employees. The "general public" term includes service participants, community partners and business guests of the Contractor.

B.20.1.2. Contractors may not provide light refreshments for activities or meetings only involving their staff.

B.20.1.3. The underlying justification of providing light refreshments is to be in accordance with OSDH, state and federal policies and validated by necessary conference or training activities that complement the agency's functions and its mission. As a health agency, OSDH is enjoined to make it easier for people to make healthy food choices by providing healthy foods at meetings and other events OSDH sponsors. A list of acceptable healthy food items is attached. *(Attachment E)*

B.21. Limited English Proficiency

B.21.1. Where a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program needs service or information in a language other than English in order to effectively be informed of or participate in the program, the Contractor shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide the information in appropriate languages to such persons. An inability by the Contractor to provide the information in the appropriate language to a significant number or proportion of the population eligible to be served or likely to be directly affected by the program shall result in termination of the contract.

B.22. Mandatory Requirements

B.22.1. The OSDH has established certain mandatory requirements that must be included in the RFP response. The use of the terms “shall”, “must” or “will” (except to indicate simple futurity) in this RFP indicate a mandatory requirement or condition, which by failure to meet or provide will be cause for the RFP response being deemed non-responsive. The word “should” or “may” in this RFP indicate desirable attributes of conditions and are permissive in nature. Deviation from or omission of such a desirable feature will not by itself cause a proposal to be non-responsive.

B.23. Non-Acceptance of Tobacco Funds

B.23.1. The Contractor certifies that it will not accept funding from, nor have an affiliation, or a contractual relationship with a tobacco company, any of its subsidiaries or parent company during the term of the contract with the OSDH.

B.24. Other Certifications

B.24.1. The Contractor certifies compliance with the provisions of Titles VI and VII of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act 1973, the Age Discrimination Act of 1975, the Hatch Act, the Pro Children Act of 1994, Drug Free Workplace Act of 1988, the American with Disabilities Act of 1990, Title IX or the Education Amendments of 1972, 31 U.S.C. Section 1352, Public Law 105-78, and the Single Audit Act of 1984 as applicable.

B.25. Personnel Activity Reports

B.25.1. The Contractor and any approved subcontractor shall maintain Personnel Activity Reports (PARs) on all employees reimbursed in whole or in part by this contract. PARs must be completed in accordance with the Federal Cost Principles applicable to the contractor’s specific entity type, i.e. State and Local Government, Non-Profit, Colleges and Universities, etc. (Contractors may refer to 45 CFR 74 or 92 to determine their applicable Federal Cost Principle.) The above requirements will apply to all Contractors regardless of the type funds being reimbursed by the OSDH.

B.26. Privacy Clause

B.26.1. The Contractor shall, at all times, maintain confidential all information pertaining to any person, patient, or client with whom it has a professional relationship, contact or contract. No information shall be released to any person or party not directly employed by the Contractor without first obtaining such person's, patient's or client's expressed written consent therefore. Confidential information pertaining to any minor shall not be released to any person or party without the express written consent of a custodial parent, court appointed guardian, court authorized foster parent, or authorized self-consenting minor, subject however, to all applicable state and federal statues, rules and regulations.

B.27. Procurement Integrity

B.27.1. The Contractor certifies they have not entered into this contract with this or any other Oklahoma state agency that would result in a substantial duplication of the services or duplication of the end product rendered by the Contractor or its employees.

B.28. Protecting And Securing Protected Health Information

B.28.1. The Contractor shall enter into a Business Associate Agreement with OSDH in order to keep secure Protected Health Information and comply with the federal regulations issued pursuant to the Heath Insurance Portability and Accountability Act. *(Attachment F)*

B.29. Promotional or Incentive Items

B.29.1. Promotional and incentive items as gifts are unallowable. Incentive items may be used to encourage an individual to participate in a program or survey by performing a specific task for the benefit of the OSDH and must conform to The OSDH Memorandum of Legal Opinion, dated June 1, 2009. The incentive item used for encouragement shall be given to the individual only after the individual has completed the task. (*Attachment G*)

B.30. Reduction of Contract Funding

B.30.1. Once a contract is awarded, the OSDH may reduce the contract funding amount for failure to achieve or maintain the proposed level of services, to expend funds appropriately and at a rate that will make full use of the award, or to provide services as set forth in the Contract.

B.31. Tobacco Free Policy

B.31.1. To the extent allowed by Oklahoma law, the Contractor providing services to the public on behalf of OSDH shall follow the OSDH Tobacco-Free Policy in the performance of services for OSDH. (*Attachment H)*

B.32. Travel and Related Expense

B.32.1. All travel costs and related expenses will be reimbursed in accordance with the Oklahoma Travel Reimbursement Act, Title 74 O.S. 200,§500.1 et seq and where applicable, the Oklahoma State Department of Health Travel Policy. *(Attachment I)*

B.32.2. If travel costs and related expenses are a part of the contract, the Contractor's request for reimbursement shall not exceed those authorized by the Federal Conus Rates published at the GSA Website located at http://www.gsa.gov/portal/category/100000.

B.32.3. OSDH allowable travel costs must be directly related to the activities of the contract and therefore, may require allocation of those costs to all programs benefitted based on an equitable allocation methodology.

B.32.4. The Contractor must have *prior approval* from OSDH MIECHV in order for out-of-state travel to be reimbursed.

B.32.5. Documentation is required for the following items:

B.32.5.1. "Designated Hotel" information must include room per night.

B.32.5.2. Receipts for all hotel bills, designated or otherwise, must be for a single room rate and include a zero balance.

B.32.5.3. Airfare receipts must include name of traveler, itinerary and zero balance.

B.32.5.4. Registration Fees for required trainings/conferences are reimbursable with a signed receipt. Prior approval from OSDH MIECHV must be sought when seeking reimbursement for Registration Fees for trainings/conferences that are not required.

B.32.5.5. Receipts are required for parking and ground transportation.

B.33. Waiver of Breach

B.33.1. No failure by the OSDH to enforce any provisions hereof after any event of default by the Contractor shall be deemed a waiver of the OSDH's rights with regard to that event, or any subsequent event. A waiver shall not be construed to be a modification of the terms of the contract.

B.34. Statement of Responsibility

B.34.1. The Parties intend that each shall be responsible for its own intentional and negligent acts or omissions to act. The OSDH shall be responsible for the acts and omissions to act of its officers and employees while acting within the scope of their employment according to the Oklahoma Governmental Tort Claims Act, Title 51, O.S., 2001, §§151 et seq. The Contractor shall be responsible for any damages or personal injury caused by the negligent acts or omissions to act by its officers, employees, or agents acting within the scope of their authority or employment.

B.35. Federal Award Information

B.35.1. Award Name: Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program

B.35.2. Award Year: 9/24/2012 (Date Issued)

B.35.3. CFDA Number: 93.505

B.35.4. CFDA Name: Maternal, Infant, and Early Childhood Home Visiting Program

B.35.5. Federal Awarding Agency: Human Resources and Services Administration (HRSA)

C. SOLICITATION SPECIFICATIONS

C.1. Purpose

C.1.1. The purpose of this Request for Proposal (RFP) is to solicit bid proposals regarding the implementation of home visitation services using the Parents as Teachers (PAT) model in Muskogee County in an effort to expand the continuum of home visitation services within the county.

C.2. Contract Period

C.2.1. This contract shall begin on Date of Award and terminate on September 29, 2014 with the option to renew for one (1) additional one-year periods. Renewal shall be contingent upon the needs of the OSDH, the Contractor's performance and available funding.

C.3. Proposer Qualifications

C.3.1. The following requirements apply to all responding Proposers:

C.3.1.1. Proposer must be an entity providing quality services to families with young children in Muskogee County.

C.3.1.2. Proposer must have the ability to provide home visitation services as described in this RFP.

C.3.1.3. Proposer must have the ability to collect and transmit required data to OSDH.

C.3.1.4. Proposer must have the ability to achieve Oklahoma's federally required and approved MIECHV Benchmarks. *(Attachment J)*

C.3.1.5. Proposer must have the ability to provide services to the identified population as outlined in the RFP in a culturally sensitive and appropriate manner.

C.3.1.6. Proposer must have partnerships with others whose cooperation assures the successful implementation of the services as outlined in this RFP.

C.4. Duties of the Contractor

C.4.1. The Contractor shall comply with the requirements as set forth in the MIECHV PAT Financial Procedures Manual developed for FFY 2012.

C.4.2. The Contractor shall provide services on a voluntary basis and at no cost to families.

C.4.3. The Contractor shall participate in financial monitoring processes including requests from OCAP and MIECHV staff and the OSDH Audit Division.

C.4.4. The Contractor shall comply with the requirements as set forth in the MIECHV PAT Program Procedures Manual developed for FFY 2012.

C.4.5. The Contractor shall comply with the PAT requirements related to PAT home visitation services "Essential Requirements for Affiliates" as well as the PAT "Quality Assurance Guidelines." In cooperation with the OSDH, PAT affiliation must be completed within one month of Date of Award. Costs associated with affiliation need to be included in the budget. (*Attachment K)*

C.4.6. The Contractor shall comply with the requirements associated with utilizing the Ages and Stages (ASQ), Ages and Stages; Social and Emotional training and ASQ Screenings. *(Attachment L)*

C.4.7. The Contractor shall work towards achieving the HRSA approved Oklahoma MIECHV Benchmarks and understands that achievement of these benchmarks is directly related to the continuation of Oklahoma receiving future MIECHV funding. *(Attachment J)*

C.4.8. The Contractor shall provide supervision as prescribed by the PAT model.

C.4.9. The Contractor shall attend all required OSDH MIECHV and PAT meetings and trainings. (*Attachment M)*

C.4.10. The Contractor shall provide at a *minimum* the number of services proposed in Contractor's RFP submission. Such services will be adjusted should the contract award amount be less than requested.

C.4.11. The Contractor shall actively work towards the OSDH "flagship issues" of reducing Oklahoma's rate of obesity, tobacco use and increasing indicators associated with children's health.

C.4.12. The Contractor shall have policies and procedures in place requiring all MIECHV PAT staff undergo a federal background check such as from the Federal Bureau of Investigation. An OSBI background check will not suffice as it does not include criminal histories from other states. The background check must be conducted *no earlier* than July 1, 2012 and be completed prior to the staff serving families. No person having a felony conviction shall work (paid or volunteer) within MIECHV PAT.

C.4.13. The Contractor shall prioritize the eligible participants who have low incomes; are beyond the 28th week of their first pregnancy or at any pregnancy stage with their second or subsequent pregnancy; are not yet 21 years of age; have a history of maltreatment or interaction with child welfare; have a history of or issues with substance abuse; have a history of mental illness or currently have an untreated mental illness; have a history of or issues related to domestic violence; are users of tobacco products; have developmental delays, disabilities or low educational achievement; and/or are active military members or returning from military service.

C.4.14. The Contractor shall refrain from providing home visitation services to a family already enrolled and engaged in another home visitation service such as Children First, Start Right/Healthy Families America, Safe Care, Healthy Start, etc. However, due to the very different nature and purpose of SoonerStart provided by the OSDH and Community Home-Based Services provided by the Oklahoma Department of Human Services, the Contractor may provide home visitation services to families participating in these two home visiting programs.

C.4.15. The Contractor shall refer families meeting the Children First enrollment criteria (mother pregnant with first child, not beyond the 29th week of pregnancy with a household income of 185% or below the Federal Poverty Level) to the local county health department for Children First home visitation services. If Children First is not able to serve the family, MIECHV PAT may serve the family if all eligibility criteria for MIECHV PAT are met.

C.4.16. The Contractor shall refer families meeting the Start Right/Healthy Families America enrollment criteria (family with a child less than three months of age) to the local Start Right or MIECHV HFA program for home visitation services. If Start Right or MIECHV HFA is not able to serve the family, MIECHV PAT may serve the family if all eligibility criteria for MIECHV PAT are met.

C.4.17. The Contractor shall participate in local and statewide efforts to develop an intake system to refer potential home visiting clients to the home visiting service for which they are eligible and that best suit their needs.

C.4.18. The Contractor shall inform all MIECHV PAT clients about the services provided by the OSDH Child Guidance Service shortly after they begin MIECHV PAT services and just before they end MIECHV PAT services, if possible. If appropriate, MIECHV PAT clients shall be referred to OSDH Child Guidance Services for center-based services including, but not limited to, behavioral health services, child development screenings, speech and language services, parenting education and/or the *Circle of Parents* Support Groups.

C.4.19. The Contractor shall refer MIECHV PAT clients to any necessary and appropriate health, mental health and/ or social services. The Contractor will make every effort to assure that the MIECHV PAT clients have connected with the referral source or have declined the referral.

C.4.20. The Contractor shall participate in the OSDH Home Visitation Leadership Advisory Coalition as well as any relevant, local coalitions, task forces, advisory groups, etc. including those associated with the Muskogee County Smart Start's MIECHV *Community Connector*.

C.4.21. The Contractor shall establish a local PAT Advisory Group as required by PAT. An existing local group may act in the capacity of a PAT Advisory Group.

C.4.22. The Contractor shall establish and maintain relationships with local hospitals that provide obstetric and pediatric care to aid in the recruitment and care of home visiting clients.

C.4.23. The Contractor shall incorporate the Strengthening Families Protective Factors as prescribed by the Center for the Study of Social Policy into all services whenever possible. *(Attachment N)*

C.4.24. The Contractor shall establish and maintain a working relationship with the local Oklahoma Department of Human Services.

C.4.25. The Contractor shall follow the OSDH policy regarding child abuse and neglect reporting as well as state law regarding the reporting of child abuse and neglect and criminal injuries of adults and children. *(Attachment O)*

C.4.26. The Contractor shall comply with the requirements as set forth in the MIECHV PAT Evaluation Procedures Manual developed for FFY 2012.

C.4.27. The Contractor shall comply with all required Quality Assurance and Continuous Quality Improvement activities including, but not limited to:

C.4.27.1. accurately entering data within one week of the service;

C.4.27.2. provide required PAT annual report to PAT and OSDH MIECVH;

C.4.27.3. cooperating with the University of Oklahoma Health Sciences Center, Center on Child Abuse and Neglect regarding all matters related to the MIECHV evaluation requirements;

C.4.27.4. maintaining in proper working order all equipment (laptops, notebooks, or tablets) data service, aircards, carrying cases provided by OSDH to aid the Contractor in collecting and transmitting required data;

C.4.27.5. participating in MIECHV PAT evaluation activities, training and meetings designed to improve or enhance MIECHV PAT efforts;

C.4.27.6. if necessary, participating in site visits conducted or arranged by the National PAT Office, OSDH MIECHV and OCAP staff; and

C.4.27.7. participating in evaluation and/or research projects required by HRSA and/or its affiliates conducting evaluation related to the MIECHV Grant.

C.5. Duties of the OSDH

C.5.1. The OSDH shall provide the MIECHV PAT Financial Procedures Manual within two weeks of the Date of Award. Subsequent revisions will be provided each renewable year on or by September 30th.

C.5.2. The OSDH shall review and approve budgets and invoices.

C.5.3. The OSDH shall assess the Contractor's financial risk and monitor their contract according to OSDH policy.

C.5.4. The OSDH shall annually complete an OSDH Financial Compliance Screening Tool. This Tool will be utilized by OSDH Procurement and Audit Services.

C.5.5. The OSDH shall audit at least one month of invoices per State Fiscal Year. Should any issues be noted, OSDH shall assist the Contractor in correcting the issues.

C.5.6. The OSDH shall provide the MIECHV PAT Program Procedures Manual two weeks within the Date of Award. Subsequent revisions will be provided each renewable year on or by September 30th.

C.5.7. The OSDH shall provide PAT model specific training and PAT Manuals.

C.5.8. The OSDH shall provide, when possible, the PAT Users Training and the relevant manuals.

C.5.9. The OSDH shall provide ASQ, ASQ – SE Training and related manuals.

C.5.10. The OSDH shall provide technical assistance for the PAT Affiliation Process.

C.5.11. The OSDH shall provide an annual training calendar including all required trainings on or before July 1st of each year.

C.5.12. The OSDH *may* provide or arrange for specific PAT required training in program areas. The OSDH will provide all supplemental training.

C.5.13. The OSDH shall provide trainings in the most efficient and effective manner possible including face-to-face, online and satellite methods.

C.5.14. The OSDH shall provide scholarships to additional relevant trainings for MIECHV PAT Contract staff when possible. Examples include annual conferences, trainings, institutes or in-services related to child abuse prevention, family relations, early childhood, etc.

C.5.15. The OSDH shall provide technical assistance, resources and expertise in the implementation of PAT when deemed necessary or upon request.

C.5.16. The OSDH shall provide routine meetings in order to address programmatic and financial issues as well as provide opportunities to learn from one another. When possible and appropriate, such opportunities shall be held in conjunction with other home visitors from other programs/models.

C.5.17. The OSDH shall notify Contractors about meetings being held by the Interagency Child Abuse Prevention Task Force, the Home Visitation Leadership Advisory Coalition and the Child Abuse Prevention Action Committee. When possible, OSDH shall arrange for individuals to join the meetings by phone or satellite.

C.5.18. The OSDH shall provide the MIECHV PAT Program Evaluation Procedures Manual within two weeks of the contract award date. Subsequent revisions will be provided each renewable year on or by September 30th.

C.5.19. The OSDH shall review the PAT Annual Report.

C.5.20. The OSDH shall assist Contactors when establishing View Only access to the Oklahoma State Immunization Information System (OSIIS) Database.

C.5.21. The OSDH shall develop and maintain a web-based database for the collection of MIECHV PAT data.

C.5.22. The OSDH shall provide all required MIECHV data to HRSA as required.

C.5.23. The OSDH shall conduct a minimum of one annual site visit for each Contractor. Such site visits may include and are not limited to the review of family files, supervision logs, personnel files, meeting with community partners, and observing home visits. The final site visit report will be provided to the Contractor within four (4) weeks of the site visit.

D. EVALUATION

D.1. Evaluation Criteria

D.1.1. This RFP will be evaluated as best value in accordance with Title 74, §85. The best value criteria for this proposal is listed below and all proposals will be reviewed and awarded based on the following evaluation criteria:.

D.1.1.1. Budget

D.1.1.2. Organizational Capacity

D.1.1.3. Ability to Provide Services

D.1.1.4. Experience with Strengthening Families Protective Factors

D.1.1.5. Partnering Agencies

D.1.1.6. Fidelity/Quality Assurance/Continuous Quality Improvement

D.1.1.7. Requested Level of Funding and Proposed Level of Service

D.1.1.8. Staffing Plan

D.1.1.9. Additional Proposer Qualities

D.2. Negotiations

D.2.1. In accordance with Title 74 §85.5, the State of Oklahoma reserves the right to negotiate with one, selected, all or none of the vendors responding to this solicitation to obtain the best value for the State. Negotiations could entail discussions on products, services, pricing, contract terminology or any other issue that may mitigate the State's risks. The State shall consider all issues negotiable and not artificially constrained by internal corporate policies. Negotiation may be with one or more vendors, for any and all items in the vendor's offer.

D.2.2. Firms that contend that they lack flexibility because of their corporate policy on a particular negotiation item shall face a significant disadvantage and may not be considered. If such negotiations are conducted, the following conditions shall apply:

D.2.3. Negotiations may be conducted in person, in writing, or by telephone.

D.2.4. Negotiations shall only be conducted with potentially acceptable offers. The State reserves the right to limit negotiations to those offers that received the highest rankings during the initial evaluation phase.

D.2.5. Terms, conditions, prices, methodology, or other features of the offeror's offer may be subject to negotiations and subsequent revision. As part of the negotiations, the offeror may be required to submit supporting financial, pricing, and other data in order to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the offer.

D.2.6. The requirements of the Request for Proposal shall not be negotiable and shall remain unchanged unless the State determines that a change in such requirements is in the best interest of the State Of Oklahoma.

E. INSTRUCTIONS TO SUPPLIER

E.1. To submit a complete Proposal Package, please do the following:

E.1.1. Thoroughly review the entire Request for Proposal (RFP) prior to attempting to answer any questions.

E.1.2. Submissions in response to this RFP must be in the form of the "Proposal Package." The Proposal Package must contain the Proposer's response and all required supporting information and documents in typewritten form and in an "8 ½ x 11" loose-leaf format using 12 point font. Do not submit the Proposal Package in binders or other presentation folders.

E.1.3. The Proposal Package must be in the following order:

E.1.3.1. Responding Proposer Information (*DCS Form 076)*

E.1.3.2. Proposal Package Narrative (see following section E.2):

E.1.3.2.1. Requested Funding Level and Proposed Level of Services

E.1.3.2.2. Organizational Capacity

E.1.3.2.3. Describe the Proposer's ability to provide evidence-based home visitation services

E.1.3.2.4. Describe the Proposer's experience with the Strengthening Families Protective Factors

E.1.3.2.5. Partnering Agencies

E.1.3.2.6. Staffing Plan

E.1.3.2.7. Fidelity/Quality Assurance/Continuous Quality Improvement

E.1.3.2.8. Additional Proposer Qualities

E.1.3.2.9. Budget (form and narrative)

E.1.3.3. The following attachments:

E.1.3.3.1. The Financial Capability Affidavit *(Attachment D)*

E.1.3.3.2. The Affidavit of Independent Contractor Status- if applicable *(Attachment B)*

E.1.3.3.3. Certification for Competitive Bid and/or Contract *(DCS Form 004)*

E.1.3.3.4. The OSDH Business Associate Agreement *(Attachment F)*

E.1.3.3.5. The Evidence of Insurability

E.2. The proposal package will include the Supplier's response to each of the following components:

E.2.1. Requested Funding Level and Proposed Level of Services

E.2.1.1. Requested funding per year. See attachment P for minimum number of families served and minimum number of home visits to be completed related to award amounts.

E.2.2. Organizational Capacity

E.2.2.1. Provide organizational background information (the following items are required, but additional, relevant information may also be included):

E.2.2.1.1. How long has the Proposer been in existence?

E.2.2.1.2. What is the Proposer's mission?

E.2.2.1.3. How is the Proposer currently funded or supported?

E.2.2.1.4. What programs/services does the Proposer provide?

E.2.2.1.5. Describe the population currently served by the Proposer.

E.2.2.1.6. Describe any unique features or characteristics of the Proposer that make it well suited to provide the work described in this RFP?

E.2.2.1.7. Include an organizational chart.

E.2.3. Ability to Provide Parents as Teachers Home Visitation Services:

E.2.3.1. Provide the definition for "evidence-based home visitation."

E.2.3.2. Describe the need for home visitation services in your identified geographic area.

E.2.3.3. How will the Proposer obtain referrals for home visitation services?

E.2.3.4. Describe the Proposer's experience with Evidence-Based Home Visiting Models:

E.2.3.4.1. What, if any, experience has the Proposer's had with providing home visitation services using the PAT Model?

E.2.3.4.2. What, if any, experience has the Proposer's had with providing home visitation services using the Parents as Teachers® Curriculum?

E.2.3.4.3. What, if any, experience has the Proposer had with providing home visitation services using other Evidence-Based Home Visiting Models?

E.2.3.4.4. What, if any, experience has the Proposer had with providing child development screenings using the Ages and Stages Questionnaires including the Social Emotional questionnaire.

E.2.3.4.5. What, if any, experience has the Proposer had with providing any other additional screenings or assessments.

E.2.4. Experience with the Strengthening Families Protective Factors:

E.2.4.1. Please describe the ways in which the Proposer incorporates the Protective Factors into daily work – particularly emphasizing home visiting if possible.

E.2.5. Partnering Agencies

E.2.5.1. Describe the Proposer's collaborative partnerships including for each:

E.2.5.1.1. Purpose and length of partnership

E.2.5.1.2. Any formal agreements

E.2.5.1.3. Benefits to home visited clients

E.2.5.2. *Suggested* Partners include, but are not limited to:

E.2.5.2.1. Mental Health Services

E.2.5.2.2. Substance Abuse Services

E.2.5.2.3. Domestic Violence Services

E.2.5.2.4. Smart Start

E.2.5.2.5. Head Start

E.2.5.2.6. Local Hospitals

E.2.5.2.7. Child Care Centers

E.2.5.2.8. Local Department of Human Services

E.2.5.2.9. Local County Health Department

E.2.5.2.10. Turning Point

E.2.5.2.11. Schools and Universities

E.2.5.2.12. Medical Community

E.2.5.2.13. Faith-Based Communities

E.2.5.2.14. Business Community

E.2.6. Staffing Plan for PAT (Including, but not limited to, PAT Supervisor, Parent Educators and administrative support staff as necessary)

E.2.6.1. Job titles

E.2.6.2. Position descriptions including percentage of time

E.2.6.3. Educational background/degrees required

E.2.6.4. Work and/or other experience required

E.2.6.5. Other information as applicable

E.2.7. Activities Related to Fidelity/Quality Assurance/Continuous Quality Improvement

E.2.7.1. Describe the Proposer's capability to achieve Parents as Teachers Affiliation.

E.2.7.2. Describe the Proposer's supervision practices as they would relate to PAT home visitation services.

E.2.7.3. Describer the Proposer's practices to maintain model fidelity.

E.2.7.4. Describe the Proposer's capacity to provide and maintain computer equipment that collect and transfer by accessing a web-based data system while maintaining confidentiality.

E.2.8. Additional Qualities Relevant to Home Visiting

E.2.8.1. Describe any additional Proposer qualities, activities, achievements that are relevant to this RFP. Examples may include transportation for clients to necessary appointments, clothing and infant care pantry, resource library for parents, etc.

E.2.9. Budgets

E.2.9.1. Submit a Budget Form for FFY 2012 (July 1, 2013 through September 29, 2013) (Attachment Q)

E.2.9.2. Submit a Budget Narrative for FFY 2012 to justify the expenses. The following outline should be followed:

E.2.9.2.1. Personnel/Salaries
Identifies all program staff by name if possible and job title including all administrative staff, clerical support staff and data entry staff positions that will be funded through MIECHV. (Use the term "vacant" for the name if the position is not currently filled.)

E.2.9.3. Fringe Benefits
Identifies what fringe benefits will be covered for MIECHV personnel and the costs associated with the fringe benefits. Fringe benefits are detailed in the dollar amount per fringe item (i.e. FICA, health insurance, life insurance, etc.). The benefits included in the proposal are reflective of the rates and package available to employees for the current proposed contract year.

E.2.9.3.1. Travel/Training
Identifies costs associated with mileage/airfare reimbursement for the program staff to travel to meetings, home visits, trainings, and conferences, per diem for program staff to attend meetings, trainings, and conferences, lodging for program staff to attend meetings, trainings and conferences, training fees to ensure that all program staff receives required trainings.

E.2.9.3.2. Supplies
Identifies costs associated with program operation supplies, educational supplies, public awareness activities, community outreach activities, equipment and durable goods.

E.2.9.3.3. Contractual
Subcontracts and other contractual agreements are clearly defined.
Identifies what program services will be purchased by subcontract with other individuals, agencies and/or organizations. For each proposed subcontracted service, identifies the minimum qualifications of the sub-supplier. For each proposed subcontracted service, identifies the unit of measurement, cost per unit of measurement and maximum dollar amount per subcontract.

E.2.9.3.4. Administrative Costs/Indirect Costs
Identifies administrative costs or an indirect cost rate associated with MIECHV PAT activities and efforts. Maximum administrative or indirect cost rate is 12% unless otherwise negotiated.

E.2.9.3.5. Other
Identifies additional costs associated with MIECHV PAT that do not fall into the above listed categories such as affiliation costs, postage, electronic communications, printing, criminal background checks, internet service, facilities, etc.

E.2.10. Submit a Budget Form and Budget Narrative for FFY 2013 (*September 30, 2013 through September 29, 2014*) using the same guidelines detailed immediately above. *(Attachment Q)*

F. CHECKLIST

None

G. OTHER

G.1. Questions

G.1.1. All questions regarding this solicitation must be submitted in writing and are to be emailed to no later than Monday, September 16, 2013 at 3:00 CDT. Questions are to be emailed to kathy.hallum@omes.ok.gov. Questions received after this date will not be answered. An Amendment will be posted after this deadline listing all questions received and their answers.

G.2. Submissions/Copies

G.2.1. Contractor is to submit five (5) complete copies of their response on CD which includes the completed proposal, including the scanned images of the OMES signed forms. CD must be an unprotected document. Original hard copies are not required. Due to several RFP's for the same thing but different counties - **Please ensure that your CD's are marked clearly with the RFP Number and the County name.**

H. PRICE AND COST

None

ATTACHMENT A
BUDGET INFORMATION

BUDGET DEVELOPMENT

1. All figures must be rounded to the nearest whole number.

2. All expenditures must be direct program costs including state and match amounts.

3. Reimbursement is made in accordance with the approved line item budget and only after the Contractor has received and paid for the goods or services. The requested budget amount may not be the awarded amount.

4. The OSDH will review the Contractor's expenditures throughout the term of the contract and may require a reduction in the contract amount if expenditure patterns demonstrate a funding lapse.

5. It is the Contractor's responsibility to monitor the individual line items from month to month in order to prevent overspending in a line item during the contract period.

6. Budget revisions require prior OSDH approval in writing.

7. Invoices must be submitted each month. Claims for reimbursement must be based on actual expenditures during the time period of the claim.

8. If the Contractor is going to seek reimbursement for facility costs related to a building that is owned by the Contractor, the Contractor will be required to submit a list of the facilities that will be depreciated and billed for as well as the depreciation method(s) used. The amount billed to OSDH should only be for OSDH's allocated share. *(*OMB Circular A-133*)*

9. The Contractor is allowed to make line item adjustments of not more than 10% of the total contract award over the period of this agreement between existing direct cost line items without seeking prior approval of the OSDH. However, a budget revision request form must be submitted to reflect the adjustments made between line items. All budget revision requests in excess of 10% of the total contract award amount must be approved and are not effective until approved in writing by the OSDH. Requests for budget revisions will not be accepted after July 15th of any given Federal Fiscal Year.

ALLOWABLE EXPENDITURES

All expenditures must be direct program costs including state and match amounts.

Personnel/Salaries

Actual salaries and wages paid to program personnel or actual worth of time donated to program by volunteers.

Fringe Benefits

Actual fringe benefits paid to program personnel.

Travel/Training

All travel expenditures must be in compliance with the Contractor's travel policy, but the OSDH will not reimburse amounts exceeding those allowed in the Oklahoma State Travel Reimbursement Act.

Travel expenditures may include:

- mileage for families transported in an agency owned vehicle;
- mileage to and from home visits;
- mileage to and from consultation meetings with referral agencies;
- mileage to and from advisory group meetings;
- mileage to and from public awareness/public education sessions;
- per diem for attending training meetings or conferences; and/or,
- overnight lodging expenses for attending training meetings or conferences (including direct payments to hotels/motels/conferences).

Training expenditures for pre-service and ongoing training of program personnel include:

- conference registration fees and
- training workshops and seminar fees.

Supplies

Supplies are consumable materials necessary to conduct the program for one year. Suppliers may not stockpile supplies for carryover into the next fiscal year. Supplies may include:

- materials used to promote the programs in the community such as pamphlets and brochures
- educational materials such as dvds, pamphlets, brochures, books, curricula
- routine office supplies such as paper, pens, pencils, file folders.

Contractual

Contractual expenditures include essential consultation or program services that cannot be provided by the Contractor. Subcontracts and other contractual agreements must be clearly defined in the approved program budget including number of hours of service and cost per hour of service. If the subcontract is for $2,500 or more, a copy of the subcontract should be submitted to OSHD MIECHV for review and approval.

Contractual expenditures may include:

- subcontract with other agencies to provide specific program-related services;
- subcontracts with program consultants;
- subcontracts with trainers; and,
- subcontracts for transportation services.

Time and Effort Sheets must be utilized to verify program-related contractual costs. Time and Effort Sheets must be signed by both the employee and the supervisor.

Administrative Costs/Indirect Costs

The maximum Indirect Costs Rate, unless otherwise negotiated, is 12%.

Other

Other program-related expenditures that include:

- Parents as Teachers Users' costs:
    - The Foundational Training fee is $695.00 which includes access to the online Foundational Curriculum.
    - The annual renewal fee for using the Foundational Curriculum is $100.00 per person each year for each Approved User.

- printing of educational materials, flyers, brochures, handouts
- postage
- long-distance telephone costs and/or itemized local phone costs
- mobile phone plan for home visitors
- Federal background checks for the purpose of hiring personnel
- audit costs based on an approved cost allocation plan
- costs of purchasing bus tokens and/or taxi fare to assist program families with transportation to program services, and/or essential community support services
- liability insurance (amount cost allocated portion to MIECHV Program only)
- general depreciation/use allowances
- facilities expenditures - must be clearly identified in the approved program budget. The method of calculation for cost of space must be defined in the approved program budget and be apportioned to the space used by MIECHV staff. Method of calculation for cost of space in the proposed budget is defined. For each identified space required, provide the cost per square foot and the number of square feet. (If facility space will be rented from another agency for meetings, workshops, and/or child care, provide the rental cost per hour or day.)

- All requests for depreciation in lieu of use allowance as an expenditure/match budget item must be approved in advance by the OSDH Audit Division. For information regarding specific documentation requirements, please contact the Audit Division at 405-271-5765.

UNALLOWABLE EXPENDITURES

- Any activity or expense that is not directly related to the program.
- Acquisition costs of real property, as well as construction costs, and/or equipment.
- Entertainment costs for amusement and diversion.
- Advocacy by staff on program time and/or advocacy efforts that involve hiring of lobbyists or travel for the purpose of lobbying.
- Program items deemed as "gifts." *(See Attachment G)*
- Fundraising expenses incurred solely to raise capital or obtain contributions, including staff time for the purpose of fundraising.
- Professional membership fees.
- Certificate of Good Standing for Incorporated Organization.
- Equipment which costs $500 or more is not an allowable expenditure.
- Food not classified as light refreshments.
- Advertising expenses for the program, including but not limited to phone book ads or billboards. Advertising is allowed only for hiring personnel.

ATTACHMENT B

OKLAHOMA STATE DEPARTMENT OF HEALTH
AFFIDAVIT OF INDEPENDENT CONTRACTOR STATUS

State of Oklahoma)

County of _____)

I, _____ state under oath as follows:

1. I, _____ (Name of Individual) operating as _____ (independent contractor's business name), have agreed to provide services to Oklahoma State Department of Health (OSDH).
2. I have read the fact sheet on page two of this affidavit and understand that an independent contractor is one who engages to perform certain services for another, according to his own manner, method, free from control and direction of his contractor in all matters connected with the performance of the service, except as to the result or product of the work.
3. I understand that based upon the representations in this Affidavit of Independent Contractor Status, I am requesting **OSDH's Policyholder** to classify my business to be that of an independent contractor; that **I am not an employee under the Worker's Compensation Act** and the OSDH policy issued by CompSource Oklahoma; and that no premium be charged for the services performed pursuant to this job/project by my business during the policy year.
4. **I am an independent contractor, not an employee of the OSDH. I do not want worker's compensation insurance and understand that I am not eligible for Workers' Compensation benefits.**
5. I will obtain workers' compensation and employers' liability insurance for my employees if I have employees, unless they are otherwise exempt from the requirements of the Workers' Compensation Act.
6. I have read and signed the fact sheet describing what is an Independent Contractor on page two of this affidavit, and the information provided is not the result of force, threats, coercion, compulsion or duress.
7. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing false, incomplete or misleading information is guilty of a felony.

Independent Contractor Signature

Date _____ Printed Name _____ Title _____

Signature _____ Business Name _____

Notary Public

Signed and sworn to before me on this _____ day of _____, 20____ by _____.

_____ My Commission Expires: _____ My Commission Number: _____
Notary Public

******SUBMIT THE SIGNED AND NOTARIZEDFORM TO THE ADDRESS BELOW******

Oklahoma State Department of Health
Procurement Division
1000 NE 10th Street
Oklahoma City, OK 73117

This form is to be signed and notarized at the start of a job/project for this contractor and is good for the job/project of any similar job/project performed for the contractor for one year from the date of notary.

INDEPENDENT CONTRACTOR FACT SHEET

An independent contractor is defined by law as one who engages to perform certain services for another, according to his own manner, method, free from control and direction of his contractor in all matters connected with the performance of the service, except as to the result or product of the work.

Below are statements to help you decide if you are an independent contractor. No one statement is controlling, and your status is based on all the facts in your situation. If a statement describes your situation, then check the box. If at least six of the statements below do not describe your business and are unchecked, you should not sign the attached affidavit.

☐ 1. The nature of the contract between you and the contractor shows you are independent from the contractor. For example: Is there a written contract where you agree that you are an independent contractor? Are you a corporation or limited liability company? Do you maintain commercial general liability insurance or other business insurance?

☐ 2. The contractor exercises very little control over your work. For example: By the agreement, can the contractor exercise control on the details of the work or your independence? Do you exercise control over most of the details of the work? Do you create plans or specifications for the job? Do you set your own work hours?

☐ 3. You are engaged in a distinct occupation or business for others. For example: Do you work for companies or individuals other than the Contractor? Do you work for competitors of the Contractor? Does your business have a logo or uniform?

☐ 4. Your job is the kind of occupation where the work is usually performed by a specialist without supervision, and not under the direction of the contractor. For example: Is your work supervised by the Contractor?

☐ 5. Your occupation requires special skills, license, education or training.

☐ 6. The Contractor does not supply the things needed to perform your job such as the tools and the place of work. For example: Do you supply any of the materials or tools for the work? Do you operate a vehicle owned by the Contractor? Was the work performed at your business or the Contractor's business location or jobsite? Do you wear a uniform supplied by the Contractor?

☐ 7. The length of the job and how long you have worked for the Contractor does not show that you are really an employee. For example: Is this a one-time job, or will you be doing this for the Contractor regularly?

☐ 8. You are paid as a separate contractor, not as an employee. For example: Do you invoice the Contractor for your services? Are you paid by the job? Do you file a federal income tax return for your business? Do you expect to receive an IRS Form 1099 from the Contractor? Does the Contractor pay your expenses?

☐ 9. Your work is not the regular business of the employer. For example: Is your work customarily done in the Contractor's line of business or as part of the Contractor's daily work? Have you ever been an employee of the Contractor? Do you work with other people hired by the Contractor on the work you perform?

☐ 10. You do not consider yourself an employee of the Contractor. For example: Will the Contractor withhold taxes or monies from your payment? Have you ever been an employee of the Contractor? Have you or your employees ever filed an insurance claim against the Contractor?

☐ 11. You do not have the right to terminate the relationship without liability. For example: If you quit before the job is finished, is there a penalty?

Based upon these factors, do you believe that you are an Independent Contractor?

_____ **Signature: _____**

Write YES or NO

Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing false, incomplete or misleading information is guilty of a felony.

ATTACHMENT C

Federal Funding Accountability and Transparency Act of 2006 (FFATA)

Reporting Requirements

Beginning October 1, 2010, the Office of Management and Budget has imposed new reporting requirements for Federal grantees concerning "Sub-awards". For grants a "sub-award" means a legal instrument to provide support for the performance of any portion of the substantive project or program for which the grant was received and that :

A. The prime recipient (OSDH) awards to an eligible sub –recipient: or
B. Sub-recipient at one tier awards to a sub-recipient at the next lower tier.

For all Federal grant awards received after October 1, 2010, not including American Recovery and Reinvestment Act of 2009 awards, OSDH will be required to submit the following information for sub-recipients whose awards are $25,000 or more.

DUNS number: *The 9-digit Data Universal Numbering System number.*

DUNS Number +4: *The four digit extension created by registrants in Central Contractor registration database (CCR)*

Name: *Name of the organization*

DBA Name: *Organization's "doing business as "name.*

Address: *Includes Street, City, State, Country, Zip+4, and Congressional district.*

Parent DUNS number: *parent organization DUNS number.*

Amount of Sub-award: *Dollar amount awarded to sub-awardee.*

Obligation/Action date: *Date the sub-award agreement was signed.*

Principal Place of Performance: *Primary site where work will be performed.*

Sub-award number: *Indentifying number assigned by OSDH to track the sub-award.*

Names and Compensation of Highly Compensated Officers: *See the specific requirements in the attachments to determine if this is required.*

Sub-award Project Description: *Description should capture the overall purpose of the sub-award.*

Authorized Official *Title* *Date*

Please see the attached documents concerning further guidance on FFATA reporting requirements.

ATTACHMENT D
FINANCIAL CAPABILITY AFFIDAVIT

BIDDER AGENCY NAME: _____

BIDDER AGENCY ADDRESS: _____

BIDDER AGENCY TELEPHONE: _____

I hereby affirm that _____ **:**
(Name of Bidder Agency)

1.) is financially capable of performing the duties of the Contractor on a cost reimbursement basis and has sufficient capital to sustain ongoing program services for at least two (2) months in the event of a temporary delay in the reimbursement of contract expenditures.

2.) has an accounting system that is capable of tracking and reporting expenditures separately by individual program**.**

_____
.
Signature of Authorized Person **Title**

_____
Date

STATE OF OKLAHOMA)
ss.
COUNTY OF)

Subscribed and sworn to before me this _____ day of _____, _____.

_____ My Commission expires: _____
Notary Public

ATTACHMENT E

GUIDELINES FOR LIGHT REFRESHMENTS FOR MEETINGS

Below is the approved List of acceptable items to be purchased for "continental Breakfasts" or as "light refreshments". This list was developed by OSDH registered dietitians and is consistent with the Dietary Guidelines for Americans.

Approved Options

Continental Breakfast Items:

- Oatmeal with brown sugar, walnuts, raisins and margarine
- Multi-grain English muffins/bagels with low-fat cream cheese, peanut butter, jam & jelly
- Blueberry & bran muffins
- Low-fat yogurt
- Fresh fruit
- Whole grain waffles with fruit topping
- Whole grain cereals

Light Refreshment Items:

- Baked chips or Baked Pita Chips
- Salsa or Fruit Salsa
- Hummus
- Bean dip or Dip made with tofu
- Guacamole
- Bite-size pinwheels with fat-free refried beans or low-fat cream cheese
- Soft pretzels with mustard
- Whole grain pitas or whole grain flat bread (cut into small pieces and served with an approved dip)
- Corn or whole grain tortillas (cut into small pieces and served with an approved dip)
- Bite-size veggie pizza pieces
- Raw vegetables with low-fat dip
- Low-fat cheese
- Whole grain crackers
- Yogurt parfait (with low-fat yogurt)
- Snack/trail mix
- Granola bars (reduced fat)
- Fig bars
- Fresh fruit
- Lite popcorn
- Pretzels
- Graham crackers
- Vanilla Wafers
- Low-fat animal crackers
- Smoothies and shakes (made with 1% or skim milk and low-fat yogurt)
- Sherbet/sorbet
- Fruit
- Low-fat cottage cheese
- Pudding (made with skim or 1% milk) or Jello
- Unsalted nuts
- Angel food cake with fresh fruit

Beverages

- 1% or skim milk (white & chocolate)
- 100% juice (fruit & vegetable)
- Coffee
- Tea (hot & cold)
- Diet Sodas
- Bottled water with individual packets Crystal Light
- Sugar-free: hot chocolate, Cider, Lemonade, etc.

Attachment F
OKLAHOMA STATE DEPARTMENT OF HEALTH
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (BAA), effective on the last signature date below, is entered into by and between the Oklahoma State Department of Health (Covered Entity) and _____ (Business Associate).

BACKGROUND AND PURPOSE: The Parties have entered into, and may in the future enter into, one or more written agreements that require Business Associate to be provided with, to have access to, and/or to create Protected Health Information (PHI), (the "underlying Contract(s)"), that is subject to the federal regulations issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and codified at 45 CFR, parts 160 and 164 (HIPAA Regulations). This BAA shall supplement and/or amend each of the Underlying Contract(s) only with respect to the Business Associate's Use, Disclosure, and creation of PHI under the Underlying Contract(s) to allow Covered Entity to comply with Sections 164.502(c) and 164.314(a)(2)(i) of the HIPAA Regulations. Business Associate acknowledges that it is to comply with the HIPAA Security and Privacy regulations pursuant to Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH),Title XIII, of the American Recovery and Reinvestment Act of 2009, including Sections 164.308, 164.310, 164.312 and 164.316 of title 45 of the Code of Federal Regulations. Except as so supplemented and/or amended, the terms of the Underlying Contract(s) shall continue unchanged and shall apply with full force and effect to govern the matters addressed in the BAA and in each of the Underlying Contract(s).

DEFINITIONS: Unless otherwise defined in this BAA, all capitalized terms used in this BAA have the meanings ascribed in the HIPAA Regulations, provided, however, that "PHI" and "ePHI" shall mean Protected Health Information and Electronic Protected Health Information, respectively, as defined in 45 CFR § 160.103, limited to the information Business Associate received from or created or received on behalf of the Oklahoma State Department of Health (OSDH) as OSDH's Business Associate. "Administrative Safeguards" shall have the same meaning as the term "administrative safeguards in 45 CFR § 164.304, with the exception that it shall apply to the management of the conduct of Business Associate's workforce, not OSDH's workforce, in relation to the protection of that information.

Business Associate. "Business Associate" shall generally have the same meaning as the term "Business Associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the entity whose name appears below.

Covered Entity. "Covered Entity" shall generally have the same meaning as the term "Covered Entity" at 45 CFR 160.103.

HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, all as may be amended.

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By law, Secretary, Security Incident, Subcontractor, Unsecured PHI, and Use.

Obligations of Business Associate: Business Associate may use Electronic PHI and PHI (collectively, "PHI") solely to perform its duties and responsibilities under this Agreement and only as provided in this Agreement. Business Associate acknowledges and agrees that PHI is confidential and shall not be used or disclosed, in whole or in part, except as provided in this Agreement or as required by law. Specifically, Business Associate agrees it will:

(a) use or further disclose PHI only as permitted in this Agreement or as Required by Law, including, but not limited to the Privacy and Security Rule;

(b) use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI, to prevent use or disclosure of PHI other than as provided for by this Agreement;

(c) implement and document appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits for or on behalf of Covered Entity in accordance with 45 CFR 164;

(d) implement and document administrative safeguards to prevent, detect, contain, and correct security violations in accordance with 45 CFR 164;

(e) make its policies and procedures required by the Security Rule available to Covered Entity solely for purposes of verifying BA's compliance and the Secretary of the Department of Health and Human Services (HHS);

(f) not receive remuneration from a third party in exchange for disclosing PHI received from or on behalf of Covered Entity;

(g) in accordance with 45 CFR 164.502(e)(1) and 164.308(b), if applicable, ensure that any subcontractors that create, receive, maintain or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information; this shall be in the form of a written HIPAA Business Associate Contract and a fully executed copy will be provided to the Contract Monitor;

(h) report to Covered Entity in writing any use or disclosure of PHI that is not permitted under this Agreement as soon as reasonably practicable but in no event later than five (5) calendar days from becoming aware of it and mitigate, to the extent practicable and in cooperation with Covered Entity, any harmful effects known to it of a use or disclosure made in violation of this Agreement;

(i) promptly report to Covered Entity in writing and without unreasonable delay and in no case later than five (5) calendar days any Security Incident, as defined in the Security Rule, with respect to Electronic PHI;

(j) with the exception of law enforcement delays that satisfy the requirements of 45 CFR 164.412, notify Covered Entity promptly, in writing and without unreasonable delay and in no case later than five (5) calendar days, upon the discovery of a breach of Unsecured PHI. Such notice shall include, to the extent possible, the name of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach. Business Associate shall also, to the extent possible, furnish Covered Entity with any other available information that Covered Entity is required to include in its notification to Individuals under 45 CFR § 164.404(c) at

the time of Business Associate's notification to Covered Entity or promptly thereafter as such information becomes available. As used in this Section, "breach" shall have the meaning given such term at 45 CFR 164.402;

(k) to the extent allowed by law, indemnify and hold Covered Entity harmless from all claims, liabilities, costs, and damages arising out of or in any manner related to the disclosure by Business Associate of any PHI or to the breach by Business Associate of any obligation related to PHI;

(l) provide access to PHI in a Designated Record Set to Covered Entity, or if directed by Covered Entity to an Individual in order to meet the requirements of 45 CFR 164.524. In the event that any Individual request access to PHI directly from Business Associate, Business Associate shall forward such request to Covered Entity within five (5) working days of receiving a request. This shall be in the form of a written HIPAA Business Associate Contract and a fully executed copy will be provided to the Contract Monitor. Any denials of access to the PHI requested shall be the responsibility of Covered Entity;

(m) make PHI available to Covered Entity for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526;

(n) document disclosure of PHI and information related to such disclosure as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI, in accordance with 45 CFR 164.528, and within five (5) working days of receiving a request from Covered Entity, make such disclosure documentation and information available to Covered Entity. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall forward within five (5) working days of receiving a request such request to Covered Entity;

(o) make its internal practices, books, and records related to the use and disclosure of PHI received from or created or received by Business Associate on behalf of Covered Entity available to the Secretary of the Department of HHS, authorized governmental officials, and Covered Entity for the purpose of determining Business Associate's compliance with the Privacy Rule. Business Associate shall give Covered Entity advance written notice of requests from DHHS or government officials and provide Covered Entity with a copy of all documents made available; and

(p) ensure that all of its subcontractors, vendors, and agents to whom it provides PHI or who create, receive, use, disclose, maintain, or have access to Covered Entity's PHI shall agree in writing to requirements, restrictions, and conditions at least as stringent as those that apply to Business Associate under this Agreement, including but not limited to implementing reasonable and appropriate safeguards to protect PHI, and shall ensure that its subcontractors, vendors, and agents agree to indemnify and hold harmless Covered Entity for their failure to comply with each of the provisions of this Agreement.

Permitted Uses and Disclosures of PHI by Business Associate: Except as otherwise provided in this Agreement, Business Associate may use or disclose PHI on behalf of or to provide services to Covered Entity for the purposes specified in this Agreement, if such use or disclosure of PHI would not violate the Privacy Rule if done by Covered Entity. Unless otherwise limited herein, Business Associate may:

(a) use PHI for its proper management and administration or to fulfill any present or future legal responsibilities of Business Associate;

(b) disclose PHI for its proper management and administration or to fulfill any present or future legal responsibilities of Business Associate, provided that (i) the disclosure is Required by Law; or (ii) Business Associate obtains reasonable assurances from any person to whom the PHI is disclosed that such PHI will be kept confidential and will be used or further disclosed only as Required by Law or for the purpose(s) for which it was disclosed to the person, and the person commits to notifying Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached;

(c) disclose PHI to report violations of law to appropriate federal and state authorities; or

(d) aggregate the PHI with other data in its possession for purposes of Covered Entity's Health Care Operations;

(e) make uses and disclosures and requests for protected health information consistent with Covered Entity's minimum necessary policies and procedures;

(f) de-identify any and all PHI obtained by Business Associate under this BAA, and use such de-identified data, all in accordance with the de-identification requirements of the Privacy Rule [45 CFR §(d)(1)].

Obligations of Covered Entity:

(a) Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

(b) Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of protected health information.

(c) Covered Entity shall not request Business Associate use or disclose PHI in any manner that would violate the Privacy Rule if done by Covered Entity.

(d) OSDH agrees to timely notify Business Associate, in writing, of any arrangements between OSDH and the Individual that is the subject of PHI that may impact in any manner the use and/or disclosure of the PHI by Business Associate under this BAA.

Term and Termination:

(a) Term. The Term of this Agreement shall be effective as of the date of the underlying agreement, and shall terminate on the date the underlying agreement terminates or on the date Covered Entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business Associate authorizes termination of this Agreement by Covered Entity, if Covered Entity determines Business Associate has violated a material term of the Agreement (and Business Associate has not cured the breach or ended the violation within the time specified by Covered Entity if a cure period is specified).

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:

1. Retain only that PHI that is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to Covered Entity (or, if agreed to by Covered Entity, destroy) the remaining PHI that the Business Associate still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
4. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at above under "Permitted Uses and Disclosures By Business Associate" that applied prior to termination; and
5. Return to Covered Entity (or, if agreed to by Covered Entity, destroy) the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

(d) All other obligations of Business Associate under this Agreement shall survive termination.

Should OSDH become aware of a pattern of activity or practice that constitutes a material breach of a material term of this BAA by Business Associate, OSDH shall provide Business Associate with written notice of such a breach in sufficient detail to enable **Contractor** to understand the specific nature of the breach. OSDH shall be entitled to terminate the Underlying Contract associated with such breach if, after OSDH provides the notice to Business Associate, Business Associate fails to cure the breach within a reasonable time period not less than thirty (30) days specified by OSDH in such notice; provided, however, that such time period specified by OSDH shall be based on the nature of the breach involved [45 CFR §§ 164.504(e)(1)(ii)(A),(B) & 164.314 (a)(2)(i)(D)].

MISCELLANEOUS:
Interpretation: The terms of this BAA shall prevail in the case of any conflict with the terms of any Underlying Contract to the extent necessary to allow OSDH to comply with the HIPAA Regulations. The bracketed citations to the HIPAA Regulations in several paragraphs of this BAA are for reference only and shall not be relevant in interpreting any provision of this BAA.

No Third Party Beneficiaries: Nothing in this BAA shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

Business Associate recognizes that any material breach of this Agreement or breach of confidentiality or misuse of PHI may result in the termination of this Agreement and/or legal action. Said termination may be immediate and need not comply with any termination provision in the parties' underlying agreement, if any.

The parties agree to amend this Agreement from time to time as is necessary for Covered Entity or BA to

comply with the requirements of the Privacy Rule and related laws and regulations.

(a) ODSH's Notice of Privacy Practices is available on its website: www.ok.gov/health.

(b) Any ambiguity in this Agreement shall be resolved in a manner that causes this Agreement to comply with HIPAA.

(c) This Agreement embodies and constitutes the entire agreement and understanding between the parties with respect to the subject matter hereof and supersedes all prior Business Associate agreements, oral or written agreements, commitments, and understandings pertaining to the subject matter hereof.

(d) If Business Associate maintains a designated record set in an electronic format on behalf of Covered Entity, then Business Associate agrees that within 30 days of expiration or termination of the parties' agreement, Business Associate shall provide to Covered Entity a complete report of all disclosures of and access to the designated record set covering the three years immediately preceding the termination or expiration. The report shall include patient name, date and time of disclosures/access, description of what was disclosed/accessed, purpose of disclosure/access, name of individual who received or accessed the information, and, if available, what action was taken within the designated record set.

Amendment: To the extent that any relevant provision of the HIPAA Regulations is materially amended in a manner that changes the obligations of Business Associates or Covered Entities, the Parties agree to negotiate in good faith appropriate amendment(s) to this BAA to give effect to these revised obligations. The parties agree to amend this Agreement from time to time as is necessary for Covered Entity or to comply with the requirements of the Privacy Rule and related laws and regulations.

A signed copy of this agreement shall be accorded the same force and effect as the original.

IN WITNESS WHEREOF, each of the undersigned has caused this BAA to be duly executed in its name and on its behalf.

OKLAHOMA STATE DEPARTMENT OF HEALTH	CONTRACTOR
By:_____	By:_____
Print Name: Robn Green, MPH	Print Name:_____
Print Title: HIPAA Privacy Officer	Print Title: _____
Date:_____	Date:_____

ATTACHMENT G

Oklahoma State
Department of Health
Creating a State of Health

Office of General Counsel
Phone: 271-6017 Facsimile: 271·1268

MEMORANDUM OF LEGAL OPINION

TO: Greg Morley
Procurement Chief

THROUGH: Nick Slaymaker
General Counsel

FROM: Tom L. Cross
Deputy General Counsel

CC: Rocky McEivany
Interim Commissioner of Health

Steve Ronck, MPH, Deputy Commissioner
Community Health Services

Angela Andrews
Procurement

RE: Incentives and Promotional Items used by Programs

DATE: June 1, 2009

Question Presented

Can program areas of the Oklahoma State Department of Health use incentives and/or promotional items given to individuals to induce those individuals to participate and/or complete a program or part of a program?

Short Answer

The use of incentives and promotional items that are used by Programs in exchange for participation in program activities are not considered a "gift" and therefore do not violate the constitutional proscription of "gifting" state assets as set out in Article 10 Section 15 of the Oklahoma Constitution.

Discussion

The program area has asked about the legality of using VISA gift cards as incentives to

increase participation in specific programs and services. The program area's experience is these incentives are necessary to insure sufficient data is collected to validate the conclusions that are drawn from the data. Each participant is given a $10 VISA gift card when that participant completes a specific part of the program, i.e. completion of a survey, keeping an appointment or completing a follow-up examination.

The $10 value of the gift card is based on a Memorandum issued by the Office of General Counsel for the Oklahoma State Department of Health dated October 9, 2000. This Memorandum has its origin in a letter from Tom Jaworsky, State Purchasing Director, Department of Central Services, dated October 2, 2000. In this letter Mr. Jaworsky stated the position of Central Purchasing is the Central Purchasing Act does not prohibit the acquisition of promotional items with a nominal value. Mr. Jaworsky set a $10 value for promotional items. The Oklahoma Constitution does not contain an exception for "nominal" gifts.

The Oklahoma Constitution contains a proscription against the State from gifting assets of the state to "any company, association or corporation[1]." The Oklahoma Supreme Court has defined the term "gift" as used in Article X Section 15 as "all appropriations for which there is no authority or enforceable claim on which rests alone some material equitable obligation which in the mind of a generous or even just individual dealing with his own money might induce him to recognize as worthy of his reward[2]." "Where specific constitutional prohibitions against gifts of public money exist, public money cannot be lawfully appropriated to meet on obligation, however just and equitable, unless it is of such a character that it could be enforced in a court of law." The Court has further defined a "gift" as a "voluntary transfer of his property by one to another without any consideration or compensation therefore. The donor must intend gratuitously to pass the title to the donee[4]·

A program area may use incentives and/or promotional items to accomplish the goals of the program area. The program area should be able to articulate how the use of the specific incentive and/or promotional item will benefit the program area and without the specific incentive and/or promotional item what will be the detriment. In other words, the recipient must give some type of "consideration" in exchange for the incentive. Consideration takes away from the transaction its donative characte,.S."

. The recipient of the incentive must be required to complete a specific task or provide something of value in exchange for the incentive prior to the incentive being delivered. OSDH is prohibited from paying for services or products prior to those services or products being delivered[6]. The amount of the incentive should be

---

[1] Oklahoma Constitution Article 10 Section 15

[2] *Hawks v Bland,* 1932 OK·101, 9 P.2d 720, 156 Okla. 48 {1932); *Veterans of Foreign Wars v Childers,* 197 Okla. 331,171 P2.d 618,1946 OK211

[3] *Veterans of Foreign Wars v Childers,* Id.

[4] *In the Matter of the Petition of University Hospitals Authority, an agency of the State of Oklahoma and University Hospitals Trust, a public trust,* 953 P.2d 314, 1997 OK 162

[5] 1d.

[6] 74 O.S. §85.448

reasonable in value in relation to the specific task, information or other consideration that is being provided by the recipient of the incentive. While the courts have decided that the use of incentives is legal, there is a policy consideration to be established to ensure that incentives used are reasonable.

Conclusion:

Program Areas of the OSDH may use gift cards or other items as incentives and/or promotional items to induce participation in specific programs or activities. The Program Area should articulate the specific benefit of using the incentive and if the incentive was not used the detriment suffered. Recipients of the incentive must be required to complete a specific task or exchange something of value for the incentive prior to receiving the incentive. OSDH should establish policy guidelines that will direct program areas what is an acceptable incentive program and when can that program be used.

ATTACHMENT H

Mary Fallin
Governor

FILED
FEB 06 2012
OKLAHOMA
SECRETARY
OF STATE

EXECUTIVE DEPARTMENT

EXECUTIVE ORDER 2012-01

I, Mary Fallin, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby direct and order as follows:

Title 63 of the Oklahoma Statutes, Section 1-1523 prohibits smoking in all public places, in any indoor workplace, and all vehicles owned by the State of Oklahoma and all of its agencies and instrumentalities.

The Oklahoma Legislature, at 63 O.S. § 1-1515 (B), has found that breathing secondhand smoke causes disease, including lung cancer in healthy non-smokers; breathing secondhand smoke causes respiratory infection, decreased respiratory function, bronchoconstriction and bronchospasm. The population at most risk are the elderly, children, people with cardiovascular disease, and people with impaired respirator function, asthmatics, and those with obstructive airway disease.

The U.S. Surgeon General has issued a report stating that there is no risk-free level of exposure to secondhand smoke, which has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.

The United State Department of Health and Human Services, Centers for Disease Control and Prevention has found that the use of smokeless tobacco is known to be a cause of cancer and increases the risk of developing cancer of the oral cavity; the use of smokeless tobacco is associated with leukoplakia, gum disease and tooth decay; and the use of smokeless tobacco during pregnancy increases the risk of preeclampsia, premature birth and low birth weight.

The use of any tobacco product shall be prohibited on any and all properties owned, leased or contracted for use by the State of Oklahoma, including but not limited to all buildings, land and vehicles owned, leased or contracted for use by agencies or instrumentalities of the State of Oklahoma.

045314

The Executive Order shall be distributed to all members of the Governor's Executive Cabinet and the chief executives of all state agencies, who shall cause the provisions of this order to be implemented by all appropriate officials and agencies of state government. Implementation shall be achieved no later than six (6) months from the date of this order. The Oklahoma State Department of Health ("OSDH") and Tobacco Settlement Endowment Trust ("TSET") will provide assistance to state agencies for implementing this order.

IN WITNESS WHEREOF, I have set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 6TH DAY of February, 2012.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

MARY FALLIN

ATTEST:

Michelle R. Day

SECRETARY OF STATE
Assistant

OKLAHOMA STATE DEPARTMENT OF HEALTH
ADMINISTRATIVE PROCEDURES MANUAL

NUMBER: 3-5
TITLE: Travel
ADOPTED July 2004
LAST REVIEWED: October 2011
RESPONSIBLE SERVICE: Administrative Services

APPROVED: _____
Terry Cline, Ph.D.
Commissioner
Signature on File

I. Purpose

The purpose of this administrative procedure is to ensure all Oklahoma State Department of Health (OSDH) employees are reimbursed for all legitimate travel expenses incurred while engaged in the transaction of official business.

II. Overview

"Legitimate travel expenses" are defined by statute, and Oklahoma law provides for severe penalty in cases of falsified travel vouchers. Title 74 O.S., § 500.1 through 500.37 provide the statutory authorization and limitations. All interstate travel must have prior approval.

A. Definitions

1. **"**Meals**"** means a substantial portion of food taken at one time to satisfy appetite, excluding snacks, continental breakfast and finger foods.

2. **"**Overnight travel period" means a trip requiring absence for a minimum period which lasts substantially longer than an ordinary day's work and during which the employee's duties require them to get necessary sleep or rest to meet the demands of their work.

   a. The absence must be of such duration and distance that the employee cannot reasonably leave and return home after each day's work.

   b. The standard for purposes of requesting overnight reimbursement is that the qualified non-employee or employee must be in travel status for more than 18 hours, must not live or have their official duty station within 60 map miles of destination, **and must have stayed overnight**. Any exemption requires **advance** approval from the Office of State Finance, or

if an emergency situation, a formal justification is sent with the Travel Voucher.

3. "Per diem" means reimbursable charges for meals while in overnight travel status.

4. “Qualified non employees” means persons who are not state employees, but who are performing substantial and necessary services to the state which have been directed or approved by the appropriate department official.

5. "Subsistence" means reimbursable charges for lodging while staying with friends or family in overnight travel status.

6. "Travel status**”** means the absence of an employee or qualified non-employee from his or her home or duty station whichever is closer while performing assigned official duties.

B. General Requirements

1. Officials, employees, and qualified non-employees of the state, traveling on authorized state business, may be reimbursed for expenses incurred in such travel in accordance with the provisions of Title 74 O.S., §500.2 through 500.37. Persons who are qualified non-employees must also abide by the same laws and policies as OSDH employees.

2. Travel expenses incurred by a person during the course of seeking employment with OSDH, unless such travel is performed at the request of OSDH, are not reimbursed.

3. An employee or qualified non-employee, authorized to travel, is responsible for planning in such a way that expenses for transportation and subsistence are kept to a minimum. Excess costs, circuitous routes, luxury accommodations and services unnecessary or unjustified in the performance of official business are not acceptable and should be avoided as a standard practice.

4. An employee or qualified non-employee whose job assignment entails field travel is responsible for making maximum use of all travel time. This means that travel is planned and work is organized as to produce the greatest possible benefit to the State for the travel time involved.

5. Employees and qualified non-employees are to allow 45 days for reimbursement of a correct travel voucher as stated in Title 74 O.S., §840.500.16A.

6. Employees will be reimbursed for their actual and necessary expenses of travel, lodging, and subsistence incurred in the performance of their duties. Receipts are required for lodging, baggage fees and registration expenses, regardless of the amount, as well as for each miscellaneous expense of $25 or more. Examples of miscellaneous expenses are: parking and toll fees; postage, gas and oil (government vehicle).

7. Employees will use the Department of Central Services (DCS) Fleet Management "Trip Optimizer System" to determine in-state mileage reimbursement at the lesser of private vehicle, motor pool vehicle or rental car in accordance with HB 2016. The DCS website refers to this system as the "Trip Calculator' and is located at https://www.ok.gov/dcs/calculator/index.php .

8. Purchase Cards are available for use for the payment of registrations while employees are traveling to either in-state or interstate objectives. Service areas are encouraged to utilize the Purchase Card when registrations are charged for employees traveling on official state business. Procedures (to include required documentation) for using the Purchase Card for registrations are located in Public Folders at: Public Folders\PCard\General P-Card References.

9. Purchase Cards are available for use for the payment of lodging expense while employees are traveling to either in-state or interstate objectives. Service areas are encouraged to utilize the Purchase Card when lodging expenses are necessary for employees traveling on official state business. The Purchase card will only be used for the cost of the room and associated taxes (where applicable). supplemental charges (e.g. room service, phone calls, movies, etc.) are the responsibility of the individual traveler. Procedures (to include required documentation) for using the Purchase Card for lodging expenses are located in Public Folders at: Public Folders\PCard\General P-Card References.

C. Travel Vouchers

All claims for reimbursement of travel expenses will be submitted on the authorized travel voucher and shall be signed by the traveler and the approving official with knowledge of the travel prior to forwarding to the Accounting Services for final approval.

1. All travel reimbursement vouchers are filed using an OSF Form 19.

2. In-state and interstate travel must be filed on separate vouchers.

3. Travel vouchers must be filed by state officials, state employees, and qualified non-employees within 60 days from the end of the month in which travel occurred. Travel vouchers not filed within this period must be submitted to the deputy commissioner with justification for payment approval. Travel vouchers are considered filed once they are received in Accounting Services.

4. A travel voucher must not exceed 31 days time frame.

5. Completion of the travel voucher requires use of the DCS Trip Optimizer. Unless specifically exempt from its use a printed copy of the "Trip Optimizer" results will be submitted when the travel voucher is filed. Exemptions from using the Trip Optimizer will include the following:

    a. Individuals who have been assigned and are utilizing a state leased vehicle.

    b. Individuals who are traveling less than 100 miles round trip for infrequent travel.

    c. Use of a personal car to travel to and from the airport or other transportation terminal when the total distance traveled is less than 100 miles round trip.

6. Claims for reimbursement of registration fees must be supported by corresponding paid receipts. Travel vouchers requesting reimbursement of registration fees for non-attendance of conferences, meetings, or workshops are subject to the approval of the appropriate deputy commissioner and are submitted with sufficient explanation and justification as to the reason of cancellation. Other than direct billing from the sponsoring entity, OSF Form 19 is the only mechanism for reimbursement of registration fees while in travel status. Direct billing of registration must be noted on the OSF Form 19.

7. The nature of "Official Business" as referenced on OSF Form 19 must be described in sufficient detail to enable persons reviewing the voucher to understand the purpose of the travel.

8. Agendas, announcements, or memoranda when in overnight travel status for conferences, seminars, or training must contain dates, times, and locations or designated lodging or lodging site and be submitted with the OSF Form 19.

9. Employees and qualified non-employees must identify on OSF Form 19 when registration, lodging, and/or any other items are directly billed.

D. Designated Lodging

Evidence such as the announcement or notice designating a pre-arranged conference, workshop and/or seminars must be attached to the OSF Form 19. Expenses may not exceed the single occupancy room rate, including tax, charged by the designated hotel, motel or other public lodging place.

1. In the course of conducting official agency business OSDH may designate a particular lodging facility. The Deputy Commissioner must approve designation of a lodging facility.

2. Employees or qualified non-employees attending meetings, workshops, conferences, or other objective trips, which are conducted at a designated hotel, motel, or other public lodging, who choose to acquire less expensive public lodging, are reimbursed the actual lodging expense not to exceed the single occupancy room rate, including tax, charged by the designated public lodging place. Those employees or qualified non-employees choosing this option are reimbursed for local transportation costs incurred while traveling between such optional lodging and the designated hotel, motel, or other public lodging place, not to exceed the difference between the cost of the designated lodging and the cost of the optional lodging. Local transportation costing $25 or more for one trip one way requires receipts.

3. Overflow hotels with documentation are considered designated hotels and are reimbursed the actual lodging expense not to exceed the single occupancy rate, including tax. Transportation costs to and from the conference site are reimbursable.

4. OSDH is authorized to make direct purchases of lodging at facilities operated by the Oklahoma Tourism and Recreation Department (OTRD). Such lodging is reimbursed at the in-state lodging rate. The in-state lodging and per diem rate must not exceed the rate established in Title 74 O.S., §500.1 through 500.37 per 24-hour period per person.

5. The OTRD requires a five-day cancellation period. Any employee canceling under the five-day limit is responsible for any charges the Agency incurs unless substantial documentation can be provided that an emergency or circumstance beyond the employee's control contributed to the delay in cancellation.

E. Per Diem Payments

1. Per diem expenses are reimbursable only for travel periods that incorporate overnight travel status. Title 74 O.S., §500.8 and 500.9 reflect per diem and lodging rates for travel both within and outside of the state of Oklahoma based upon the amount authorized by the provisions of the Internal Revenue Code of 1986.

2. Authorized per diem reimbursement rates vary depending on the location of travel as identified in Government Services Administration's (GSA) Continental United States (CONUS) rates for domestic locations and for locations outside of the Continental United States (OCONUS). A complete listing of the CONUS and OCONUS locations and rates can be obtained from the GSA web site: www.policyworks.gov/perdiem.

3. An employee attending a conference or workshop in which meals are provided, as part of the package plan must attach a copy of the agenda or workshop notice to the OSF Form 19. A deduction of one-fourth of the per diem amount shall be made against the per diem amount for each meal provided.

4. Out-of-state reimbursement for per diem and lodging does not begin more than 24 hours before or continue more than 24 hours after the objective of the trip, such as meeting, workshop, or conference, except as stated in this paragraph. Under limited circumstances involving airline travel, reimbursement may begin as many as 48 hours before and extend as many as 48 hours after the objective of the trip if airfare is lower than the amount which would have been reimbursed had the 24 hour rule been applied. Any extra days must be a weekend day.

5. OSF Form 19 must have a detailed cost comparison of the additional per diem and lodging versus the savings on airfare. The airfare rate used in the comparison must come from the same travel agency where the ticket was purchased. The total reimbursement cannot exceed the amount of eligible reimbursement if the 24-hour rule is adhered to including the airfare rate available at the time.

6. An increased per diem allowance in lieu of subsistence is authorized if in overnight travel status. This allowance is applicable when staying with others and is claimed in the per diem column of OSF Form 19.

F. Interstate Travel

1. An employee who plans to travel outside the state of Oklahoma must complete an Interstate Travel Request/Authorization form, ODH 81. Electronic routing of the ODH 81 is the required method of obtaining approval for interstate travel. Exceptions to the electronic routing method are only available to those deputy areas and Commissioner's direct reporting units where there is not a designated travel coordinator.

2. The Commissioner has designated the authority to approve OSDH interstate travel requests to the chief operating officer and to the appropriate service area deputy commissioners. All interstate travel shall receive prior documented approval from the division director or service chief, deputy commissioner or the chief operating officer, and the budget analyst. The final approved request will be sent to the appropriate travel coordinator for processing. The travel coordinator will provide the required approvals to Accounting Services. The travel claim cannot be processed without the required approvals.

3. The employee must obtain the documented approval for out-of-state travel before incurring binding obligations or making expenditures for travel-related expenses, including but not limited to airfare, registration fees, or lodging. Expenditures or obligations made prior to approval of the out-of-state travel request will not be reimbursed. Prior to receipt of the approval for interstate travel, the employee may make reservations and other arrangements necessary for travel-planning and cost-estimation, but must not pay for such reservations.

4. Regardless of the mode of travel, including privately owned vehicles, reimbursement for interstate transportation costs will not exceed that of coach airfare.

5. When requesting a mode of travel other than contract airfare, a "Car Travel Reimbursement Cost Comparison" must accompany the ODH 81. The "Car Travel Reimbursement Cost Comparison" must compare the "low dollar contract tier fare" of both the departure and return flights with the cost of travel computed using the DCS website "Trip Calculator" located at:
https://www.ok.gov/dcs/calculator/index.php

6. The cost comparison should be completed by the traveler or the designated travel coordinator serving that traveler and submitted with the ODH 81 for approval. Instructions for obtaining the "low dollar contract tier fare" and using the "Car Travel Reimbursement Cost Comparison" can be found at:
Public Folders\PCard\General P-Card References

III. References

Title 74, O.S., § 500.1 through 500.37; 840.500.16A

Internal Revenue Code of 1986

IV. Action

The Chief Operating Officer is responsible for ensuring the annual review of this administrative procedure.

Administrative Services is responsible for the annual review and revision of this administrative procedure.

Any exceptions to this administrative procedure require prior written approval of the Commissioner.

This procedure is effective immediately as indicated.

V. Attachments

Attachments	Title	Location
ODH Form No. 81	Interstate Travel/Request Authorization	Attached

Attachment A

OKLAHOMA STATE DEPARTMENT OF HEALTH
INTERSTATE TRAVEL REQUEST/AUTHORIZATION

DIVISION: _____

APPLICANT: _____ POSITION (Title):_____

NATURE OF TRIP:

_____

_____ _____ _____
(Name) (Date) (Location)

JUSTIFICATION FOR TRIP:

_____

_____

_____

DEPARTURE: _____ DATE OF RETURN:_____

MODE OF TRANSPORTATION (Private – Public): Airline Ticket: _____ Car: _____ Bus: _____
(If traveling by car a cost comparison must be attached)

DURATION OF TRIP WILL INCLUDE: _____DAYS AT MEETING AND _____DAYS ENROUTE

TOTAL NUMBER OF DAYS: _____

ESTIMATED COST: $_____ $_____ $_____ $_____
(Travel) (Per Diem) (Other) (Total)

APPROVED

_____
(Division Director/Service Chief)

ACCOUNTING SERVICES

FUNDING: _____ _____ _____ _____
(Fund) (Account) (Sub-Activity) (CFDA #)

Reimbursed by

_____
(Used when non-OSDH resources are covering the entire cost of the meeting)

_____
(Accounting Services Approval)

APPROVAL AND TRAVEL AUTHORIZATION

The individual named is authorized to perform official travel as indicated:

_____ _____ _____
Name Title Date
(Deputy Commissioner/Commissioner)

ATTACHMENT J
MIECHV Benchmarks and Constructs

Improved Maternal and Child Health	• Prenatal care • Parental use of alcohol, tobacco, or illicit drugs • Preconception care • Inter-birth intervals • Screening for maternal depressive symptoms • Breastfeeding • Well-child visits • Maternal and child health insurance status
Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	• Visits for children to the emergency department from all causes • Visits of mothers to the emergency department from all causes • Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety • Incidence of child injuries requiring medical treatment. • Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated) • Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program • First-time victims of maltreatment for children in the program
Improvements in School Readiness and Achievement	• Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child) • Parent knowledge of child development and of their child's developmental progress • Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions) • Parent emotional well-being or parenting stress • Child's communication, language and emergent literacy • Child's general cognitive skills • Child's positive approaches to learning including attention • Child's social behavior, emotion regulation, and emotional well-being • Child's physical health and development

Crime or Domestic Violence	• Crime o Arrests o Convictions • Domestic Violence o Screening for domestic violence o Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries): o Of families identified for the presence of domestic violence, number of families for which a safety plan was completed
Family Economic Self-Sufficiency	• Household income and benefits • Employment or education of adult members of the household • Health insurance status
Coordination and Referrals for Other Community Resources and Supports	• Number of families identified for necessary services • Number of families that required services and received a referral to available community resources • MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community • Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies • Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided.)

Adapted from the HRSA Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program, available at:
http://www.ok.gov/health/documents/3rd%20Phase%20of%20HV%20Guidance.pdf

04/01/11

Main Menu

Home
About
Results
Training
Model Implementation
Training Gateway
Pricing Structure
Knowledge Studio
Conference
Advocacy
Support Us
Resources
Contact

Model Implementation

This collection of resources is designed to help organizations fully understand and put into practice those things that make a quality Parents as Teachers affiliate. Having all this information in the design stage helps an organization begin with the end in mind!

Understanding the model

- **Logic Model**
- **Essential Requirements summary**
- **Quality Assurance Guidelines**

Becoming an affiliate

- **Readiness Reflection**
- **Budgeting Tool**
  - *These two resources help ensure an organization is well positioned to develop a Parents as Teachers affiliate.*
- **Affiliate Plan**
  - *This plan helps an organization design its Parents as Teachers services based on community needs, funding requirements and our essential requirements, linking program inputs and activities to outputs and outcomes for families.*

Creating a picture of a Parents as Teachers affiliate

- **Quality Assessment: Quality Standards and Self-Study Tool**

Our model has 4 dynamic components:

- Personal visits
- Group connections
- Screenings
- Resource network

Areas of emphasis in the model components:

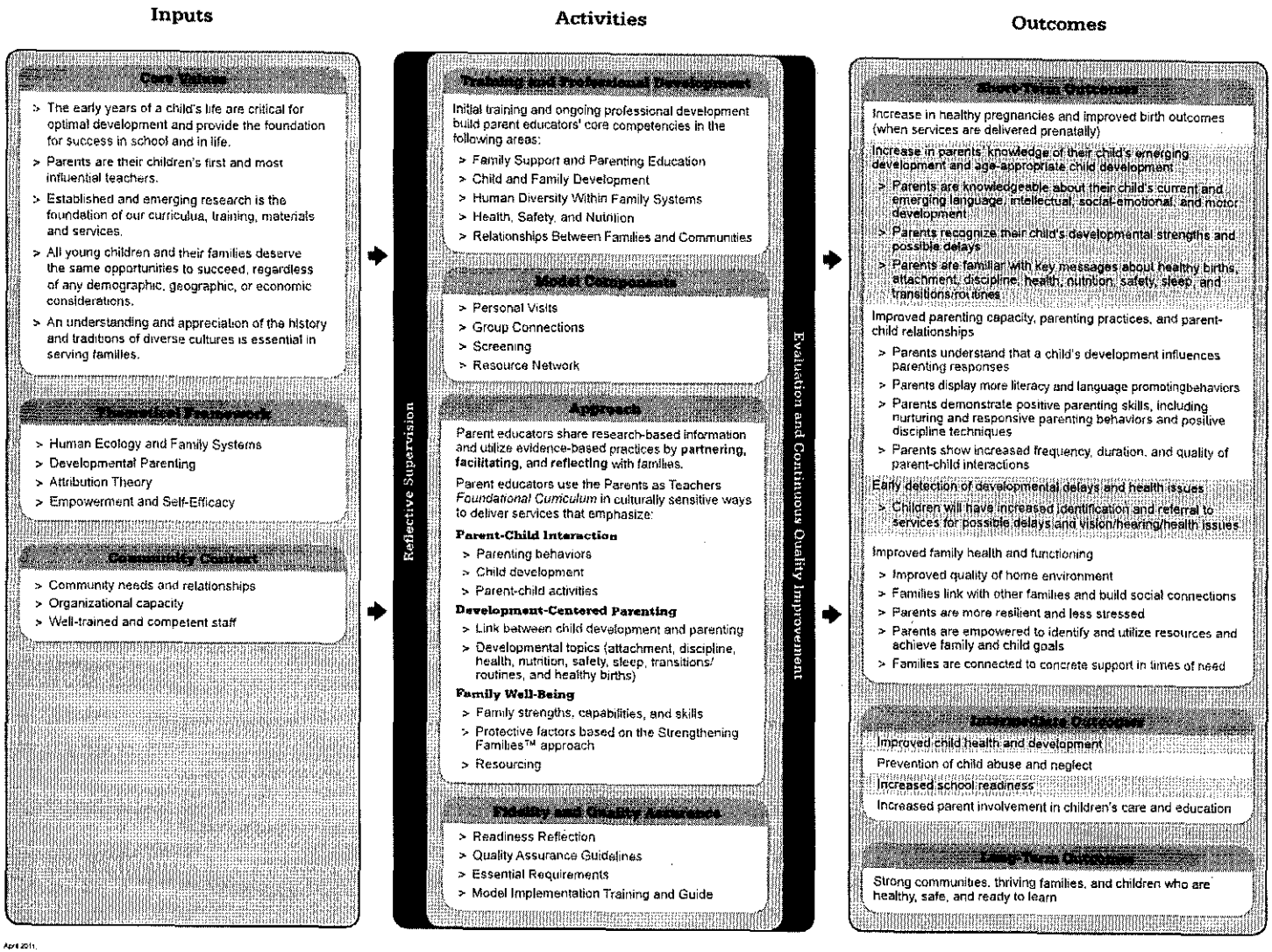
- Parent-child interaction
- Development-centered parenting
- Family well-being

Contact Us | (314) 432-4330 | 2228 Ball Drive, St. Louis, Mo 63146

Back to Top

PARENTS AS TEACHERS LOGIC MODEL

Parents as Teachers



What is a logic model?

This logic model provides a simplified, visual description of the Parents as Teachers' theory of change and provides a general picture of how the evidence-based Parents as Teachers model is intended to work to achieve desired outcomes.

The logic model represents a sequence of events. It flows from left to right and shows how change occurs over time. Reading the logic model is similar to reading a series of "If...then" statements.

Parents as Teachers consists of four dynamic and interrelated components, however additional strategies or model enhancements may be appropriate to best address families' needs at the local level. For example, implementation may be modified to be culturally responsive, directed to special populations, or offered in conjunction with other early childhood programs as determined by community need.

How can the logic model be used?

The logic model provides a conceptual framework that can be used in program planning, training and professional development, allocation of personnel and resources, and evaluation. By demonstrating that activities are not ends unto themselves, parent educators can be increasingly intentional as they work with families to create change and achieve the goals of Parents as Teachers.

Parents as Teachers goals

The goal of Parents as Teachers are woven throughout the short-term, intermediate, and long-term outcomes. The four goals are:

- Increase parent knowledge of early childhood development and improve parenting practices.
- Provide early detection of developmental delays and health issues.
- Prevent child abuse and neglect.
- Increase children's school readiness and school success.

April 2011
Developed by Parents as Teachers

2228 Ball Drive Saint Louis, MO 63146 1.866.PAT.4YOU (1.866.728.4968) www.ParentsAsTeachers.org

Essential Requirements for Affiliates
Updated September 2012

Parents as Teachers

The following are the essential requirements for an organization to become and remain a Parents as Teachers affiliate with approval to implement the Parents as Teachers model. Implementation and service delivery data that address the essential requirements are reported at the end of each program year on the Affiliate Performance Report (APR).[1] New affiliates' intentions to comply with these requirements are initially demonstrated through the Affiliate Plan.

Areas		Essential Requirements
Organizational Design	Infrastructure and Staffing	1. Affiliates provide at least two years of services to families with children between prenatal and kindergarten entry.
		2. The minimum qualifications for parent educators are a high school diploma or GED and two years' previous supervised work experience with young children and/or parents.
	Leadership and Administration	3. Each affiliate has an advisory committee that meets at least every 6 months.
		4. The affiliate follows the standard guidelines regarding copyright, trademark and logo use established by Parents as Teachers.
	Supervision	5. Each month, parent educators working more than .5 FTE participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings and parent educators working .5 FTE or less participate in a minimum of one hour of reflective supervision and two hours of staff meetings.
		6. Each supervisor, mentor or lead parent educator is assigned no more than 12 parent educators, regardless of whether the parent educators being supervised are full-time or part-time employees.
Training and Professional Development	Training for New Parent Educators and Supervisors	7. All new parent educators in an organization who will deliver Parents as Teachers services to families attend the Foundational and Model Implementation Trainings before delivering Parents as Teachers; new supervisors attend the Model Implementation Training.[2]
	Competency-based Professional Development and Annual Recertification	8. Parent educators obtain competency-based professional development and renew certification with the national office annually.
Family-Centered Assessment and Goal Setting	Assessment	9. Parent educators complete and document a family-centered assessment within 90 days of enrollment and then at least annually thereafter.
	Goal-setting	10. Parent educators develop and document goals with each family they serve.

[1] All affiliates in existence prior to 1/2011 must be providing services that comply with each essential requirement by July 1, 2014.Data submitted by affiliates to the national office on the 2014-2015 APR (and annually thereafter) will be utilized to measure performance.

[2] Organizations newly implementing the Parents as Teachers model must receive approval for their Affiliate Plan before registering staff for Foundational and Model Implementation Training. Parent educators certified prior to January 1, 2011, who are with an existing program must attend Foundational Training and a Model Implementation Retraining prior to July, 2014; supervisors who have been with an existing program must attend a Model implementation Retraining prior to July, 2014.

Areas		Essential Requirements
Parents as Teachers Model Components	Personal Visits *Personal visits are delivered by model certified parent educators and defined by their focus on 3 major areas of emphasis: parent-child interaction, development-centered parenting and family well-being.*	11. Parent educators use the foundational visit plans and planning guide from the curriculum to design and deliver personal visits to families.
		12. Families with 1 or fewer high needs characteristics receive at least 12 personal visits annually and families with 2 or more high needs characteristics receive at least 24 personal visits annually.
		13. Full time 1st year parent educators complete no more than 48 visits per month during their first year and full time parent educators in their 2nd year and beyond complete no more than 60 visits per month.
	Group Connections *Group connections are staffed by at least 1 model certified parent educator or supervisor and are focused across the program year on the 3 major areas of emphasis.*	14. Affiliates deliver at least 12 group connections across the program year.
	Screening	15. Screening takes place within 90 days of enrollment for children 4 months or older and then at least annually thereafter (infants enrolled prior to 4 months of age are screened prior to 7 months of age). A complete screening includes developmental screening using PAT approved screening tools, along with hearing and vision screening[3], and completion of a health record. Developmental domains that require screening include language, intellectual, social-emotional and motor development.
	Resource Network	16. Parent educators connect families to resources that help them reach their goals and address their needs.
Evaluation & Continuous Quality Improvement	Family Feedback	17. At least annually, the affiliate gathers and summarizes feedback from families about the services they've received, using the results for program improvement.
	Affiliate Performance Report	18. The affiliate annually reports data on service delivery and program implementation through the Affiliate Performance Report; affiliates use data in an ongoing way for purposes of continuous quality improvement.[4]

[3] If an affiliate is unable to use OAE or pure tone audiometry, parent report or documentation that the child's hearing has been checked by a healthcare provider within the last 12 months can be used as the hearing screening portion of the complete annual screening.

[4] Timely reporting requires that the Affiliate Performance Report be completed no later than August 15.

Parents as Teachers

QUALITY ASSURANCE GUIDELINES FOR PARENTS AS TEACHERS AFFILIATES

March 2013

This is a notated version of the QA Guidelines that highlights the changes from the 9/2012 version. All new text is highlighted in blue.

Introduction

The Parents as Teachers model is an evidence-based early childhood home visiting program that builds strong communities, thriving families and children who are healthy, safe and ready to learn. Certified parent educators who implement the Parents as Teachers model emphasize parent-child interaction, development-centered parenting and family well-being in their work with families. There are four interrelated and integrated components of the model: personal visits, group connections, screening, and resource network. Together, these form a dynamic package of services.

The Parents as Teachers model has four primary goals:

- Increase parent knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

In order to become familiar with the expectations for replication of the model, you will need to carefully review the following Quality Assurance Guidelines. They were developed by the Parents as Teachers national office to provide clear requirements and guidance for replication of the Parents as Teachers model. The guidelines and essential requirements described in this document represent the programmatic elements necessary for model fidelity and should be used to guide the development and growth of your Parents as Teachers affiliate.

☆*The Essential Requirements for model replication are starred throughout this document and summarized in Appendix A.*

Page numbering has changed

If your organization already provides home visiting services to families of young children, you may be choosing Parents as Teachers affiliation to enhance the child development and parenting focus of your home visitors and maximize consistency of service delivery in order to best achieve outcomes. Nonetheless, it is still important that you closely review these Quality Assurance Guidelines and ensure that your organization is either already meeting the requirements or will meet the requirements before newly implementing the Parents as Teachers model. If your organization is establishing a new home visiting program, you will need to use the Quality Assurance Guidelines for guidance in designing and building your affiliate. In both cases, it is important to consider that home visiting services are part of a continuum of supports for families of young children and that strong communities provide multiple coordinated and well-integrated avenues for the optimal development of young children.

 Throughout the QA Guidelines, you will see this icon highlighting a related tool provided by Parents as Teachers national center.

Toolbox icon throughout is a new addition

Next Steps for Organizations New to Parents as Teachers:

1. Carefully review the following Quality Assurance Guidelines (pay particular attention to the essential requirements).
2. Complete the Parents as Teachers Readiness Reflection to assure that your organization is well positioned to develop a Parents as Teachers affiliate. This tool provides reflection and discussion points- it is not necessary to submit responses to the Parents as Teachers national office. (found in Appendix B)
3. Complete the Parents as Teachers Affiliate Plan found on the Parents as Teachers website and submit it to the national office or appropriate Parents as Teachers state office (organizations newly implementing the Parents as Teachers model must receive approval for their Affiliate Plan before registering staff for Foundational and Model Implementation Training.).

Removed note for existing affiliates regarding retraining dates

Organizational Design

Successful replication of the evidence-based Parents as Teachers model occurs within an organizational context that has the community relationships, capacity, funding, and staffing necessary for successful implementation and achievement of outcomes.

moved from pg. 1

Community and Cultural Context

Community Needs

It is important for your organization to have a current and comprehensive understanding of the communities you are serving so that your Parents as Teachers affiliate can best meet families' needs and be an integrated part of a comprehensive system of care. It is equally important that your organization builds and maintains community relationships and collaborations that help your Parents as Teachers affiliate grow and sustain its services.

Populations to be served

moved from under Infrastructure & Staffing

Age of Children	The Parents as Teachers model is designed to serve families throughout pregnancy until their child(ren) enter kindergarten. An organization can choose to focus services primarily on families with children Prenatal to 3 or extend their Parents as Teachers services to families with children ages 3 years to the age of kindergarten entry by having their parent educators attend the *Parents as Teachers*, 3 Years to Kindergarten Entry Training. This training is available only to parent educators who have attended the foundational training.
Target Population	Some affiliates target services to a specific community or geographic location. Communities may be identified as particularly in need of home visiting because of demographic data (e.g., levels of infant mortality, poverty, or low educational attainment). The type of community – major city, small town, urban, rural, or suburban – and associated characteristics, such as geographic isolation or lack of accessible resources, will also influence the development of your affiliate, particularly as you determine appropriate recruitment strategies, budget for travel costs, and determine your community partners and key resources for families.

Eligibility Criteria	In addition, some affiliates have specific eligibility criteria for the families who receive services. Such eligibility criteria might include children with special needs, families at risk for child abuse, income-based criteria, teen parents, first time parents, immigrant families, low literate families, or parents with mental health or substance abuse issues. The Parents as Teachers model is suitable for varied target populations and communities and affiliates typically serve families with a range of risk and protective factors.

Duration of Services

moved from under Infrastructure & Staffing

☆ **Parents as Teachers affiliates provide at least two years of services to families with children between prenatal and kindergarten entry.** Affiliates that provide only the minimum two years of services to families typically deliver an increased frequency of services during this period as compared to affiliates serving families for a greater length of time. Duration of services refers to the affiliate's overall design. As long as your affiliate is designed to provide at least two years of service, families can enroll when their child is any age within the affiliate's overall age range. However, since optimal impact is more likely when enrolled prenatally or at birth, affiliates may choose to target recruitment strategies to enroll families prenatally or at birth to maximize outcomes. It is important to monitor and maximize the duration of service individual families are actually receiving as well. This is also a retention issue; affiliates need to use engagement and retention strategies to keep families enrolled for at least 2 years.

Affiliates should provide services to families all 12 months of the year so that families can enroll in and receive services as quickly as possible and families' needs are consistently met.

Infrastructure and Leadership

Heading changed from Infrastructure and Staffing

Subheading changed from Funding Sources & Funding Duration

Funding and Resources

Funding for a Parents as Teachers affiliate can come from a variety of sources, including federal, state, local and private. Your program may be receiving all types or some combination of one or more. It is preferable for an organization to come in with three or more years of funding in place for Parents as Teachers. However, an affiliate's major sources of funding should be secured for at least 2 years. We recognize that many funding sources must be renewed annually. These are different from a funding source designed for one year only. Your affiliate's funding and in kind support will need to be sufficient to fulfill the Parents as Teachers essential requirements and to provide sufficient workspace, storage and technology.

☛ An Excel budgeting template that helps you plan for the costs of implementing and delivering Parents as Teachers can be found at http://www.parentsasteachers.org/training/training-gateway.

Policies and Procedures

Because Parents as Teachers affiliates are often part of a larger organization, they are subject to the specific policies and procedures of their sponsoring organization as well as applicable licensing, regulation and funder requirements. At a minimum, policies and procedures should address:

- Client Rights
- Intake and Enrollment
- Documentation and maintenance of records
- Ethical practice

- Financial management
- Human Resources
- Risk Management
- Supervision and Training
- Transition and Exit from Services

☆ **The affiliate follows the standard guidelines regarding copyright, trademark and logo use established by Parents as Teachers.**

Moved from earlier in document

Staff Selection

Changed from Staffing

The Supervisor

The Parents as Teachers supervisor provides leadership, oversight and vision for the work of the affiliate. The supervisor's responsibilities include directing, coordinating, supporting, and evaluating the on-the-job performance of parent educators in accordance with the affiliate's policies and procedures.

For the supervisor, a college degree or beyond in early childhood education, elementary education, behavioral or social sciences or a related field is recommended. A combination of education, work experience and effective interpersonal and communication skills is critical for the supervisor as well. In addition, the supervisor should have at least 5 years' experience working with families and young children, as well as knowledge of reflective supervision and program management. He or she must also successfully complete the Model Implementation Training. It is strongly encouraged that the supervisor attends the Foundational Training as well.

For supervision purposes, a mentor or lead parent educator with a similar education and experience level as the supervisor can be designated to support and provide guidance for parent educators. This approach is most applicable to an affiliate with many parent educators.

☆ **Each supervisor, mentor or lead parent educator is assigned no more than 12 parent educators, regardless of whether the parent educators being supervised are full-time or part-time employees.** The maximum number of supervisees is based on a full time supervisor/mentor/lead parent educator and should be less if the supervisor/mentor/lead parent educator is not full time. This maximum ratio of supervisees to supervisor/mentor/lead parent educator is designed to allow sufficient time for formal and informal supervision of parent educators, as well as for the supervisor's program management and operations responsibilities.

The Parent Educator

Affiliate quality is highly dependent on hiring parent educators who value working with parents of young children and who have the skills and commitment to develop positive and enduring relationships with families. Parent educators use the Parents as Teachers Foundational Curriculum with families at each visit, ensuring that families receive consistent research-based, evidence-informed information and that parents are empowered to use the information to create safe and nurturing environments for their children.

Your organization should have clearly defined criteria for the selection of parent educators, including expected education, work experience, skills and characteristics. It is preferable for parent educators to have a bachelor's or four-year degree in early childhood or a related field.

Ordering of some sentences has changed in this section

☆ **The minimum qualifications for parent educators are a high school diploma or GED and two years' previous supervised work experience with young children and/or parents.** While it is

beneficial for parent educators with an associate's degree/60 college hours to have previous supervised work experience with young children and/or parents, this is a requirement only for parent educators with no more than a high school diploma or GED. Individual programs may require additional educational or work history requirements that they find appropriate.

A sample Parents as Teachers parent educator job description is provided in Appendix C.

An important factor in successful hiring is the supervisor's familiarity with the core competencies that parent educators must develop. Priority should be given to hiring parent educators with effective communication and interpersonal skills (e.g., outgoing, empathic, non-judgmental, patient, tactful) since these skills are necessary building blocks for each of the five core competency areas. Within each competency area are the knowledge, skills, and practices that parent educators need to develop over time through training and experience.

Competency Area		Definition and Description
I.	Family Support and Parenting Education	Parent educators practice a strength-based family support and parenting education approach to support the growth of parents' capacities through research-based methods and principles.
II.	Child and Family Development	Parent educators are knowledgeable about child and parent development, and are skilled in fostering positive parent-child interactions.
III.	Human Diversity within Family Systems	Parent educators demonstrate respect for diverse needs and characteristics of families and understand the influence of varied family systems, culture, and socioeconomic status in child rearing practices and school readiness.
IV.	Health, Safety, and Nutrition	Parent educators assist parents in establishing healthy and safe environments and parenting practices that promote the optimal development of children.
V.	Relationships between Families and Communities	Parent educators strengthen families by building partnerships, connecting parents to supports, and fostering parent engagement and leadership in schools and other community organizations.

High quality affiliates strive to hire parent educators that collectively reflect the community, cultural and language backgrounds of the families being served. In addition, parent educators must be committed to continual growth in their ability to respond effectively to families' community, cultural, and language backgrounds.

When interviewing, provide the candidate with a comprehensive picture of the job, posing specific scenarios and questions that clearly illustrate a parent educator's responsibilities. Keep in mind during an interview that the behavior demonstrated by the candidate is indicative of how he or she will behave with parents. Candidates who fumble for words, act awkwardly, avoid eye contact, give inappropriate answers or do not actively listen may not be the best candidates for the parent educator position. Always check references.

As professionals working in the home with families, parent educators are expected to have background checks before beginning employment. In addition, it is expected that your organization comply with all applicable licensing and statutory requirements.

Advisory Committee

☆ **Each Parents as Teachers affiliate has an advisory committee that meets at least every 6 months.** A more frequent meeting schedule for the advisory committee should be considered based on the needs of your affiliate. The advisory committee can be part of a larger committee

Removed Leadership & Administration subheading

or coalition as long as the group includes a regular focus on the Parents as Teachers affiliate. At a minimum, the advisory committee includes program personnel, community service providers, families who have received or are receiving Parents as Teachers services, and community leaders. In addition, the advisory committee should reflect the cultural backgrounds, demographics and geographic locations of the program's service population.

The Parents as Teachers advisory committee has several key functions, most notably to advise, provide support for, promote, and offer input to the Parents as Teachers affiliate. Specifically, the advisory committee:

- Provides support for the development and promotion of the affiliate.
- Helps identify existing and potential funding sources.
- Provides input into program planning and evaluation.

It is important to recognize that the Parents as Teachers advisory committee is different from an organization's governing board or board of trustees (Merrill Associates, 2003, para 1). A volunteer advisory group, board, committee, or council is typically formed to give advice and counsel related to the operation of the organization and/or the planning of events and activities for programming, and contributes without legal authority (Macduff, 1998, & Merrill, 2003, as cited in Edwards, 2008, p.4).

Before recruiting committee members, an affiliate should consider the different representatives to be included. Which groups and organizations are currently important stakeholders in your organization? Who could be valuable new resources?

You should also consider the following in developing the advisory committee:

- The purpose of the advisory committee
- Committee member job descriptions
- Size, structure and makeup of the committee
- How long each member serves
- Frequency and duration of meetings
- Officers and related duties (as applicable)
- Relationship of the committee to staff and the governing board

Training, Supervision and Professional Development

A skilled and capable workforce is critical to the effectiveness of Parents as Teachers services. Staff competence begins with careful staff selection and high quality initial training and is advanced through regular reflective supervision, ongoing professional development and formal education.

Initial Training

☆ **All new parent educators in an organization who will deliver Parents as Teachers services to families attend the Foundational and Model Implementation Trainings before delivering Parents as Teachers; new supervisors attend the Model Implementation Training.**

The Foundational training lays the groundwork for effective use of the Parents as Teachers Foundational Curriculum. The training introduces the Parents as Teachers approach to home visiting with coursework centered around three main areas of emphasis: Parent-Child Interaction, Development-Centered Parenting and Family Well-Being. Model Implementation Training helps organizations successfully replicate the Parents as Teachers model and offers

implementation strategies that bring to life quality Parents as Teachers services. For more information about the required trainings, please visit our website.

Support for New Parent Educators

A comprehensive orientation should be provided for new parent educators. Whenever possible, the orientation process should begin before Parents as Teachers training to help ensure that new parent educators get the most from training and return ready to apply what they have learned. Comprehensive orientation includes:

- orienting them to the sponsoring organization's mission, goals and operations,
- reviewing written job description, policies and procedures, and
- discussing the Affiliate Plan or most recent Affiliate Performance Report

It is important to provide focused guidance to parent educators throughout their first year. Within their first 6 months of employment, new parent educators observe experienced parent educators deliver personal visits, group connections and screening. The new parent educator is then observed delivering these same services within 6 months after Parents as Teachers training and again at 1 year.

In addition, support for new parent educators should address (but is not limited to):

- development of parent educator core competencies
- protocols for the assessment and screening tools used by the affiliate
- planning, organizational and documentation procedures, including use of a management information system
- allocation and use of time for personal visits, group connections and other responsibilities related to effective and high quality early childhood home visitation services

Supervision

☆ **Each month, parent educators working more than .5 FTE participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings and parent educators working .5 FTE or less participate in a minimum of one hour of reflective supervision and two hours of staff meetings.**

Reflective supervision as defined by Rebecca Parlakian is "the practice of meeting regularly with staff members to discuss their experiences, thoughts, and feelings about their work." (Parlakian, 2002, p. 1). Administrative and monitoring issues need to be covered along with the more reflective aspects of supervision. It is important to note as well that ongoing supervision takes into account observations of service delivery and feedback.

Some rewording and additions in this paragraph

The following list outlines some key topics that should be addressed through ongoing supervision.

- expectations and challenges regarding the role, ethics and boundaries of parent educators
- relationship-building with families
- development of parent educator core competencies
- how to care for one's own well-being and avoid burnout
- effective and appropriate use of curricula and additional intervention strategies
- family and child screening, assessment and progress toward goals
- working effectively with community resources
- timely and accurate documentation

Some additions & clarifications to this list of bullets

- evaluation and data collection issues

Staff meetings should also cover more than administrative issues, providing opportunities for review of use of the curriculum, screening protocols, case discussion, peer support, discussion of the core competencies and strategies to prevent burnout. As long as a monthly staff meeting is provided to each parent educator, staff meetings can be done in subgroups. For example an affiliate may have staff that provide visits during the daytime and staff that provide evening and weekend visits. In this example, the supervisor might convene a monthly staff meeting of its daytime parent educators and a monthly staff meeting of its evening and weekend parent educators.

The supervisor needs to maintain a record of supervision with each parent educator, as well as documentation of staff meetings. Such records should include dates, duration and key topics.

Ongoing Professional Development

Ongoing professional development enhances parent educators' knowledge and increases their competence in delivering services to children and families. Observing parent educators delivering services and providing feedback that improves their skills is an important element of this. Therefore, it is expected that parent educators in their 2nd year of employment and beyond are observed delivering a personal visit annually (more often if concerns are identified) and that a sample of the affiliate's group connections are observed annually as well.

The Parents as Teachers Personal Visit Observation Tool helps the supervisor assess specific content and delivery of a visit and also incorporates the Home Visit Rating Scales (HOVRS-A+) as a guide in assessing the visit's overall process and effectiveness quality. The Group Connections Observation tool helps one focus on key aspects of a group connection based on the Parents as Teachers standards. These tools are found in the online Quality Assurance Handbook located in the Parents as Teachers portal.

Using the Parents as Teachers Core Competencies Self-Assessment tool, parent educators rate their knowledge, skills and practices. The supervisor and parent educator use this assessment, along with observation of service delivery and review of progress on the previous year's goals to assess performance and set written professional development goals. Specific training or professional growth opportunities can then be identified to meet these goals.

☆ **Parent educators obtain competency-based professional development and renew certification with the national office annually.**

Professional development should relate to the five Parents as Teachers core competency areas: Family Support and Parenting Education; Child and Family Development; Human Diversity within Family Systems; Health, Safety, and Nutrition; and Relationships between Families and Communities.

- 1st year of certification: 20 clock hours of professional development required
- 2nd year after certification: 15 clock hours of professional development required
- 3rd year after certification and beyond: 10 clock hours of professional development required

Hours may be obtained through:

- Parents as Teachers trainings and professional development opportunities
- Undergraduate or graduate courses by accredited community colleges, colleges or universities

- Continuing education or professional development conferences
- Workshops or seminars sponsored by your organization or other organizations in the community
- Online training provided by a credible organization

Once the affiliate submits its annual Affiliate Performance Report, parent educators renew certification online through the Parents as Teachers e-business system (includes confirming required professional development hours, electronically re-signing the Ethical Agreement and paying a fee). Renewal by the required deadline allows parent educators to be recertified and continue to receive online access to curriculum resources.

Formatting change in this paragraph

Recruitment and Enrollment

Parents as Teachers affiliates promote their services in the community, recruit and serve eligible families and facilitate families' ongoing participation in services.

Section was moved from under Organizational Design & supporting sentence moved from 1st paragraph

Parents as Teachers affiliates develop a written recruitment plan, identifying effective approaches and settings in which to recruit the populations(s) they serve. For affiliates that receive all families through a centralized intake system, this plan outlines how your affiliate works with the system. With centralized intake, your affiliate needs to make sure that their eligibility criteria and services are well understood and represented. Whenever possible, affiliate staff should take an active role in the centralized intake process, including screening measures, timelines and communication of referrals.

For affiliates who directly recruit families, recruitment settings to consider as you develop your plan include: hospitals/health clinics/doctors' offices, organizations providing diagnostic and early intervention services, social services organizations, schools, mental health agencies, other early childhood programs, community resources such as libraries and job training centers, and faith based organizations.

Recruitment methods and strategies to consider include: print materials, personal contact by parent educators, informal meetings, website, radio or TV, signage (lawn signs, billboards, etc.), family recruitment events, and hosting booths at family oriented events.

Because effective recruitment materials and strategies are responsive to the cultural diversity and cultural norms of the populations to be recruited, they will vary. Nonetheless, we offer several general principles for recruitment:

1) Organize before you recruit.
2) Maintain high quality services so you can be confident you are providing a valuable service.
3) Make every contact with Parents as Teachers well worth the parents' time.
4) Do not minimize the impact of word-of-mouth. Satisfied parents are valuable partners for marketing your affiliate in the community.
5) Give participants ownership. Involve them and their ideas in your plan to recruit families.
6) Utilize relationship-based recruitment. For example, arrange with agencies to spend time in their waiting room playing with the young children and parents who are there. Take toys, books, and brochures. Some families will need time to develop sufficient trust, particularly if there have been prior negative experiences with agencies or programs. Thus, it can be beneficial to establish a presence and rapport with some families before actively recruiting them for Parents as Teachers.

7) Make sure that your recruitment materials give a clear picture of what families can expect from Parents as Teachers services.

When a family meets eligibility criteria and indicates a desire to participate, services should begin promptly[1]. This gives parents confidence that the program will do what it promises. Assignment of families to parent educators should take into consideration several key factors, including but not limited to the family's primary language and parent educator experience with particular family backgrounds and characteristics. Families who cannot be served, or cannot be served promptly, need to be connected to appropriate resources and services.

The enrollment process includes providing families with written information about the program and discussing mutual expectations for participation in services. By the end of the first visit, the parent(s) and parent educator will sign a participation agreement that explains the role of the parent educator and the affiliate's services, including assessment, goal setting, and the four components of the model. The agreement should be written in clear and understandable language. It is important to note that the process of informed consent for services is as important as the signed family agreement itself. The parent educator talks through each item on the family agreement with the parent(s); invites the parent(s) to share any questions or concerns about the agreement; and tells the parents that if they do change their mind about this agreement, they can always let the parent educator know.

These items now spelled out

Because of the variety of sponsoring organizations for Parents as Teachers affiliates and the additional services provided by some affiliates, it is not possible to have one standard participation agreement for all Parents as Teachers affiliates. Therefore, we provide the following guidelines of what is typically covered (your affiliate may have additional items).

A typical participation agreement covers:	For example:
A full description of services, including purpose	Parents as Teachers informs, support and encourages you in your parenting role. Our services are designed to help you learn more about parenting and your child's development, help you cope with the challenges of family life, and help identify and address any potential delays in your child's development. Together, we will focus on ways you can support your child's development, work through your parenting questions and concerns and build a healthy environment for your child. First, we will get to know you better by learning about your family. We will also set and work on goals throughout our time together. You will receive regular personal visits in your home, participate in group connections with other families and be connected to resources in the community. In addition, your child will receive vision, hearing, health and developmental screening. Services are voluntary.
The limits of the services	Parent educators are not psychologists or medical professionals. They do not diagnose developmental, psychological or medical conditions. However, they can help you connect to qualified professionals who can do so.

There are some adjustments to the language & content in this table

[1] Promptly is defined here as the first personal visit scheduled to take place no more than 3 weeks after the initial request for service.

A typical participation agreement covers:	For example:
The risks and benefits of the service (could present as: "Things to consider about Parents as Teachers services")	There are many benefits you can get from Parents as Teachers services: support; learning more about your child's development and parenting; identification of potential developmental delays; connection to community resources; meeting other families, etc. It is possible that you could find a topic uncomfortable or difficult to talk about, but we hope that working through this will be helpful to you and your family. If you ever feel this way, please talk about this with your parent educator.
Any financial costs to the family	There are no costs for your family to participate in Parents as Teachers services.
Expectations for participation	Parents as Teachers provides you with personal visits, group connections, screening of your child and connections with community resources. Services will continue until your child is – (age). We expect that you will be present for visits, attend group connections, contribute your observations to screening and connect with community resources. I you need to cancel a visit or reschedule for a different day, please contact your parent educator at least 24 hours in advance. This participation agreement will be in effect until --. If you no longer wish to participate, please let your parent educator or the program supervisor know.
Record keeping	Routine information will be collected during your participation in Parents as Teachers. This includes information such as the assessment, screening, services and recommendations you and your child receive. Parents or legal guardians have access to the family record.
Confidentiality	With the exception of the following situations, Parents as Teachers will keep your information confidential and will not release it outside the program without your written permission or a court order. Parents as Teachers staff members are "mandated reporters." This means that by law staff must make a report to protect your family's safety if there are concerns about child abuse or neglect, domestic violence, elder abuse, or intent to harm self or others.
A dated, signed agreement to participate	If I have any questions about this agreement form or Parents as Teachers services, I can discuss them with my parent educator. I have read and understand the above. I agree to participate in Parents as Teachers services. I understand that at any time, I can let my parent educator or the supervisor know that I no longer want to participate.

Enrolling families in the program is only the beginning. Once families are enrolled in Parents as Teachers, parent educators facilitate families' continued participation in services through a variety of strategies. For example, checking in with the family before each visit helps keep the family and parent educator connected and can facilitate the family's sense of ownership for and engagement with services. **Some affiliates also send written visit reminders (e.g. postcards), email/text message visit reminders, or leave stickers to place on the calendar as a reminder. In addition, affiliates may choose to have parent educators provide a book or other incentive at each visit.**

When a visit is missed or canceled, the parent educator should contact the parent(s) within 24 hours and reschedule the visit to take place as soon as possible. **Ultimately, it is the relationship between the family and the parent educator that most impacts retention.**

Parents as Teachers Services

Family-centered assessment and goal setting accompany the model's four interrelated and integrated components: personal visits, group connections, screening and resource network. Together, these form a dynamic package of services.

Section title changed from Parents as Teachers Model Components; Assessment & Goal Setting now integrated into this section

Family-Centered Assessment

In Parents as Teachers, family-centered assessment is a mechanism to get to know and genuinely understand the family, to recognize factors that promote family resilience and well-being, and to facilitate goal setting with the family. "Assessment forms the foundation of effective practice with children and families. Family-centered assessment focuses on the whole family, values family participation and experience, and respects the family's culture and ethnicity," ("Family Centered Assessment", n.d., para 1).

☆ **Parent educators complete and document a family-centered assessment within 90 days of enrollment and then at least annually thereafter.**

The family-centered assessment needs to be sufficiently comprehensive to provide the parent educator with an understanding of the family and help guide services. At a minimum, a family-centered assessment should contain items that assist parent educators with understanding families' strengths, resources, and needs in each of the areas listed below.

- Parenting (such as parent knowledge, capacity, parenting practices, and/or parent-child relationship)
- Family relationships and formal and informal support systems
- Parent educational and vocational information
- Parent general health
- Parent/child access to medical care, including health insurance coverage
- Adequacy and stability of income for food, clothing, and other expenses
- Adequacy and stability of housing

This list of items has been updated consistent with RQI TA brief #2

The information gathered in the areas outlined above should be integrated with the child's developmental, health, vision and hearing screenings to gain a full understanding of the family's strengths, resources and needs.

In addition to the minimum areas listed above, you are strongly encouraged to gather information about broader contextual factors that influence family and child well-being, including neighborhood and community factors (e.g., safety, availability of resources, social connections, etc.). It is important that family-centered assessment is utilized with all families served by your affiliate, regardless of their needs characteristics, to facilitate goal-setting with each family.

To ensure that the family-centered assessment is sufficiently comprehensive, more than one survey (either a formal instrument or informal questions developed by your affiliate) may be needed. In some cases affiliates may develop their own family-centered assessment rather than selecting an existing instrument.

Parents as Teachers' recommended family-centered assessment tool is the Life Skills Progression (LSP). The manual *Life Skills Progression: An Outcome and Intervention Planning Instrument for Use with Families at Risk* by Linda Wollesen and Karen Peifer can be purchased at www.brookespublishing.com/store/books/wollesen-8302. In addition, Parents as Teachers offers a training on the Life Skills Progression that covers how to use and score the LSP, how to monitor progress of the parent(s) and child, and how this work facilitates goal setting.

Information on this training is available in the training section of the Parents as Teachers website under Knowledge Studio.

Parents as Teachers recognizes that your organization or funding source may require that you use a different family assessment tool. When selecting your approach to family-centered assessment it is important to consider the following:

- Is your approach to assessment comprehensive (covers all required topics)?
- Can the results of the assessment be used for goal-setting with families?
- Can the assessment be used with families in a strengths-based and collaborative way?

Regardless of the tool(s) you select, parent educators need to be provided with training on how to administer the family assessment measures according to their protocol.

Please see Appendix D for a table providing some examples of commonly used family-centered assessment instruments and suggestions for supplementing them (if needed) with additional questions or scales. For additional information on family-centered assessment, refer to Parents as Teachers Research and Quality Improvement Technical Assistance Brief #2 *Guidance for Family-Centered Assessment* found under Affiliate Updates on the Parents as Teachers website.

If your affiliate will participate in a centralized family-centered assessment process, you will need to have documentation of how the process will work, including tools used, timelines and how the assessment results will be communicated with your staff.

Goal Setting

Family-centered assessment is a fundamental building block for goal setting with families. Goal setting with families receiving Parents as Teachers services focuses on:

- nurturing positive parenting behavior,
- promoting healthy child development and school readiness, and
- supporting parent and family well-being, including maternal health, economic self-sufficiency and a safe and stable home environment.

☆ **Parent educators develop and document goals with each family they serve.** The goals that parent educators and families set together are informed by, but not limited to, the findings of family-centered assessment, along with child screening and assessment. Goals address at least one of the following areas: parenting behaviors, child development and family well-being. Depending on a family's capacity, more than one goal can be addressed at a time. Together, parent educators and families use goals to plan services. It is important to recognize that referrals to and coordination with other community resources and supports will be necessary in order to achieve the goals set by families through Parents as Teachers services.

← clarification

Parent educators and families work together to develop action plans and accomplish goals. A plan should include but is not limited to the timeline, specific steps toward accomplishing the goal(s), needed resources, and review of progress. On a regular basis, parent educators and families should discuss progress and adjust goals and action plans as necessary. As goals are achieved, new goals are developed, maintaining at least one goal at all times. If a goal has not been achieved within a year, it should be updated. Parent educators and parents might assess progress on goals quarterly, using the last quarterly review of the year as a more formal assessment of progress. During this annual review, parent educators and parents take time to recognize accomplishments over the year, adding new goals to take the place of goals that have been achieved.

The Parent Handout on Goal Setting and the Goal Tracking Sheet found in the Model Implementation Guide help to guide and record goal setting and monitoring.

Personal Visits

Parent educators use the Parents as Teachers *Foundational Curriculum* in culturally sensitive ways to deliver services that emphasize parent-child Interaction, development-centered parenting and family well-being.

☆ **Parent educators use the Parents as Teachers foundational visit plans and planning guide from the curriculum to design and deliver personal visits to families**. The amount of time spent in each visit on each area of emphasis will vary based on family needs and goals. Parents as Teachers personals visits are designed to last approximately 1 hour and be conducted in the home in order to build on and maximize the primary learning environment of the family. Personal visits can be delivered in a mutually agreed upon site outside the home when individual circumstances preclude having visits in the home. For example, visits may take place temporarily at a safe location for families dealing with domestic violence issues or visits might take place in a hospital when a child is in the NICU. Ultimately, the majority of personal visits should take place in the home setting. Parent educators should strive to involve both parents and/or caregivers of the child in the visits.

How often do visits take place?

☆ **Families with 1 or fewer high needs characteristics receive at least 12 personal visits annually and families with 2 or more high needs characteristics receive at least 24 personal visits annually.** See Appendix E for a table defining High Need Characteristics.

While programs may be designed to provide services at a high level of intensity, it is important that staff work to ensure that families actually *receive* an appropriate number of home visits. Typically, families with 2 or more high needs characteristics receive at least twice-monthly visits, while families with 1 or fewer high needs characteristics receive at least monthly visits. In some cases, visit frequency may be gradually decreased as the family transitions out and into other services.

For additional information on visit frequency refer to Parents as Teachers Research and Quality Improvement Technical Assistance Brief #1 *Intensity Matters: Unpacking Personal Visit Frequency* found under Affiliate Updates on the Parents as Teachers website.

How many visits does a parent educator complete each month?

☆ **Full time 1st year parent educators complete no more than 48 visits per month during their first year and full time parent educators in their 2nd year and beyond complete no more than 60 visits per month.**

The lower number of visits parent educators should complete monthly during their first year reflects additional time for supervision, as well as for planning, preparation and documentation of a personal visit typically needed by new parent educators. It is understood that it takes some time for parent educators in a brand new affiliate to build up to their full caseload. This is alsó true for new parent educators.

If your program sets the number of visits that parent educators will complete at the highest allowable levels (as outlined above), it is important to have supports in place that lessen the individual parent educator's responsibilities. For example, designated staff for recruitment, group connections, case management or data entry. If these types of arrangements are not possible or if there are extensive evaluation requirements tied to your funding, it is

recommended that affiliates set the expected number of visits delivered by each parent educator *below* the maximum allowed.

The term "full-time" is based upon 40 hours (1.0 Full Time Equivalent/FTE) of employment weekly. Parent educators should complete visits proportional to the percent of their employment.

How many families should a parent educator serve?
Overall, it is important that caseload size facilitates quality services for each family served, is manageable, and permits time for all the responsibilities of a parent educator. Responsibilities include but are not limited to delivering the four components of the model, documentation, supervision, staff meetings and professional development.

Consider at least the following factors when determining (or revisiting) caseload size:

- the total responsibilities of parent educators in your affiliate
- the frequency that families receive personal visits
- the total amount of time allocated for each personal visit
- the number of visits per month parent educators are expected to complete
- the frequency and length of both individual, reflective supervision and staff meetings
- the expectations for professional development

As an example, if all families receive twice monthly visits, the maximum caseload for the first year parent educator would be 24. For additional information on determining appropriate caseload size, refer to the *Parents as Teachers Guidance for Determining Caseload Size for your Affiliate* found under Affiliate Updates on the Parents as Teachers website.

Personal visits are documented as soon as possible after the visit (but within 2 business days), using a Personal Visit Record (paper or electronic version).

Group Connections

Group connections are designed so that families build social connections with each other, engage in parent-child interaction, and increase their knowledge of ways to support children's development.

Group connections are staffed by at least one model certified parent educator or Parents as Teachers supervisor and are focused across the program year on the three major areas of emphasis. Across the program year, your affiliate should address these areas of emphasis through a variety of group connection formats and topics suited to family members' interests, needs and cultural backgrounds. Group connection formats include family activities, ongoing groups, presentation, community events and parent café.

☆**Affiliates deliver at least 12 group connections across the program year.** Each year, you will develop a written plan for the group connections your affiliate will deliver in the upcoming year. Across each year, the group connections offered by a Parents as Teachers affiliate should incorporate all age groups of children served by the affiliate and all areas of child development.

It is important to use a variety of methods to publicize group connections and encourage family member's regular participation in them. In addition, offering group connections at times and locations that are convenient for family members, offering child care, and involving parents in the planning of group connections can all help maximize families' participation. To encourage participation at group connections, it may be beneficial to offer incentives, food, or

transportation. Make sure your budget includes adequate staff time and funding for these activities.

The more community and family relationships a family has, the less isolated they feel. Thus, an important aspect of Parents as Teachers group connections is to encourage parents to build support networks by talking with each other about common experiences and concerns. Some programs may find it beneficial to offer peer-facilitated group connections. Group connections can also be a form of recruitment for "service-shy" families.

For some affiliates in which transportation is a challenge, such as rural areas, it requires creativity and flexibility to offer monthly group connections. Nonetheless, it can be done successfully. One consideration is that group connections do not have to be based at your organization's facility, particularly if transportation or parking is a challenge. A parent educator could convene a group meeting at a community location more central to multiple families. In addition to monthly group connections, your affiliate might want to consider using online social networking approaches to share child development and parenting information, build support between parents, and encourage affiliate participation. Confidentiality of family information will need to be maintained when using social networking.

Records of the planning and delivery of group connections need to be maintained, along with participant feedback on each group connection.

Screening

Screening provides regular information about each child's health and developmental progress, increases parents' understanding of their child's development, and identifies strengths and abilities, as well as potential areas of concern.

☆ **Screening takes place within 90 days of enrollment for children 4 months or older and then at least annually thereafter (infants enrolled prior to 4 months of age are screened prior to 7 months of age[2]). A complete screening includes developmental screening using PAT approved screening tools, along with hearing and vision screening[3], and completion of a health record. Developmental domains that require screening include language, intellectual, social-emotional and motor development.**

The screening component of the Parents as Teachers model specifically refers to the following four areas:

Hearing

Early identification of hearing concerns can have a profound impact upon a child's development. Otoacoustic emissions (OAE) for children younger than 36 months of age and pure tone audiometry for children 36 months of age and older are the most accurate ways to identify hearing concerns. Therefore, it is best practice for your affiliate to use these methods when conducting hearing screening. If your affiliate contracts out hearing screening, your contracted provider needs to use these methods as well. Please note that following the Foundational and Model Implementation trainings, additional training will be necessary to apply the protocol for otoacoustic emissions (OAE) or pure tone audiometry.

[2] Infants enrolled prior to 4 months of age are screened prior to 7 months of age rather than within 90 days of enrollment because elements of the complete screening cannot be done with newborns.

[3] Documentation of hearing and/or vision screening by a healthcare provider can be used as the hearing and/or vision screening portion of the complete screening.

If your affiliate is unable to use OAE or pure tone audiometry, parent report or documentation that the child's hearing has been checked by a healthcare provider within the last 12 months can be used as the hearing screening portion of the complete annual screening. For the initial screening, parent report or documentation that the child's hearing has been checked by a healthcare provider within the last 90 days can be used. Parent report that the child's hearing has been checked by a healthcare provider is recorded on the Health Record, using the updated Fillable Form in the Online Curriculum.

The newborn hearing screening results will satisfy the hearing screening requirement for up to the first 12 months of life as long as the child passed. However, best practice suggests that the hearing screening should be repeated at 6 months of age. You should request and review documentation of the newborn hearing screening results and include this information on the Health Record. If the child received a refer result then they should return to the hospital for a rescreen. If the family is not following up on the refer result, it is important that the parent educator works with them to do so.

Vision

Researchers have shown that the most sensitive period for the development of vision occurs between birth and age two. Parent educators provide functional vision screens, observing the muscle movement of the eyes and whether both eyes are working together to help ensure that vision problems in children do not go unnoticed and untreated.

The Model Implementation Training includes brief training on functional vision screening, which satisfies the essential requirement for vision screening and is suitable for children from birth onwards. Additional practice will be necessary. Please see Appendix F for a list of Parents as Teachers approved vision screening tools for use with children 30 months of age and older.

Documentation of vision screening by a healthcare provider can be used as the vision screening portion of the complete screening. It is beneficial for the documentation to indicate the vision screening method that was used by the healthcare provider. The parent educator will need to request the documentation from the family or have written permission from the family to request documentation of vision screening from the healthcare provider. Once obtained, the parent educator reviews the documentation, and places it in the family's file.

Health

A primary goal of any early childhood program must be to support the healthy growth and development of all children. To this end, while parent educators do not perform medical screenings, they do gather and maintain information on each enrolled child's health status. This is done by completing a health record for each child using either the Parents as Teachers health record from the curriculum or a similar comprehensive health record. This information is updated each year to confirm that children are receiving necessary medical care and are current on their immunizations.

Development

Regular review of each child's developmental progress identifies strengths as well as potential areas of concern that may require referral for further assessment. Following the Foundational and Model Implementation trainings, additional training on how to use the specific developmental screening tool your affiliate selects will be necessary. Please see Appendix F for a list of Parents as Teachers approved developmental screening tools. If the developmental screening tool your affiliate chooses does not include social-emotional development (e.g., the Ages and Stages Questionnaire (ASQ), an additional tool focusing on

social-emotional development must also be used (e.g., ASQ: Social-Emotional).

Key considerations for screening:

- Screening should take place in an environment that is optimal for the child's performance
- Parents' observations of their child are an integral part of screening
- Parents need to be given verbal and written summaries of all screening results, including information about next stages of development and strategies to promote development
- When indicated by an earlier screening, re-screening should be done in accordance with the screening instrument's protocol
- Documentation of screening results (including those done by contractors) is maintained as part of the family record

For particular areas of concern identified through screening, parent educators make specific recommendations for follow-up activities to support the child's development and, if indicated, a referral for further assessment. When a recommendation is made for further assessment, parent educators support families in following through on the recommendation.

Typically, parent educators perform screenings during personal visits with families. As an alternative, an affiliate may have other trained personnel or agencies conduct the screenings. If your affiliate will contract out or outsource any screening services, you will need to develop a written agreement (e.g. a Memorandum of Understanding) that outlines the contracted services, including the instruments used and how results are communicated to both Parents as Teachers staff and to parents.

In addition to formal screening, the affiliate monitors and records children's achievement of developmental milestones, using the Parents as Teachers milestones form.

Resource Network

Each Parents as Teachers affiliate assists families in connecting to needed resources, strengthening protective factors and fostering positive change. The affiliate takes an active role in the community, establishing relationships with other institutions and organizations that serve families.

In every community, there is an array of programs designed to nurture and help families. Parents as Teachers is not intended to be the only service a family will need. However, Parents as Teachers' child development focused approach to family support makes it a valuable part of the community's network of human services programs. When these organizations, agencies, coalitions, government-supported programs, schools and faith based communities connect with each other, they provide a powerful network of support for families.

☆ **Parent educators connect families to resources that help them reach their goals and address their needs.**

Your affiliate needs to equip parent educators with knowledge about the various organizations and agencies in your community that families may need or want to access, maintaining key information in an up to date and comprehensive resource network directory. Parent educators should be familiar with community medical and dental health, mental health, education and social service organizations, as well as the names of individuals in those organizations who can assist families. Parent educators use this information to help families prepare to access a

community resource. In addition, parent educators record referrals, follow-up efforts and outcomes of referrals.

Parent educators' active collaboration with community resources complement and extend Parents as Teachers services. A parent educator's role is to help provide the bridge between families and needed resources, not merely to refer them to services. For example, parent educators explore with families emotional, physical and cultural barriers to accessing services and collaboratively problem-solve these barriers. In addition, with family permission, parent educators consult with other organizations serving the family in order to coordinate services and optimally support the family.

Many organizations offer multiple services to Parents as Teachers families. For example, in addition to the four component Parents as Teachers model, an organization might provide case management or family literacy services to all or a subset of their Parents as Teachers families. Further, as noted in the introduction, some organizations incorporate or blend Parents as Teachers with another early childhood home visitation model or family support program such as Early Head Start or Healthy Families America. Adding Parents as Teachers to existing services in your organization can greatly strengthen your impact on children and families.

Completing and transitioning out of Parents as Teachers services should be a planned process that includes connecting families to ongoing services and community resources that meet their interests and needs.

The Overall Picture

Now that we've talked about each component of the Parents as Teachers model, let's look at the overall picture of how a parent educator allocates his or her time.

Time allocation for personal visits	Approximately 1 hour for the delivery of each personal visit, along with another hour for visit planning and preparation, travel and documentation of the visit. If travel time is significantly greater, the number of visits the parent educator can complete monthly will decrease. In addition, if the parent educator is visiting a family with more than one enrolled child, visiting time will be approximately 75 minutes and the total number of visits the parent educator can complete monthly will decrease.
Time allocation for responsibilities related to effective and high quality early childhood home visitation services	Implementation of retention strategies, dedicated time for making up cancelled and missed visits, resource network facilitation and follow up, along with participation in supervision sessions and staff meetings.
Time allocation for group connections responsibilities	Parent educators in many affiliates plan and facilitate group connections. Therefore, time must be allocated for these responsibilities. If an affiliate dedicates parent educators' time to personal visits only and employs other staff that are responsible for planning and facilitating group connections, then a parent educator may be able to complete additional visits weekly.
Time allocation for recruitment activities	Affiliates that do not participate in a centralized intake system or have designated staff who focus on recruiting families for services must allocate time for parent educators' recruitment activities.
Time allocation for additional responsibilities	Parent educators in many Parents as Teachers affiliates have additional responsibilities related to their funding or sponsoring organization. For example, extensive data collection responsibilities.

Changed text

An addition

Evaluation and Continuous Quality Improvement

In order to demonstrate fidelity to the Parents as Teachers model and achieve outcomes for families, affiliates monitor the quality of their services and operations on an ongoing basis, regularly evaluate program implementation and outcomes, and engage in continuous quality improvement.

Supporting sentence moved from 1st paragraph

Quality Assurance

Each Parents as Teachers affiliate needs to maintain an efficient and comprehensive system of service documentation, data collection and reporting. Clear, organized and easily retrievable information is key to quality service delivery and best practices, as well as being essential to accountability. Data needed for annual reports, research, and tracking families' success toward accomplishing goals will be found in the documentation parent educators and supervisors maintain as part of their daily work.

What information is necessary to record?

- Enrollment information (and waiting list if applicable)
- Family agreement/consent to participate
- Family-centered assessment
- Goal setting and progress
- Information about service delivery, including personal visits, group connections, screenings and referrals/resource connections
- Child health information
- Contact History
- Exit/transition information

It is important to collect and record sufficient information for each of the above areas so that documentation presents a comprehensive picture of the family and the services being provided. In order to do this successfully, your affiliate will need written data collection procedures that include timelines to ensure the accurate and timely collection of information and documentation of services. See Appendix G for a table of the necessary data and information to record in each of the above areas.

Computerized recordkeeping is the preferred method for documentation of services and data tracking. With computerized recordkeeping, information is entered via the computer, rather than written on paper. Visit Tracker, www.visittrackerweb.com, is the Parents as Teachers approved web-based recordkeeping and service delivery tracking system (cost information provided in the budgeting tool.) Affiliates incorporating Parents as Teachers into existing services may have existing data management systems that will work effectively for their affiliate as well.

Affiliates using a computerized or web-based management information system (such as Visit Tracker) maintain the majority of this information in the management information system. However, there are often still several items maintained in the physical file. For example, consent to participate, permissions for release of information, correspondence with or information from other providers, certain assessment and screening protocols, goal worksheet/action plans, health record, and exit summary. Records should be maintained according to your organization's policy or for 3 years from the last date of service to the family- whichever is longer. It may be necessary to maintain longer than 3 years if subject to HIPAA, state law or other applicable federal or state statutes.

Parents as Teachers affiliates use the *Affiliate Quality Assurance Blueprint* to regularly monitor model fidelity and pursue continuous quality improvement. The blueprint describes necessary quality assurance activities, along with who completes the activities and at what frequency. It also functions as a tracking tool, helping the supervisor stay on top of implementation of the essential requirements. The quality assurance activities address: Supervision and professional development; Record review; Review of data on services for families and children.

The Parents as Teachers Documentation Review tool facilitates a comprehensive review of records as outlined in the Affiliate Quality Assurance Blueprint. Both the Affiliate Quality Assurance Blueprint and the Documentation Review tool are found in the online Quality Assurance Handbook (available only to Parents as Teachers affiliates) located in the Parents as Teachers portal.

Evaluation of Program Implementation and Outcomes

Affiliate Performance Report

☆ **The affiliate annually reports data on service delivery, program implementation, and compliance with the essential requirements through the Affiliate Performance Report; affiliates use data in an ongoing way for purposes of continuous quality improvement.**

Affiliates will annually report data to the national office on service delivery, program implementation, and compliance with the model replication requirements through the Affiliate Performance Report (APR), a web-based reporting system.[4]

This system is open for data entry beginning May 1 of each year. Timely reporting requires that the Affiliate Performance Report be completed by August 15. Therefore, we recommend (but do not require) that affiliates define a program year as July 1- June 30. Along with descriptive information about your program, the APR helps you look at your affiliate's implementation of the Parents as Teachers model during the program year.

In addition, APR data is used to produce a Performance Measures Report that helps you understand your affiliate's performance on the essential requirements, consider how your affiliate's performance compares with national minimum levels and informs your continuous quality improvement efforts.

[4] New affiliates with parent educators trained before May 1st must complete the Affiliate Performance Report that year.

Measuring Service Delivery: National Minimum Levels

Essential Requirements There are a total of 18 essential requirements. 6 of the essential requirements focused on service delivery have minimum, national levels. These essential requirements are listed below.	**National Minimum Levels** These define what it means to be sufficiently meeting these 6 essential requirements.
Parent educators complete and document a family-centered assessment within 90 days of enrollment and then at least annually thereafter.	At least 60% of newly enrolled families had an initial family-centered assessment completed within 90 days of enrollment.
	At least 60% of families that received at least 1 personal visit during the program year (excluding newly enrolled families) had an annually updated family-centered assessment.
Parent educators develop and document goals with each family they served.	At least 60% of the families that received at least 1 personal visit had at least 1 documented goal during the program year.
Parents as Teachers affiliates are designed so that families with 1 or fewer high needs characteristics receive at least monthly personal visits and families with 2 or more high needs characteristics receive at least twice-monthly personal visits.	At least 60% of families with 1 or fewer high needs receive at least 75% of the required number of visits
	At least 60% of families with 2 or more high needs receive at least 75% of the required number of visits
Affiliates deliver at least 12 group connections across the program year.	Your affiliate delivered at least 9 of the 12 required group connections during the program year.[5]
Screening takes place within 90 days of enrollment for children 4 months or older and then at least annually thereafter (infants enrolled prior to 4 months of age are screened prior to 7 months of age). A complete screening includes developmental screening using PAT approved screening tools, along with hearing and vision screening, and completion of a health record. Developmental domains that require screening include language, intellectual, social- emotional and motor development.	At least 60% of the children enrolled this program year at age 4 months or older had a complete initial screening within 90 days of enrollment.
	At least 60% of the of children enrolled prior to age 4 months and who reached 7 months of age before the end of the program year had a complete initial screening prior to 7 mos. of age.
	At least 60% of children received a complete annual screening (excluding newly enrolled children).
Parent educators connect families to resources that help them reach their goals and address their needs.	At least 60% of families that received at least 1 personal visit (excluding families enrolled less than 90 days) were connected by their parent educators to 2 or more community resources.

The general benchmark represented in these national minimums is 60%. It is important to highlight that this is a *minimum* benchmark and is in line with studies that have found positive

[5] The national minimum level for group connections is 75% rather than 60% as in the other national minimum levels.

results with implementation levels around 60 percent (Durlak & DuPre, 2008). This minimum level also acknowledges that flexibility in the measurement of this essential requirement is needed to give programs the ability to tailor the frequency of visits to meet families' individual needs and circumstances.

Family Feedback

☆ **At least annually, the affiliate gathers and summarizes feedback from families about the services they've received, using the results for program improvement.**

Within the Parents as Teachers Model Implementation Guide, we provide a parent satisfaction survey and group connections feedback form (the Parenting Satisfaction Survey also has an online data entry form). These tools can be used for obtaining feedback from families about their experiences with Parents as Teachers. However, affiliates may choose to use a different survey or group connection feedback form. Affiliates may also utilize focus groups or interview techniques for soliciting feedback from parents. Regardless of the approach, it is important for affiliates to use the information they gather from families for improving the services they deliver.

Affiliate Quality Assessment

The 2012 edition of the Parents as Teachers quality standards and an accompanying affiliate quality assessment (made up of a self-study and quality endorsement process) are being piloted through late spring 2013. Once the pilot concludes, the national office will make final revisions to the standards and the quality endorsement process. The national office will then release the standards so that affiliates can become familiar with them. We anticipate that affiliates will be able to begin the self-study and quality endorsement process in July 2013, although the process will not be required until after July 2014.

Outcomes Measurement

We strongly encourage you to plan for the measurement of outcomes for the children and families you serve. The specific outcome indicators that an affiliate chooses to track should be:

- Sensitive to identifying change in participants over time.
- Responsive to the needs of the funding sources.
- Consistent with the stated outcomes of the Parents as Teachers logic model.
- Minimally burdensome to participants.

An outcome evaluation assesses change in knowledge, attitudes, and/or behaviors of program participants resulting from Parents as Teachers services. For example, change can be measured through:

- Parent self-report of change in knowledge, attitudes, and behavior
- Observational parenting assessments of specific parenting behaviors
- Observational assessments of the quality of the home environment (e.g., reading to children, home safety, etc.)
- Parent report of child development and school readiness (may also include child report or teacher report of school readiness)

At this time the national office does not have a required outcome tool that affiliates must use, acknowledging that funding sources often dictate the specific measures used. Parents as Teachers national center provides the Parenting Reflection Survey that is made up of 9 items

intended to measure parents' beliefs about how their parenting knowledge and skills have changed as a result of Parents as Teachers. **Your grant or funder may also require particular outcome indicators to be tracked over time using administrative data, such as number of children with a medical home or number of hospitalizations or emergency room visits. In addition, results from parent satisfaction surveys and anecdotal examples of impact provide a rich picture of the impact of services on families. Overall, it is important that outcomes measurement choices are consistent with the Parents as Teachers logic model and any additional services that your organization provides.**

Program Affiliation and Support

Parents as Teachers national office, state leaders and regional hubs provide Parents as Teachers affiliates with support to help ensure program quality and outcomes for children and families. Program support is tailored to the different stages of affiliate implementation: Design, Initial Implementation and Quality Implementation.

Support and affiliation benefits include:

- Individualized start-up consultation
- Phone and email support for implementation, affiliate quality assessment and evaluation projects
- Learning communities
- Visit Tracker subscription
- Access to online quality tools and resources
- Recognition as an evidence-based model provider
- Access to funding available exclusively to evidence-based programs
- Special pricing on Knowledge Studio offerings and Parents as Teachers conference registration
- Discount programs, resources, awards, scholarships and special opportunities
- Use of Parents as Teachers name and logo
- Benefit from Parents as Teachers advocacy, fund raising, media relations and research

For the most current information regarding the fees associated with affiliation and renewal, go to http://www.parentsasteachers.org/training/training-gateway.

Appendix Table of Contents

Appendix A: Essential Requirements for Affiliates

The following are the essential requirements for an organization to become and remain a Parents as Teachers affiliate with approval to implement the Parents as Teachers model. Implementation and service delivery data that address the essential requirements are reported at the end of each program year on the Affiliate Performance Report (APR).[6] New affiliates' intentions to comply with these requirements are initially demonstrated through the Affiliate Plan.

Areas		Essential Requirements
Organizational Design	Infrastructure and Staffing	1. Affiliates provide at least two years of services to families with children between prenatal and kindergarten entry.
		2. The minimum qualifications for parent educators are a high school diploma or GED and two years' previous supervised work experience with young children and/or parents.
	Leadership and Administration	3. Each affiliate has an advisory committee that meets at least every 6 months.
		4. The affiliate follows the standard guidelines regarding copyright, trademark and logo use established by Parents as Teachers.
	Supervision	5. Each month, parent educators working more than .5 FTE participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings and parent educators working .5 FTE or less participate in a minimum of one hour of reflective supervision and two hours of staff meetings.
		6. Each supervisor, mentor or lead parent educator is assigned no more than 12 parent educators, regardless of whether the parent educators being supervised are full-time or part-time employees.
Training, Supervision and Professional Development	Training for New Parent Educators and Supervisors	7. All new parent educators in an organization who will deliver Parents as Teachers services to families attend the Foundational and Model Implementation Trainings before delivering Parents as Teachers; new supervisors attend the Model Implementation Training.[7]
	Competency-based Professional Development and Annual Recertification	8. Parent educators obtain competency-based professional development and renew certification with the national office annually.
Parents as Teachers Services	Assessment	9. Parent educators complete and document a family-centered assessment within 90 days of enrollment and then at least annually thereafter.
	Goal-setting	10. Parent educators develop and document goals with each family they serve.

[6] All affiliates in existence prior to 1/2011 must be providing services that comply with each essential requirement by July 1, 2014. Data submitted by affiliates to the national office on the 2014-2015 APR (and annually thereafter) will be utilized to measure performance.

[7] Organizations newly implementing the Parents as Teachers model must receive approval for their Affiliate Plan before registering staff for Foundational and Model Implementation Training. Parent educators certified prior to January 1, 2011, who are with an existing program must attend Foundational Training and a Model Implementation Retraining prior to July, 2014; supervisors who have been with an existing program must attend a Model implementation Retraining prior to July, 2014.

Areas		Essential Requirements
Parents as Teachers Services *continued*	Personal Visits *Personal visits are delivered by model certified parent educators and defined by their focus on 3 major areas of emphasis: parent-child interaction, development-centered parenting and family well-being.*	11. Parent educators use the foundational visit plans and planning guide from the curriculum to design and deliver personal visits to families.
		12. Families with 1 or fewer high needs characteristics receive at least 12 personal visits annually and families with 2 or more high needs characteristics receive at least 24 personal visits annually.
		13. Full time 1st year parent educators complete no more than 48 visits per month during their first year and full time parent educators in their 2nd year and beyond complete no more than 60 visits per month.
	Group Connections *Group connections are staffed by at least 1 model certified parent educator or supervisor and are focused across the program year on the 3 major areas of emphasis.*	14. Affiliates deliver at least 12 group connections across the program year.
	Screening	15. Screening takes place within 90 days of enrollment for children 4 months or older and then at least annually thereafter (infants enrolled prior to 4 months of age are screened prior to 7 months of age). A complete screening includes developmental screening using PAT approved screening tools, along with hearing and vision screening[8], and completion of a health record. Developmental domains that require screening include language, intellectual, social-emotional and motor development.
	Resource Network	16. Parent educators connect families to resources that help them reach their goals and address their needs.
Evaluation & Continuous Quality Improvement	Family Feedback	17. At least annually, the affiliate gathers and summarizes feedback from families about the services they've received, using the results for program improvement.
	Affiliate Performance Report	18. The affiliate annually reports data on service delivery and program implementation through the Affiliate Performance Report; affiliates use data in an ongoing way for purposes of continuous quality improvement.[9]

[8] If your affiliate is unable to use OAE or pure tone audiometry, parent report or documentation that the child's hearing has been checked by a healthcare provider within the last 12 months can be used as the hearing screening portion of the complete annual screening. For the initial screening, parent report or documentation that the child's hearing has been checked by a healthcare provider within the last 90 days can be used.

[9] Timely reporting requires that the Affiliate Performance Report be completed no later than August 15.

Appendix B: Readiness Reflection

Communities replicate the evidence-based Parents as Teachers model within an organizational context that has the staffing, capacity, and community relationships necessary for successful implementation and achievement of outcomes.

We are pleased that you are interested in implementing the Parents as Teachers model to address the needs of families in your community. The following questions are intended as reflection or discussion points to maximize the success of a new Parents as Teachers affiliate. It is not necessary to submit responses to the Parents as Teachers national office. Organizations should use the Readiness Reflection to assure that they are well positioned to develop the Parents as Teachers Affiliate Plan.

Since compliance with the Essential Requirements is necessary to become a Parents as Teachers Affiliate, please ensure that key decision makers review the Parents as Teachers Quality Assurance (QA) Guidelines. The QA Guidelines clearly lay out the expectations for replication of the Parents as Teachers model with an emphasis on meeting the Essential Requirements.

Community Context: Needs & Relationships	How have you determined a need for Parents as Teachers in your community?
	Are you aware of other similar services in your community? If so, how will Parents as Teachers complement and extend these services?
	If you are blending Parents as Teachers with another early childhood or family support model, how will you integrate the replication and data reporting requirements?
	What community relationships (groups, agencies, etc.) does your organization have presently? How do you collaborate with them?
	What community relationships do you plan to cultivate as you develop your Parents as Teachers affiliate? How might you utilize these relationships to help build your affiliate (e.g. advisory committee members, referral sources, resources for families)?
Organizational capacity	Does your organization have or are you putting in place the necessary capacity and systems for successful implementation of the Parents as Teachers model? For example: • Leadership: direct supervision of parent educators, administration, advisory committee, etc. • Resources allocated to technical assistance, quality and evaluation • Information technology • Financial planning and oversight • Mechanisms/strategies to promote sustainability
Staffing: Parent Educators & Supervisors	Thinking about the Essential Requirements and the communities you will be serving, are there specific skills, capabilities and qualities that your staff and supervisor(s) should have? Consider the following: • Appropriate educational background and work experience • Fit with the needs and characteristics of the populations to be served • Reflective supervision and administrative skills
	What assets are already in place in your organization and what resources might you bring in to strengthen the staffing component?

Next Steps

Once you have completed the Readiness Reflection and are ready to become a Parents as Teachers affiliate, the next step is to complete the Affiliate Plan (download at www.parentsasteachers.org located on the Training Gateway). The Affiliate Plan must be completed and approved by the national office or approved state office prior to registering staff for certification training. To become certified parent educators, staff must successfully complete both the Foundational and Model Implementation Trainings.

There is significant value in being affiliated with Parents as Teachers. As a Parents as Teachers affiliate, your organization becomes a partner with an evidence-based home visiting model with numerous studies demonstrating positive outcomes. A successful and sustainable program must clearly demonstrate its evidence and research base, as well as mechanisms for establishing and maintaining model fidelity. Parents as Teachers provides this foundation to your organization- and more.

If, after completing the Readiness Reflection and reviewing the Essential Requirements, your organization determines that it simply cannot meet the requirements for affiliation, the Approved User status is an option to consider. Your staff can be trained in the Parents as Teachers approach by registering for Foundational Training. This training lays the foundation for home visiting as a methodology within the early childhood system and connects the theoretical framework of Parents as Teachers with practice. Staff that complete this training become approved users of the Parents as Teachers Foundational Curriculum. For more information, go to the Training tab on the Parents as Teachers website.

Questions about becoming a Parents as Teachers Affiliate with certified parent educators?
Contact Jan Watson, Technical Assistance Manager at the national office,
Jan.Watson@ParentsasTeachers.org, ***or your Parents as Teachers state office.***

Parents as Teachers

Parents as Teachers Parent Educator Job Description

This is a multi-faceted and demanding position.

- Bachelor or four-year degree in early childhood or a related field is recommended. However, it is also acceptable for parent educators to have a two-year degree or 60 college hours in early childhood or a related field. Supervised experience working with young children and/or parents is also recommended. It is essential that the education and experience level for parent educators is at least a high school diploma or GED and a minimum of two years' previous supervised work experience with young children and/or parents.
- Be highly organized and accountable.
- Be an independent, self-motivated worker.
- Be able to learn and understand and incorporate the three roles of a parent educator: partnering, facilitating, and reflecting into daily practice with families.
- Be able to establish rapport with families and empower them by building on their strengths.
- Be competent with computer skills; including web browsing, e-mail, Internet, and word-processing.

Duties and Responsibilities of a Parent Educator

- Become knowledgeable about the Parents as Teachers model including the Essential Requirements necessary for model fidelity.
- Conduct personal visits (50-60 minutes) using the Parents as Teachers curriculum on a weekly or bi-weekly basis with each family.
- Plan the visit, gather materials, travel, conduct the visit, and clearly document the visit.
- Provide parent group connections focusing on a minimum of one of the following areas of emphasis: parent-child interaction, development-centered parenting, or family well-being.
- Complete developmental, health, vision and hearing screenings on each child every year.
- Develop and maintain a community resource network in order to be able to link families with them as needed.
- Maintain and submit in a timely way all required family and program documentation.
- Organize and inventory supplies/materials, etc.
- Meet at a minimum of twice monthly with supervisor for reflective supervision sessions.
- Help parents and children transition to other services as needed, to preschool, or to kindergarten.
- Complete annually required competency-based professional development hours in order to remain a certified Parents as Teachers parent educator (see Parents as Teachers Core Competencies for more details).

Appendix D: Family-Centered Assessment Tools

Family-Centered Assessment	Cost	Training	Assessment Strategy	Scoring Software Available	Psychometric Data Available	Spanish Version	Parenting	Family relationship & support systems	Education & vocation	Parents' general health	Access to medical care, including health insurance	Adequacy & stability of income for food, clothing, other	Adequacy and stability of housing
Life Skills Progression http://www.lifeskillsprogression.com/home/index	$44.95 for CD of the instrument & forms. Additional training costs apply.	1-day training strongly recommended	Observation & semi-structured interview with parent	X	X	X	X	X	X	X	X	X	X
Family Development Matrix http://www.factoc.org/dataevaluation/263-fdm.html	Free	Training support provided by a how-to guide	Observation & semi-structured interview with parent	X	–	X	X	X	X	X	–	X	X
Family Resource Scale http://www.wbpress.com/index.php?main_page=product_book_info&products_id=237	Book for training, $25 $10 per set of 10 scales.	Training support provided by book titled "Supporting and Strengthening Families: Methods, Strategies, and Practices".	Parent Self-Report Survey	–	X	X	–	X	No items on parent education	–	No items on health ins.	X	X
The Protective Factors Survey http://friendsnrc.org/protective-factors-survey	Free	Training support provided by a how-to guide	Parent Self-Report Survey	X	X	–	X	X	No items on parent vocation	–	–	No items on income stability	No items on housing adequacy
Massachusetts Family Self-Sufficiency Scales and LADDERS Assessment www.mass.gov/hed/docs/dhcd/cd/csbg/slguide.doc www.mass.gov/hed/docs/dhcd/cd/csbg/scales-ladders1.doc	Free	Training support provided by a how-to guide	Semi-structured interview with parent	–	–	–	X	X	X	X	X	X	X
Measure of Family Well-Being http://friendsnrc.org/component/joomdoc/doc_details/147-outcome-accountability-measure-of-family-well-being	Free	None required.	Parent self-report & observation	–	–	–	X	X	X	X	No items on access to health ins.	No items on income stability	No items on housing adequacy

Family-Centered Assessment	Cost	Training	Assessment Strategy	Scoring Software Available	Psychometric Data Available	Spanish Version	Parenting	Family relationship & support systems	Education & vocation	Parents' general health	Access to medical care, including health insurance	Adequacy & stability of income for food, clothing, other	Adequacy and stability of housing
Missouri Community Action Family Self-Sufficiency Scale http://www.roma1.org/web/module/tr/submit/true/interior.html?dstate=MO	Free	Interview Guide Available	Semi-structured interview with parent	–	–	–	–	–	X	X	No items on parent or child access to medical care	X	X
North Carolina Family Assessment Scale http://www.nfpn.org/assessment-tools.html	See website to request price quote.	Training package available; see website for details.	Observation & semi-structured interview with parent	X	X	X	X	X	X	X	–	X	X
The Kempe Family Stress Inventory (KFSI) http://friendsnrc.org/joomdocs/fsc.pdf	Free	Need specialized training if using supplemental rating criteria copyrighted by Health Families America.	Observation & semi-structured interview with parent.	–	X	–	X	X	–	–	–	X	X
Family Map http://familymedicine.uams.edu/FamilyMap/About	See website to request price quote.	Required: 1½ hr. online training followed by a 6-hr group training session led by a Family Map Trainer.	Semi-structured interview with parent	–	X	–	X	X	X	X	X	X	No items on housing adequacy
Family Assessment Form http://familyassessmentform.com/index.php	$14.95 for paper version; see website for cost of software app	Two half-day sessions for use of tool; additional 2 hours for use of software.	Observation & semi-structured interview with parent	X	X	X	X	X	No items on parent education	–	X	X	No items on housing stability

Appendix E: High Need Characteristics

2011-2012 High Need Characteristic[i]	Citations of Relevant Research[ii]
Teen Parent[iii] Definition: *Parent(s)under the age of 20 years during the program year*	Characteristic aligns with the HRSA MIECHV guideline that participants who are pregnant women who have not attained age 21 are given priority for receiving services. Ryan-Krause, P., Meadows-Oliver, M., Sadler, L. & Swartz, M.K. (2009). Developmental status of children of teen mothers: Contrasting objective assessments with maternal reports. *Journal of Pediatric Health Care, 23*(5), 303-309. Carothers, S. S., Borkowski, J. G. & Whitman, T. L. (2006). Children of adolescent mothers: exposure to negative life events and the role of social supports on their socioemotional adjustment. *Journal of Youth and Adolescence, Vol 35*(5), 827-837. http://www.childwelfare.gov/can/factors/parentcaregiver/teen.cfm
Child with disabilities or chronic health condition Definition: *Child being served has a physical, cognitive, emotional or health-related condition or impairment that substantially limits one or more major life activities or qualifies the child for services under IDEA Part C*	Definition Source: Americans with Disabilities Act http://www.eeoc.gov/policy/docs/902cm.html#902.1; IDEA Part C http://nichcy.org/laws/idea/partc/ Characteristic aligns with the HRSA MIECHV guidance that participants who have children with developmental delays or disabilities are given priority for receiving services. Treyvaud, K., Doyle, L.W., Lee, Katherine J.; Roberts, G.; Cheong, J.L.Y.; Inder, T.E. & Anderson, P. J. (2011). Family functioning, burden and parenting stress 2 years after very preterm birth. *Early Human Development, 87*(6), 427-431. http://www.childwelfare.gov/can/factors/child/#disabilities
Parent with disabilities or chronic health condition Definition: *Parent has a physical, cognitive or other health-related condition or impairment that substantially limits one or more major life activities*	Definition Source: Americans with Disabilities Act http://www.eeoc.gov/policy/docs/902cm.html#902.1 http://www.childwelfare.gov/can/factors/parentcaregiver/characteristics.cfm David, D.H., Styron, T. & Davidson, L. (2011). Supported parenting to meet the needs and concerns of mothers with severe mental illness. *American Journal of Psychiatric Rehabilitation, 14*(2), 137-153. Kelley, S. D. M., Sikka, A., Venkatesan, S. (1997). A review of research on parental disability: Implications for research and counseling practice. *Rehabilitation Counseling Bulletin, 41*(2), 105-121.
Parent with Mental Illness Definition: *Parent has been diagnosed with a thought, mood, or behavior disorder (or some combination) associated with distress and/or impaired functioning.*	Definition Source: http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html Harvey, E., Stoessel, B. & Herbert, S. (2011). Psychopathology and parenting practices of parents of preschool children with behavior problems. *Parenting: Science and Practice, 11*(4), 239-263. Mason, Z. S., Briggs, R. D. & Silver, E. J. (2011). Maternal attachment feelings mediate between maternal reports of depression, infant social–emotional development, and parenting stress. *Journal of Reproductive and Infant Psychology, 29*(4), 382-394.
Low educational attainment Definition: *Parent did not complete high school or GED and is not currently enrolled*	Johnson, W., Mcgue, M. & Iacono, W.G. (2007). How parents influence school grades: Hints from a sample of adoptive and biological families. *Learning and Individual Differences, 17*(3), 201-219. Carothers, S. S., Borkowski, J. G. & Whitman, T. L. (2006). Children of adolescent mothers: exposure to negative life events and the role of social supports on their socioemotional adjustment. *Journal of Youth and Adolescence, Vol 35*(5), 827-837. Hoff, E. & Tian, C. (2005). Socioeconomic status and cultural influences on language. Journal of Communication Disorders, 38(4), 271-278.
Low income Definition: *Families eligible for Free and Reduced Lunches, Public Housing, Child Care Subsidy, WIC, Food Stamps, TANF, Head Start/Early Head Start, and/or Medicaid*	Definition Source: Most public assistance programs use federal poverty guidelines (or a % of the guidelines) to establish low income level http://aspe.hhs.gov/poverty/12poverty.shtml Characteristic aligns with the HRSA MIECHV guidance that participants who have low incomes are given priority for receiving services. http://www.childwelfare.gov/can/factors/family/structure.cfm Najman, J. M., Hayatbakhsh, M. R., Heron, M. A., Bor, W., O'Callaghan, M. J. & Williams, G. M. (2009). The impact of episodic and chronic poverty on child cognitive development. *The Journal of Pediatrics, 154*(2), 284-289.

2011-2012 High Need Characteristic[1]	Citations of Relevant Research[2]
Recent immigrant or refugee family Definition: *One or both parents are foreign-born and entered the country within the past 5 years.*	Definition Source: 2010 United States Census *http://www.census.gov/prod/2011pubs/acsbr10-16.pdf* http://www.uscis.gov/portal/site/uscis http://www.irs.gov/businesses/small/international/article/0,,id=129236,00.html http://www.nccp.org/publications/pub_609.html#note1 Segal, U.A. & Mayadas, N.S. (2005). The Assessment of issues facing immigrant and refugee families. *Child Welfare: Journal of Policy, Practice, and Program, Vol 84*(5), 563-584. McNaughton, D.B., Cowell, J.M., Gross, D., Fogg, L. & Ailey, S.H. (2004). Relationship between maternal and child mental health in Mexican immigrant families. *Research and Theory for Nursing Practice: An International Journal,18*(2-3), 229-242.
Substance abuse Definition: *Parent has used or is currently using substances despite negative social, interpersonal, legal, medical or other consequences.*	Characteristic aligns with the HRSA MIECHV guidance that participants who have a history of substance abuse or needs substance abuse treatment are given priority for receiving services. Grant, T., Huggins, J., Graham, J. C., Ernst, C., Whitney, N. & Wilson, D. (2011). Definition Source: DSM-IV-TR; National Institute on Drug Abuse (NIDA) Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not. *Children and Youth Services Review, 33*(11), 2176-2185. http://www.childwelfare.gov/can/factors/parentcaregiver/substance.cfm
Court-appointed legal guardians and/or foster care Definition: *The child has a court-appointed legal guardians or is in foster care*	Definition Source: Code of Federal Regulations, 45CFR1355.20 Healey, C.V. & Fisher, P.A. (2011). Young children in foster care and the development of favorable outcomes. *Children and Youth Services Review, 33*(10), 1822-1830. Lloyd, E. C. & Barth, R.P. (2011). Developmental outcomes after five years for foster children returned home, remaining in care, or adopted. *Children and Youth Services Review, 33*, 1383-1391.
Homeless or unstable housing Definition: *Lives in emergency/transitional housing or in a place not intended for regular housing and/or moved more than twice in the past year due to problems with housing*	Definition Source: Institute for Children, Poverty & Homelessness http://www.icphusa.org/PDF/reports/ICPH_ProfilesofRisk_No.1.pdf www.familyhomelessness.org Howard, K.S. & Cartwright, S., Barajas, R. G. (2009). Examining the impact of parental risk on family functioning among homeless and housed families. *American Journal of Orthopsychiatry, 79*(3), 326-335. Gewirtz, A.H., DeGarmo, D.S., Plowman, E.J.; August, G. & Realmuto, G. (2009). Parenting, parental mental health, and child functioning in families residing in supportive housing. *American Journal of Orthopsychiatry, 79*(3), 336-347.
Incarcerated parent(s) Definition: *Parent(s) is incarcerated in federal or state prison or local jail or was released from incarceration with the past year*	Definition Source: http://bjs.ojp.usdoj.gov/index.cfm?ty=tdtp&tid=1 http://www.fcnetwork.org/reading/what_we_know_now.pdf http://aspe.hhs.gov/hsp/prison2home02/parke&stewart.pdf http://www.ncsl.org/documents/cyf/childrenofincarceratedparents.pdf Murray, J., Farrington, D.P. & Sekol, I. (2012). Children's antisocial behavior, mental health, drug use, and educational performance after parental incarceration: A systematic review and meta-analysis. *Psychological Bulletin*.
Very low birth weight Definition: *Birth weight is under 1500 grams or 3.3 lbs.*	Definition Source: U.S. Department of Health and Human Services, Health Resources Administration http://mchb.hrsa.gov/chusa11/hstat/hsi/pages/202vlbw.html http://www.marchofdimes.com/professionals/medicalresources_lowbirthweight.html http://www.childtrendsdatabank.org/?q=node/67 Ni, T.L., Huang, C.C. & Guo, N.W. (2011). Executive function deficit in preschool children born very low birth weight with normal early development. *Early Human Development, 87*(2), 137-141. Datar, A. & Jacknowitz, A. (2009). Birth weight effects on children's mental, motor, and physical development: Evidence from twins data. *Maternal and **Child** Health Journal, 13*, 780-794.

2011-2012 High Need Characteristic[I]	Citations of Relevant Research[II]
Death in the immediate family Definition: *The death of the child, parent or sibling*	Graham-Bermann, S.A., Howell, K., Habarth, J., Krishnan, S., Loree, A. & Bermann, E.A. (2008). Toward assessing traumatic events and stress symptoms in preschool children from low income families. *American Journal of Orthopsychiatry, Vol 78*(2), 220-228. Grover, R.L., Ginsburg, G. S. & Lalongo, N. (2005). Childhood predictors of anxiety symptoms: A longitudinal study. *Child Psychiatry and Human Development, Vol 36*(2),133-153.
Domestic violence Definition: *Parent is involved in intimate partner violence*	Definition Source: http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html http://www.childwelfare.gov/can/factors/family/domviolence.cfm
Child Abuse or Neglect Definition: *Suspected or substantiated abuse/neglect of child or sibling(s)*	Definition Source: http://www.childwelfare.gov/can/defining/federal.cfm Characteristic aligns with the HRSA MIECHV guidance that participants who have a history of child abuse or neglect or have had interactions with the child welfare system are given priority for receiving services. http://www.childwelfare.gov/can/factors/risk/
Military family Definition: *Parent/guardian is currently deployed or is within 2 years of returning from a deployment as an active duty member of the armed forces.* *"Deployment" is defined as any current or past event or activity that relates to duty in the armed forces that involves an operation, location, command or duty that is different from his/her normal duty assignment.*	Definition Source: http://www.pdhealth.mil/guidelines/annoC.asp Characteristic aligns with the HRSA MIECHV guidance that participants who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States are given priority for receiving services. Riggs, S.A. & Riggs, D.S. (2011). Risk and resilience in military families experiencing deployment: The role of the family attachment network. *Journal of **Family** Psychology, 25*(5), 675-687 http://www.childwelfare.gov/can/factors/family/structure.cfm

[I] Table created to provide clearer guidance and rationale for the high needs characteristics that sites will use to determine visit frequency.

[II] Research regarding the impact of co-occurring risk: http://www.childwelfare.gov/can/factors/risk/co_occurring_risk.cfm

[III] Note: "parent" can refer to any parent, step-parent or other adult caregiver who is a member of the same household as the child.

Appendix F: Approved Development, Hearing and Vision Screening Tools for Children

Approved Development Screening Tools for Children

(Also available on the Parents as Teachers website: Training Gateway page)

Instrument	Date	Age Range	Cost	Time (in minutes)	Publisher	Validity (concurrent and/or predictive)	Reliability (interrater and/or test-retest)	Sensitivity	Specificity	Standardized	Norm-Referenced	Scoring Software	Culturally Sensitive	Spanish	Training videos
Recommendation–Tier 1															
Ages and Stages Questionnaire-3 (ASQ-3)	2009	1 month to 5.5 years	$275	10 to 20	Brookes Publishing Co.	E	E	G	E	X	X	X	X	X	X
Batelle Developmental Inventory, Second Edition*	2004	birth - 8 years	$340	20 to 30	Riverside Publishing	P to E[2]	E[2]	G[2]	G[2]	X	X	X	X	X	X
Brigance Early Childhood Screens*	2005 2005	Infant-Toddler Early Preschool	see web site	10 to 15	Curriculum Associates	P to G[3]	E[3]	G[3]	G[3]	X	X	X	–	X	X
Developmental Indicators for the Assessment of Learning (DIAL-4)	2011	3 years to 5.11 years	$625	30	Pearson Assessments	P to G	E	E	E	X	X	X	X	X	X
Early Screening Inventory-Revised[1]	1997	ESI-R: 3 to 4.6 years ESI-K: 4 to 6 years	$139.50 each	15 to 20	Pearson Assessments	G	E	E	E	X	X	X	X	X	X
First STEP: Screening Test for Preschoolers[1]	1993	2.9 years to 6.2 years	$278	15	Pearson Assessments	P to E	E	G to E	G to E	X	X	–	–	X	X
Recommendation–Tier 2															
Developmental Observation Checklist (DOCS)*	1994	Birth to 6 years	$190	15 to 45	Pro-Ed	P to G	E	--	--	--	X	–	–	–	–
Learning Accomplishment Profile(LAP)-D Screens*	1997	3 years to 5 years	$349.95	15	Kaplan	P to E[4]	G to E	E	--	X	X	–	–	X	–
Parents' Observation of Infants and Toddlers (POINT)*	2006	2 months to 3 years	$212	15 to 20	Pearson	--	G to E	--	--	X	X	–	X	X	–

X = Present or Yes, -- = Unavailable or not reported

E = Excellent or >80%; G = Good or 70%-79%; F =Fair or 60%-69%; P = >60%

*Based on individual screening test manuals provided by the publishers, except where noted.

[1]Meisels, S.J. & Atkins-Burnett, S. (2005). Developmental Screeing in Early Childhood: A Guide. Washington, DC: NAEYC; Brassard, M.R. & Boehm, A.E. (2007). Preschool Assessment: Principles and Practices. NY: The Guilford Press.

[2]Based on Batelle Developmental Inventory, 1st Edition Examiner's Manual (1984); No Validity/Reliability index reported for BDI Screening which may be a concern, although BDI screening scores have high correlations with BDI scores.

[3]Based on Glascoe, F.P. (2002). Technical Report for the Brigance Screens; and Glascoe, F.P. et al. (1990) retrieved August 26, 2007 from a link on the Curriculum Associates website at http://www.casamples.com/downloads/BrigScreens-research.pdf

[4]Based on LAP-Diagnostic (not LAP-D Screen) concurrent validity result reported in Brassard, M.R. & Boehm, A.E. (2007).

Approved Social-Emotional Screening Tools

Instrument	Date	Age Range	Cost	Time in minutes	Publisher	Validity (concurrent and/or predictive)	Reliability (interrater and/or test-retest)	Sensitivity	Specificity	Stardardized	Norm-Referenced	Scoring Software	Culturally Sensitive	Spanish	Training Videos
Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)	2003	4 month - 5 years	$225	15	Brookes Publishing Co.	E	E	G	--	X	X	X	X	X	X
Devereux Early Childhood Assessment for Infants and Toddlers (DECA-IT) Devereux Early Childhood Assessment (DECA)	2006	1 - 36 months 2-5 years	$200	10	Kaplan Early Learning Co.	G	E	G	G	X	X	X	X	X	--
Brief Infant Toddler Social Emotional Assessment (BITSEA)	2006	12-35 months	$108	10	Pearson	G	E	E	G	X	X	X	x	X	--

X = Present or Yes; -- = Unavailable or not reported;

Approved Hearing and Screening Tools

For the most recent information on costs and training guidelines, please see the company's website.

Instrument	Type	Cost	Company
Hearing Screening Tools **Audiometry is not suitable for children below the age of 30 months. Hearing screening using otoacoustic emissions is required for meeting the essential requirement for hearing screening if you are serving children between the ages of birth and 36 months.**			
AuDX®	Otoacoustic emissions technology	$3,580	Bio-logic www.natus.com
Ero-Scan		$3,920	Maico Diagnostics www.maico-diagnostics.com
Otoread		$4,195	Interacoustics www.interacoustics--us.com
Echo-Screen		$3,656	Natus www.natus.com
Maico Pure Tone Screener	Audiometer *Adiometry is not suitable for children below the age of 30 months*	$900	Maico Diagnostics www.maico-diagnostics.com
Pilot audiometer		$2,195	Maico Diagnostics www.maico-diagnostics.com
Vision Screening Tools (for Children 30 months of age and older) **The Model Implementation Training includes training on functional vision screening, which satisfies the essential requirement for vision screening and is suitable for children from birth onwards.**			
Lea Symbols	Acuity charts	$36	School Health catalog www.schoolhealth.com
Wright Eye chart	Acuity charts	$35	AAP Bookstore www.aap.org

Optional

PediaVision® Assessment Solution [Includes camera device, laptop, printer, software]	Automated technology	$10,000+	PediaVision® http://www.pediavision.com/

Appendix G: Service Documentation and Data Collection ~ What to record

Area	Items within each area
Enrollment *Some of this information may be gathered through the family-centered assessment.*	• Initial contact(s) • Referral source • Enrollment date (defined as date of first completed visit) • Family contact information • Family demographic information, including ethnicity/race and languages spoken • Family characteristics, such as high need characteristics • Additional child info (DOB, pregnancy/birth info, medical conditions, healthcare provider, etc.) • Eligibility for services (e.g. family factors, geographic area, etc.) • Participation agreement
Contact History	• Completed visits and screenings, group connections attended • Appointments not completed (e.g. cancelled, by whom, no-shows, etc.)
Assessment	• Assessment type: instrument(s) used and initial assessment, annual assessment, etc. • Date of completion • Assessment results (refer to pg. 11 for a complete description of the areas that should be assessed)
Goal Setting	• Goals • Timeline (e.g. date established & target completion dates) • Action steps • Resources needed • Review of progress (with dates) • Date goals are achieved
Personal Visits *Personal visits are documented as soon as possible, but no more than 2 business days after the visit, using the Personal Visit Record (paper or electronic version).*	You must collect all the data elements captured on the personal visit record, which include: • Identifying information (e.g. participants) • Visit statistics (date, location, duration, check-in completed, etc.) • Assessment, screening, outcome measures, etc. conducted • Family strengths and protective factors focused on • Family well-being topics/Linkages to resources (e.g. information shared, referrals made) • Action steps toward goals • Developmental milestones • Parent-child interaction/activity • Development centered parenting topics • Parent educator next steps, comments, or reminders
Group Connections *Documentation occurs both before and after a group connection.*	• Date & time held • Areas of emphasis • Logistics (location, format, topics, etc.) • Materials and resources • Content & process (welcome, topics & activities, closing, etc.) • Attendance
Screening: Vision, Hearing and Development	• Child identifying information • Basic screening information (screening date, person doing screening, screening instrument) • Screening type: initial, re-screen, annual, etc. • Screening results • Screening recommendations & referrals for further assessment (including dates made) • Date follow up completed, if applicable • Results of referrals/recommendations for further assessment • Developmental milestones

Area	Items within each area
Child Health Information	• Health history (e.g. child's medical history, medications and check-ups) • Medical care and concerns • Safety precautions (e.g. car seat use) • General development • Sleep habits • Immunization history • Dental health
Resources and Referrals *Information provided to the family regarding community resources and referrals made to community resources.*	• Date • Made by • Type and name of resource • Permission to exchange information as applicable • Outcome (e.g. service received?)
Exit or transition information *To be completed within 30 days of program exit.*	*A summary report that typically pulls the following data together from multiple sources:* • Identifying information • Exit date & age • Reason for exit • Summary of contacts and services offered & received • Resource recommendations & referrals (including whether they were accessed, refused or outcome is unknown) • Screenings administered & results • Status of age-appropriate child development in each domain at time of exit • Status of immunizations • Outcomes and goals achieved • Transition plan

Appendix H: References

Center for the Study of Social Policy. (n.d.). *Strengthening Families ™ Initiative.* Retrieved Feb. 13, 2008, from www.cssp.org

Child Welfare Information Gateway, Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services (n.d.). Family-centered assessment. Retrieved Oct. 4, 2010, from www.childwelfare.gov/famcentered/casework/assessment.cfm.

Durlak, J. A., & Dupre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*, 327-350.

Family Strengthening PolicyEdwards, H. C. (2008). Volunteers in Leadership Roles: Successfully Engaging Advisory Councils. *International Journal of Volunteer Administration*, 25(2), 9-11. Retrieved Nov. 16, 2010, from www.ijova.org/PDF/IJOVA%20Sample%201%20Manuscript%20May%2014.pdf

Merrill Associates. (2003) *Developing Effective Advisory Committees*. Retrieved Nov. 16, 2010, from www.merrillassociates.com/topic/2003/02/developing-effective-advisory-committees

Parlakian, R. (Ed.). (2002). *Reflective supervision in practice: Stories from the field.* Washington, DC: ZERO TO THREE

Wollesen, L. & Peifer, K. (2006). *Life Skills Progression: An outcome and intervention planning instrument for use with families at risk*. Baltimore, MD: Paul H. Brookes.

Parents as Teachers

Affiliate Plan:
The Initial Step for Implementation of the Parents as Teachers Model

Parents as Teachers welcomes you to our family! The Affiliate Plan is the initial step in building a strong and consistent foundation for implementation of the Parents as Teachers model. It will help you determine appropriate staffing, budget, and program design in order to implement all of the Essential Requirements with fidelity and quality. The Affiliate Plan is closely connected to the Affiliate Performance Report (APR), the performance report submitted to the national office annually. The Affiliate Plan is structured as a logic model and links program inputs and activities to outputs and outcomes for families. Keeping in mind the impact you will have on families is important as you develop an Affiliate Plan focused on high quality implementation.

Guidance on Successfully Completing Your Affiliate Plan:

- **Carefully review the most up-to-date versions of the *Parents as Teachers Quality Assurance (QA) Guidelines* and the *Essential Requirements* located on the Parents as Teachers website. Use the instructions in Appendix A of this document to ensure that your affiliate plan is accurate, complete, and that your organization will meet the essential requirements.**

- **You may not register staff for training without a prior approved Affiliate Plan.** Once the plan has been approved and parent educators have successfully completed training, your organization will officially become a Parents as Teachers affiliate.

- Please do not use abbreviations or initials in the plan unless you define them first; if you check an "other" box, please provide additional specifics to the right.

- This version of the Affiliate Plan is editable and will allow for changes and updates during the approval process. **Please save a copy of the Affiliate Plan prior to submitting it.** If needed, the supervisor can make any appropriate changes and submit an updated version of the Affiliate Plan to the Parents as Teachers national office or appropriate State Office.

- If you have questions at any point, please contact Jan Watson at the Parents as Teachers national office or the contact at the appropriate State Office.

Section I. BACKGROUND INFORMATION

Organization/Affiliate Name:	**Date Completed (mm/dd/yyyy):**	***Office Use Only:***
Affiliate Administrator:	**Title:**	Plan approved by:
Supervisor Name (if different from above):	**Title:**	Date:
Organization Address: **City:** **State:** **County:** **Zip:**		Company ID: *(to be assigned by the national office)*
Telephone: ( ) - **ext.** **Fax:** ( ) - **Email:**		

Are you seeking new affiliation or are you an existing affiliate?

☐ New* ☐ Existing*

Are you submitting this plan as an Affiliate currently receiving or anticipating federal MIECHV (Maternal, Infant Early Childhood Home Visiting) funding?*

☐ Yes ☐ No

***Note**: If you are completing this plan because of receiving federal MIECHV funding, only mark "new" if your organization is not currently operating a PAT affiliate. If your organization is currently operating a PAT affiliate and MIECHV funds are being used to expand services, please mark "Existing".**

Who is the primary funder (receive 50% or more of funding) of your affiliate?

State Funding	**Local Funding**	**Federal Funding**
☐ State Dept of Education	☐ City or County Tax Initiative	☐ Head Start/Early Head Start
☐ State Dept of Social Services	☐ United Way	☐ Title I
☐ State Department of Health	☐ Local School District	☐ MIECHV (Maternal, Infant Early Childhood Home Visiting)
☐ Other:	☐ Other:	☐ Other:

What type of organization will house your Parents as Teachers affiliate?

☐ School System	☐ Private/Public Non-Profit	☐ Social Service Agency
☐ Family Resource Center	☐ Hospital or Medical Facility	☐ University/Extension
☐ Government Agency	☐ Health Department	☐ Early Intervention/Part C
☐ Child Care Center	☐ Tribal Government/BIE	☐ Other:
☐ Migrant Program	☐ Community Action Agency	

Will your Parents as Teachers services be incorporated within, or blended with, any of the following early childhood service delivery models?

☐ **No** ☐ **Yes (If yes, please check all that apply.)**

☐ Early Head Start ☐ Healthy Families America ☐ Other (please specify):

Training	Anticipated Location of Training (City, State):	Start date of Training (mm/dd/yyyy)	Number of staff who will attend (include supervisory staff):	Names of all staff attending the Training: (*If unknown at this time, the supervisor must complete the participant list by the beginning of the training week.)* NOTE: If you have more staff than will fit below, please include an additional page.
Foundational				
Model Implementation				

SECTION II. STAFFING, SUPERVISION AND LEADERSHIP

A. What are your affiliate's minimum educational requirements for parent educators? *(The minimum qualifications required for parent educators is at least a high school diploma or GED plus two years' previous supervised work experience with young children and/or parents is also required.)*

☐ High school diploma/GED PLUS at least two years of previous supervised work experience in early childhood
☐ Child Development Associate (CDA)
☐ Associate's Degree/60 college hours
☐ Bachelor's Degree/4-year degree
☐ Master's Degree
☐ Beyond Master's Degree
☐ Other Early Childhood Certificate or Credential (please specify): _____

B. How many total personal visits will each parent educator deliver to their families per month? *(not to exceed 48 for 1st year 1.0 FTE parent educators; not to exceed 60 visits/month for 2nd year and beyond 1.0 FTE parent educators)*
_____ # of visits/month completed by a 1st year Full Time (1.0 FTE) parent educator
_____ # of visits/month completed by a 1st year Part-time (.50 FTE) parent educator
_____ # of visits/month completed by a 2nd year (and beyond) FT parent educator

C. How many parent educators will be assigned to each supervisor/mentor/lead parent educator? (*Each supervisor, mentor or lead parent educator should be assigned to no more than 12 parent educators, regardless of whether the parent educators being supervised are full-time or part-time employees)* _____

D. Please indicate the number of hours of individual reflective supervision parent educators will receive monthly (*Each month, parent educators working more than .50 FTE participate in a minimum of two hours of individual reflective supervision and parent educators working .50 FTE or less participate in a minimum of one hour of reflective supervision*)?
1) Parent educators employed at greater than .50 FTE (more than 20 hrs/wk) will receive how many hours of supervision per month?_____
2) Parent educators employed at .50 FTE or less (20 hrs or less/wk) will receive how many hours of supervision per month? _____

E. How many hours will the affiliate devote to staff meetings per month? (*Each month, parent educators must participate in a minimum of two hours of staff meetings.)* _____

F. How frequently will the affiliate's Advisory Committee meet? (*The advisory committee must meet at least every 6 months)*
☐ Monthly ☐ Every 2 months ☐ Quarterly ☐ Every 6 months

SECTION III. PARENTS AS TEACHERS AFFILIATE PLAN

Important Note: Use the ***Quality Assurance Guidelines*** and instructions in Appendix A to guide your answers to the items in this section.

Inputs *Resources and contributions*	**Activities** *What will you do?*	**Projected Outputs** *How many?*	**Outcomes** *Expected measurable changes in the next 1 to 3 years?*

Inputs: *Resources and contributions*

A **Primary funding** *(provides 50% or more of the funds used to support your PAT services):*

	Type	**Funding Duration** *(2 years or more is recommended)*
1)	☐Federal ☐State ☐Local ☐Private ☐Other	☐1 year ☐2 years ☐3 or more **Renewable?** ☐Yes ☐No
Secondary funding (more than 15% of funds)		
2)	☐Federal ☐State ☐Local ☐Private ☐Other	☐less than 1 year ☐1 year ☐2 years ☐3 or more **Renewable?** ☐Yes ☐No
3)	☐Federal ☐State ☐Local ☐Private ☐Other	☐less than 1 year ☐1 year ☐2 years ☐3 or more **Renewable?** ☐Yes ☐No
4)	☐Federal ☐State ☐Local ☐Private ☐Other	☐less than 1 year ☐1 year ☐2 years ☐3 or more **Renewable?** ☐Yes ☐No
Additional comments:		Additional comments:

B **Parent educators**:

Total number of parent educators to be employed:

Total number of parent educator FTEs devoted to Parents as Teachers affiliate activities:

C **Service Duration** *(affiliates are designed to provide at least 2 years of services to families):*

Affiliates plan to provide:

☐24-35 months of service
☐36+ months of service
☐ Other:

D **Recruitment of Families to be Served**:

Which of the following child ages will your affiliate target the majority of its recruitment efforts? ***Note***: 2 years of service is optimal (check all that apply):

☐Prenatal
☐1 year
☐2 years
☐3 years
☐4 years
☐5 years

Which of the following high need charactersitics will your affiliate target when recruiting families ? (check all that apply):

☐Teen parent
☐Child with disabilities or chronic health condition
☐Parent with disabilities or chronic health condition
☐Parent with mental illness
☐Parent with low educational attainment
☐Low Income
☐Recent immigrant or refugee family
☐Substance abuse
☐Court-appointed legal guardians/foster care
☐Homeless or unstable housing
☐Incarcerated parent(s)
☐Very low birth weight
☐Death in immediate family
☐Domestic violence
☐Child abuse or neglect
☐Military family
☐Other:

Will your PAT affiliate target services to a high risk community or geographic area?

☐Yes ☐No

Additional comments about inputs and/or details about families or community being served:

Activities: *What will you do?*

E Retention and Engagement Strategies:

- ☐ Written visit reminders
- ☐ Email/text message visit reminders
- ☐ Phone or text message contact between visits
- ☐ Incentives for completed visits or group connection attendance
- ☐ Other:

F Family–Centered Assessment: (*required within 90 days of enrollment & updated at least annually*)

- ☐ Life Skills Progression
- ☐ Other:

Updated at least how often?

- ☐ Every 6 months
- ☐ Annually
- ☐ Other:

G Goal Setting: *(Parent educators develop and document goals with each family)*

Goals will be developed annually within which of the 3 areas of emphasis (check all that apply):

- ☐ Parent-child interaction
- ☐ Development-centered parenting
- ☐ Family-well being

How often will goals be updated?

- ☐ Quarterly
- ☐ Every 6 months
- ☐ Annually

H Group Connections:

Total # group connections offered per year *(at least 12 required)*:

I Personal Visits Frequency (*at least 12 annually is required for families with 1 or fewer high needs; at least 24 annually is required for families with 2 or more high needs*)

Total # of personal visits/yr. for families with 1 or fewer high needs:

Visit frequency: ☐ Weekly ☐ Twice Monthly ☐ Monthly

Total # of personal visits/yr. for families with 2 or more high needs:

Visit Frequency: ☐ Weekly ☐ Twice Monthly ☐ Monthly

J Screening: (*required within 90 days of enrollment for children 4 mo or older and then at least annually thereafter (infants enrolled prior to 4 mo are screened prior to 7 mo of age)*

Hearing

- ☐ By affiliate staff
- ☐ Documentation from healthcare provider
- ☐ Contracted out (provide agency name):

Frequency after initial screen:

- ☐ Annually
- ☐ More frequent than annual:

Method used (check all that apply):

- ☐ Otoacoustic Emissions (OAE) for children < 36 mo
- ☐ Audiometry (36 mo +)
- ☐ Other:

Vision

- ☐ By affiliate staff
- ☐ Documentation from healthcare provider
- ☐ Contracted out (provide agency name):

Frequency after initial screen:

- ☐ Annually
- ☐ More frequent than annual:

Method used:

- ☐ PAT Vision Screen plus which tool(s) for 30+ mos:
  - ☐ Acuity charts/cards
  - ☐ Other:

Health Record

- ☐ By affiliate staff
- ☐ Documentation from healthcare provider
- ☐ Contracted out (provide agency name):

Frequency after initial screen:

- ☐ Annually
- ☐ More frequent than annual:

Method used:

- ☐ PAT Health Record
- ☐ Other:

Developmental (must include language, intellectual, social-emotional and motor)

- ☐ By affiliate staff
- ☐ Documentation from healthcare provider
- ☐ Contracted out (provide agency name):

Frequency after initial screen:

- ☐ Annually
- ☐ More frequent than annual:

Screening Tool used:

- ☐ ASQ
- ☐ Other:

Social Emotional Tool used (Required):

- ☐ ASQ-SE
- ☐ Other:

K Resource Network:

List up to 5 community agencies you will partner with for additional services to families:

1.
2.
3.
4.
5.

How many MOAs are currently in place? :

L Evaluation and Continuous Quality Improvement:

For tracking and summarizing data for the PAT Affiliate Performance Report, what computerized data management system will you be using?

- ☐ Visit Tracker Web(PAT Recommended); if using Visit Tracker, will this be a new Subscription? ☐ Yes ☐ No
- ☐ Other computerized system (specify:)
- ☐ Will not use a computerized system.

How often will you gather and summarize feedback from families about the services they've received (*gathering and summarizing feedback for program improvement must occur at least annually)*?

☐ Annually ☐ More frequent than annual:

Projected Outputs: *How many?* ***To answer this section, make your best estimate at the current time. For some items, Parents as Teachers has established targets for outputs.***	**Outcomes: *Expected measurable changes in the next 1 to 3 years?*** ***To answer this section, make your best estimate at the current time. You may use the examples on p.10 as a guide. Please complete the checkboxes below and then provide more detailed outcomes if known at this time.***
M # families served in a 12 month period # children served in a 12 month period	What outcomes will your affiliate be tracking and summarizing? (check all that apply) **Short-Term Outcomes:** ☐ Increase in healthy pregnancies and birth outcomes ☐ Increase in parents' knowledge of their child's emerging development and age-appropriate child development ☐ Improved parenting capacity, parenting practices and parent-child relationships ☐ Early detection of developmental delays and health issues ☐ Improved family health and functioning **Intermediate Outcomes:** ☐ Improved child health and development ☐ Prevention of child abuse and neglect ☐ Increased school readiness ☐ Increased parent involvement in children's care and education ☐ Other (specify): ☐ None at this time.
N # of months affiliate will offer services to families % of families receiving services for at least 24 months	
O % families with a family-centered assessment documented within 90 days and updated annually* % families with at least 1 goal developed and documented during the program year* % of families that met 1 or more goals by the end of the program year	
P % families with 1 or fewer high needs characteristics receive at least 12 visits per year* % families with 2 or more high needs characteristics receive at least 24 visits per year* % families that receive more than 24 visits annually	
Q % of families attend at least one group connection/ year Total # of group connections offered in a year (12 minimum)*	
R % of children enrolled at age 4 mos or older screened in all areas within 90 days of enrollment (or by 7 months of age for infants enrolled prior to age 4 months) and annually thereafter.* % Hearing % Vision % Health % Developmental (includes social-emotional)	**How will you measure changes in the above outcomes? Please be specific about outcome tools and indicators that will be tracked and any targets already established** (see Appendix A Instructions, p. 10 for examples):
S % of families are connected to 2 or more community resources each year*	
T % of families that leave the affiliate annually (attrition) before the child ages out or the service cycle is completed (We recommend no more than 15%)	
U % families providing feedback about the services they've received.	
V Additional Outputs (please explain or attach):	☐ We have not yet determined how will specifically measure change

***Please refer to the *QA Guidelines*, page 21, for the minimum levels expected by the national office to be sufficiently meeting these service delivery essential requirements.**

SECTION IV. BUDGET WORKSHEET $_____ = Your affiliate's total annual funding for PAT services (include both direct funding and in-kind in this total)

Use the budget worksheet below to indicate how your affiliate will allocate funding and resources for each item by checking *Yes* and indicating if the allocation is direct funding or in kind. If your affiliate has not allocated funds or resources for a particular item, please check *No* and provide an explanation. An interactive, Excel budget template for planning the costs of implementing the PAT model can be found at **http://www.parentsasteachers.org/training/training-gateway.**

		Budget Items for Implementing the Parents as Teachers Model	Estimated Costs (Actual Costs May Vary)	Resources Allocated?*			Please explain any No answers
				Yes, Funded directly	Yes In kind	No	
Start Up (One time costs)	A	Parents as Teachers Initial training and curriculum costs[1] (Initial training costs do not include travel and lodging expenses, which may be needed for participation in training)	$1055 per parent educator for Foundational and Model Implementation Training, Curriculum	☐	☐	☐	
	B	Two-day Model Implementation training fee for supervisors	$300 per supervisor	☐	☐	☐	
	C	Books, toys, and non-consumable materials	$300 per parent educator	☐	☐	☐	
	D-1	Developmental screening expenses[2]	$275 (ASQ-3 cost; additional training costs may apply)	☐	☐	☐	
	D-2	Developmental screening expenses - Social/Emotional domain[2]	$225 (ASQ-SE cost; additional training costs may apply)	☐	☐	☐	
	E	Hearing screening expenses[2]	$3600-$4200 (OAE cost; additional training costs may apply)	☐	☐	☐	
	F	Family-centered assessment[2]	$45 (LSP cost; additional training costs may apply)	☐	☐	☐	
	G	Outcomes measurement tools (may be determined by funding requirements)	Costs will vary based on the outcome tools selected	☐	☐	☐	
Annual Recurring Costs	H	Parent educator salaries	$35,000/year + 30% benefits	☐	☐	☐	
	I	Supervisor salary (4 hours/weekly per parent educator)	$50,000/year + 30% benefits	☐	☐	☐	
	J	Support staff (2 hours per parent educator & supervisor)	$28,000 + 30% benefits	☐	☐	☐	
	K	Parent educator renewal fees[1]	**Renewal Fees do not apply in Year 1**. After Year 1, Renewal Fees are $150 per parent educator (capped at 12 model certified educators).	☐	☐	☐	
	L	Consumables and incentive costs (books for families, brochures, materials for parent-child activities, etc.)	$50 per family per year	☐	☐	☐	
	M	Group connections (e.g. materials, refreshments, guest speakers, etc.).	12 meetings per year, budgeted at $80 per meeting	☐	☐	☐	
	N	Annual professional development costs	$350 per parent educator and supervisor	☐	☐	☐	
	O	Supplies, copier, phone, fax, internet access/computer	$100/person/month	☐	☐	☐	
	P	Transportation costs for parent educators conducting personal visits and supervisor transportation for observation of staff and other work-related transportation	Estimate miles per visit with desired number of visits per month per family (for Supervisors use 50% of PE travel. Rural communities may need to budget more.	☐	☐	☐	
	Q	Affiliation Fee[1] -- For more information about the benefits and services associated with this fee, please refer to: http://www.parentsasteachers.org/images/stories/documents/ThisIsPAT_968_web.pdf.	$3,500 **for Year 1** ***After Year 1, the Affiliate Fee decreases to $1,500 per year***	☐	☐	☐	
	R	Indirect costs by your organization for human resource expenses, liability insurance, etc.	Optional: Refer to your organizational policies for guidance.	☐	☐	☐	(Optional)

[1] Please note that fees are subject to annual increases; the amounts for the costs listed on this worksheet are accurate as of 3/5/13.

[2] The specific developmental and hearing screening tools and the family centered assessment listed in this budget are examples of recommended (not required) tools. Please refer to the Quality Assurance Guidelines for more information about these and other recommended tools.

Parents as Teachers

SECTION V. TERMS OF AGREEMENT FOR AFFILIATES

As a condition of affiliation with Parents as Teachers, your organization agrees to implement all of the **Parents as Teachers Essential Requirements** which include those outlined in Sections II and III of your Affiliate Plan as well as the following:

1. **Attendance at required Foundational and Model Implementation Training prior to providing services to families.** New parent educators and supervisors will attend the Parents as Teachers Foundational and Model Implementation Trainings and successfully complete all requirements for certification before delivering the Parents as Teachers model.
   - Each parent educator is required to attend the Foundational and Model Implementation training. Supervisors must attend the Model Implementation training. Neither supervisors nor parent educators are allowed to train others in the Parents as Teachers model.
   - The supervisor reviews either the Affiliate Plan (if a new affiliate) or Affiliate Performance Report (if an existing affiliate) with each new parent educator before Trainings.

2. **Use of the foundational visit plans and planning guide from the curriculum to design and deliver personal visits to families.**

3. **Completion of the required number of competency-based professional development hours per year and annual recertification by parent educators**.
   - 1st year of certification: 20 clock hours of professional development required
   - 2nd year after certification: 15 clock hours of professional development required
   - 3rd year after certification and beyond: 10 clock hours of professional development required

4. **Adherence to standard guidelines regarding copyright, trademark and logo use established by Parents as Teachers.**

5. **Accurate completion and submission of the Affiliate Performance Report (APR) to the national office by the required date each year.** APR data focuses on service delivery and program implementation; affiliates use data in an ongoing way for purposes of continuous quality improvement.

☐ **I have read the above and agree to comply with the terms set forth.**

Printed name of person with signature authority in the organization

Date

Organization/Affiliate Name:

Appendix A. INSTRUCTIONS

Please try to **be as specific as possible when completing the inputs and activities**. This will help us understand your affiliate design and how you will serve families. Refer to the ***Quality Assurance Guidelines*** for detailed information about the essential requirements and other recommendations for designing a high quality Parents as Teachers affiliate. Specific page numbers to applicable sections of the *QA Guidelines* are provided for you in the table below.

Affiliate Plan Section	Instructions for Item Completion	QA Guideline Reference Page(s)
Inputs: Resources and contributions		
A. Funding Sources and Funding Duration	List primary and secondary funding sources from which you will receive funding and select the type for each funding source. Primary funding sources are those which supply **50% or more of the funds** to support your PAT services. Secondary funding sources represent **15% or more** of your funding. For each funding source, check "yes" or "no" to indicate whether it is renewable or not and check the applicable duration of the funding.	Page 3
B. Total Number of Parent Educators	Specify the total number of parent educators, including both full-time and part-time, that will be employed by your affiliate. Next, specify the total number of parent educator FTEs your affiliate will devote to Parents as Teachers. Note: FTE = Full Time Equivalent, e.g., 40 hours = 1 FTE; 30 hours = .75 FTE; 20 hours = .50 FTE, etc.	Page 4, 6-7, 14-15, 18-19 Appendix C
C. Service Duration	Indicate the total number of months of service your affiliate will provide to families.	Page 3
D. Recruitment of families to be served	Indicate the age(s) your affiliate will primarily focus its recruitment efforts (check all that apply), whether or not your affiliate will serve a high risk community or geographic area and family eligibility criteria.	Pages 2-3, 9-11
Activities: What will you do?		
E. Family Retention and Engagement Strategies	Once families are enrolled, parent educators must facilitate families' continued participation in services through a variety of strategies. Check the retention and engagement strategies that your affiliate will employ.	Pages 3, 11, 19
F. Family-Centered Assessment	Check or indicate which family-centered assessment tool your affiliate will be using and the frequency it will be updated after the initial assessment is completed.	Pages 11-13, Appendix D
G. Goal Setting	Indicate the number of goals families will develop each year and the frequency with which goals will be reviewed and updated.	Page 13
H. Group Connections	Indicate the total number of group connections that will be offered to families per year.	Page 15
I. Personal Visits	Indicate the total number of personal visits per year and the frequency they will be offered to families who have 1 or fewer high needs characteristics and to families with 2 or more high needs characteristics.	Page 13-15 Appendix E
J. Screenings	For each type of screening, check who will conduct them, the frequency that they will be completed, and the tools or methods that will be used.	Pages 16-18, Appendix F
K. Resource Network	List the top five community resources that families may be connected to, such as health, mental health, education, and social service organizations. Please do not use abbreviations for the organization or agencies. Next, indicate how many MOAs (Memorandum of Agreement) are currently in place between your affiliate and organizations that can provide resources/services to families in your community.	Page 18
L. Evaluation and Continuous Quality Improvement	Indicate which computerized record keeping and data management system your affiliate will be using. In addition, indicate the frequency with which your affiliate will gather and summarize feedback from families about the services they've received.	Pages 19-23, Appendix G

Affiliate Plan Section	Instructions for Item Completion	QA Guideline Reference Page(s)
Projected Outputs: How many?		
M. – V. Projected Outputs	**For each output listed, provide numbers and percentages that are your expected targets.** The outputs presented in blue font correspond to performance measures that have been established by the national office. Your affiliate will report service delivery data to the national office via the annual Affiliate Performance Report (APR) that will enable you to assess your affiliate's model implementation. As part of your continuous quality improvement process (CQI), you should establish targets for your expected outputs at the beginning of each program year and then use your APR data to evaluate your achievement of those targets. Please refer to the QA Guidelines, Page 21, for the minimum levels expected by the national office to be sufficiently meeting the essential requirements related to service delivery. APR data requirements should be carefully reviewed prior to beginning service delivery and yearly thereafter to ensure you are collecting the necessary data for reporting.	Pages 19-23, Appendix G

Outcomes: Expected measurable changes in the next 1 to 3 years?

We strongly encourage you to plan for the measurement of outcomes from the start. For the outcomes column, make your best estimate at the current time. Complete the top section by checking the appropriate boxes and then provide specific examples of how you will measure change in the outcomes. You can revise these as you more fully implement your affiliate. Below we provide some examples to guide you as you complete this section, but note that your outcomes should be directly linked to the Parents as Teachers logic model, your affiliate goals and activities, and your funder's requirements. You do not have to cover each area addressed by our examples. These measures will not be the basis of your plan's approval by the Parents as Teachers national office, but you should not leave this column blank.

Affiliates often set a goal of 75-80% of parents and children who will demonstrate positive change after receiving full service for one year or a certain number of personal visits and group connections. Your targets can vary based on the guidelines of the outcome measures you are using, the needs of families, and the intensity of services received. As a part of an evaluation plan, you will need to determine the intervals at which measures are administered, as well as the minimum time between administrations of measures. It is likely that you will be able to be increasingly specific about your outcome goals as you gain experience in implementing Parents as Teachers and become more familiar with the outcomes measure you are using.

REVIEW THESE EXAMPLES TO GUIDE YOU AS YOU ANSWER THE OUTCOMES SECTION OF THE AFFILIATE PLAN.

Families who participate in Parents as Teachers will show increases in protective factors (nurturing/attachment, family resiliency/functioning, social support, concrete support, knowledge of child development and parenting) as measured by the Protective Factors Survey. [See http://www.friendsnrc.org/protective-factors-survey]

Parents who participate in Parents as Teachers will show increases in positive parenting behaviors, as measured by an observational parenting assessment, such as the Keys to Interactive Parenting Scale. [See http://www.comfortconsults.com/kips.htm]

Children whose families participate in Parents as Teachers will show age appropriate developmental skills, as measured by the ASQ-3 [See http://www.agesandstages.com/order/index.html]

Parents as Teachers children who are identified through screening as in need of further evaluation will receive follow up assessments or interventions, and over time **the majority** of these will have their delays or health issues remediated.

Parents will show increased knowledge and skills in promoting their children's healthy development, as measured by the Parents as Teachers parent survey. [See the Model Implementation Guide]

As compared to non-participating children, children whose families participate in Parents as Teachers will show greater school readiness at school entry, based on school readiness assessments and/or as reported by kindergarten teachers.

ATTACHMENT L
AGES AND STAGES QUESTIONNAIRE INFORMATION

Brookes Publishing Co.
P.O. Box 10624
Baltimore, MD 21285-0624
1-800-638-3775; Fax:1-410-337-8539
http://www.brookespublishing.com/store/index.htm

ATTACHMENT M
REQUIRED TRAININGS

TRAINING OUTLINE PROGRAM/CORE (MODEL SPECIFIC)					
Training Delivery	**MIECHV/Children First (C1)**	**Training Delivery**	**MIECHV/Start Right/Healthy Families America (HFA)**	**Training Delivery**	**MIECHV - PAT**
	Year 1		**HFA Specific Training**		**Parents As Teachers Specific**
Online	Adoption	F2F	Integrated Strategies for Home Visitors (Formerly FSW Core Training)	F2FOOS	PAT - Foundational Training
F2F	Ages & Stages	F2F	Parent Survey (Formerly FAW Core Training)	F2FOOS	PAT - Model Implementation
F2F	Attachment	F2F	Advanced Supervisor Training		
F2F	Breastfeeding		**Within 6 months of Hire (Required)**		**Professional Development for Parent Educators – Year 1/ 20 Clock hours**
F2F	Car Seat Safety	Online	Orientation		Specific topics as listed in OSDH/FSPS Central Training
F2F	Case Management	Online	Infant Care		
F2F	Child Abuse Medical Examiner	Online	Child Health & Safety		
Online	Cultural Awareness	Online	Maternal & Family Heath		**Professional Development for Parent Educators – Year 2/ 15 Clock hours**
F2F	Domestic Violence	Online	Infant & Child Development		Specific topics as listed in OSDH/FSPS Central Training
F2F	Genetics-Special Screening	Online	Role of Culture in Parenting		
F2F	Grief	Online	Parent/Child Interaction		
Online	HIPAA		**Within 12 months of Hire (Required)**		
F2F	Keys to Care giving	Online	Child Abuse & Neglect		
F2F	New Employee Orientation	Online	Family Violence		
Online	NFP Unit 1	Online	Substance Abuse		
F2F	NFP Unit 2	Online	Staff Related Issues		**Professional Development for Parent Educators – Year 3 and beyond / 10 Clock hours**
Online	NFP Unit 3	Online	Family Issues		Specific topics as listed in OSDH/FSPS Central Training
F2F	OK-1 Training/C1 Overview/Maternal Health Assessment		**Ongoing Training-Parents As Teachers (PAT)**		**Ongoing Training-Parents As Teachers (PAT)**
F2FOOS	OK-2 Training/Infant and Toddler Assessment	F2FOOS	PAT - Foundational Training	F2FOOS	PAT - Three Years to Kindergarten Entry
F2F	OK-3 Training/Infancy/Toddler Period	F2FOOS	PAT - Three Years to Kindergarten Entry	F2FOOS	PAT - Partnering with Teen Parents
Online	Paternity/Legal	F2FOOS	PAT - Partnering with Teen Parents		
O/F2FOOS	PIPE		**Screening Training**		**Screening Training**
Online	SIDS	F2F	Ages and Stages Questionnaires Third Edition (ASQ)	F2F	Ages and Stages Questionnaires Third Edition (ASQ)
iPower	Addictive Behaviors	F2F	Ages and Stages Questionnaires :Social-Emotional (ASQ:SE)	F2F	Ages and Stages Questionnaires :Social-Emotional (ASQ:SE)
iPower	Substance Abuse		**Additional Training**		**Additional Training**

ATTACHMENT M
REQUIRED TRAININGS

Online	TANF/Medicaid	*Online/F2F	Strengthening Families	Online/F2F	Strengthening Families
	Year 2	• **Model Specific trainings for Children First are scheduled for 2013-2014 (these trainings are scheduled according to participant need)** • **Model Specific trainings for Start Right HFA can be accessed by staff at this time (2012 forward)** • **MIECHV HFA/PAT will begin Model Specific Training after contracts have been awarded and staff are hired by the MIECHV contractors** • **Trainings required to provide services are offered through the Model Specific Trainings provided by each program**			
F2F	Continuing Education (program specific)				
F2F	NCAST Feeding				
F2F	NCAST Teaching				
	Year 3				
	Continuing Education (program specific)				
	PIPE Review				
	NCAST Review (If applicable)				

ATTACHMENT M
REQUIRED TRAININGS

OSDH/FSPS CENTRAL TRAINING	
Training Delivery	**Central Training Topics**
Online, F2F or via iPower	Adoption
Online, F2F or via iPower	Ages & Stages
Online, F2F or via iPower	Attachment
Online, F2F or via iPower	Car Seat Safety
Online, F2F or via iPower	Case Management
Online, F2F or via iPower	Child Abuse Medical Examiner (CAME)
Online, F2F or via iPower	Diversity and Culture in Family systems
Online, F2F or via iPower	Domestic Violence
Online, F2F or via iPower	HIPAA
Online, F2F or via iPower	SIDS
Online, F2F or via iPower	TANF/Medicaid
Online, F2F or via iPower	Strengthening Families
Online, F2F or via iPower	*Motivational Interviewing
Online, F2F or via iPower	*Breastfeeding
Online, F2F or via iPower	*Family Planning
Online, F2F or via iPower	*Interconception/Pre-Conception
Online, F2F or via iPower	Mental Health (Maternal Depression, Grief)
Online, F2F or via iPower	Addictive Behaviors (Tobacco, Alcohol, Substance Abuse, ACE Study)
Online, F2F or via iPower	*Fatherhood
Online, F2F or via iPower	Infant Mental Health
Online, F2F or via iPower	Reflective Supervision
Online, F2F or via iPower	Safe Sleep/Co-Sleep

KEY:	
O	Online (includes trainings received on program specific sites, & OK-TRAIN)
iPower	Videoconferencing

ATTACHMENT M
REQUIRED TRAININGS

F2F	Face -to -Face
F2FOOS	Face -to-Face Out of State (refers to any training held outside of OK)
*	Start Right/MIECHV (HFA/PAT) Trainings not required by C1/ or provided in a different format for each discipline

ATTACHMENT N
STRENGTHENING FAMILIES
PROTECTIVE FACTORS INFORMATION

For information about the Center for the Study of Social Policy's Stengthening Families Protective Factors, go to: http://www.cssp.org/reform/strengthening-families/resources.

The Protective Factors Framework

Five Protective Factors are the foundation of the Strengthening Families Approach: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children. Research studies support the common-sense notion that when these Protective Factors are well established in a family, the likelihood of child abuse and neglect diminishes. Research shows that these protective factors are also "promotive" factors that build family strengths and a family environment that promotes optimal child and youth development.

1. Parental Resilience

No one can eliminate stress from parenting, but a parent's capacity for resilience can affect how a parent deals with stress. Resilience is the ability to manage and bounce back from all types of challenges that emerge in every family's life. It means finding ways to solve problems, building and sustaining trusting relationships including relationships with your own child, and knowing how to seek help when necessary.

2. Social Connections

Friends, family members, neighbors and community members provide emotional support, help solve problems, offer parenting advice and give concrete assistance to parents. Networks of support are essential to parents and also offer opportunities for people to "give back", an important part of self- esteem as well as a benefit for the community. Isolated families may need extra help in reaching out to build positive relationships.

3. Concrete Support in Times of Need

Meeting basic economic needs like food, shelter, clothing and health care is essential for families to thrive. Likewise, when families encounter a crisis such as domestic violence, mental illness or substance abuse, adequate services and supports need to be in place to provide stability, treatment and help for family members to get through the crisis.

4. Knowledge of Parenting and Child Development

Accurate information about child development and appropriate expectations for

children's behavior at every age help parents see their children and youth in a positive light and promote their healthy development. Information can come from many sources, including family members as well as parent education classes and surfing the internet. Studies show information is most effective when it comes at the precise time parents need it to understand their own children. Parents who experienced harsh discipline or other negative childhood experiences may need extra help to change the parenting patterns they learned as children.

5. Social and Emotional Competence of Children

A child or youth's ability to interact positively with others, self-regulate their behavior and effectively communicate their feelings has a positive impact on their relationships with their family, other adults, and peers. Challenging behaviors or delayed development create extra stress for families, so early identification and assistance for both parents and children can head off negative results and keep development on track.

OKLAHOMA STATE DEPARTMENT OF HEALTH
ADMINISTRATIVE PROCEDURES MANUAL

NUMBER: 1-17
TITLE: Reporting Child Abuse or Neglect
ADOPTED: April 1999
LAST REVIEWED: October 2011
RESPONSIBLE SERVICE: Administration

APPROVED: _____
Terry Cline, Ph.D.
Commissioner
Signature on File

I. Purpose

The purpose of this administrative procedure is to define the Oklahoma State Department of Health's (OSDH) process for reporting child abuse and/or neglect.

II. Reporting Child Abuse and/or Neglect

A. Process

As required by Title 10A of the Oklahoma Statutes, Section 1-2-101 should any OSDH employee have reason to believe that a child under the age of 18 years is a victim of abuse or neglect, as the terms are defined in Title 10A of the Oklahoma Statutes, Section 1-1-105, the following actions must be taken:

1. Utilizing the information gathered for the "Child Abuse Reporting Form," (Attachment A, ODH Form 333F) promptly contact the Oklahoma Department of Human Services Statewide Child Abuse Reporting Hotline at 1-800-522-3511.

    a. The definition of "promptly" may vary from incident to incident depending on the severity of the abuse and/or neglect and the age or vulnerability of the child. However, all reports must be made less than 24 clock hours from the time the employee had reason to believe that the child was a victim of abuse or neglect.

    b. If an employee has reason to believe that a child is in immediate physical danger, the employee must contact local law

enforcement in addition to making a report to the OKDHS Child Abuse Reporting Hotline.

2. Following the verbal report to the OKDHS Child Abuse Reporting Hotline, the employee should immediately complete the "Child Abuse Reporting Form," (Attachment A, ODH Form 333F) including as much information as possible. The documented information should objectively and accurately reflect the nature of the abuse and/or neglect without overstating or minimizing the incident(s).

3. The original completed "Child Abuse Reporting Form," (Attachment A, ODH Form 333F) should immediately be mailed to the OKDHS office where the child resides or where the injury occurred--whichever office seems most reasonable. The "One Week Follow-Up" Section of the "Child Abuse Reporting Form," (Attachment A, Form 333F) will be left incomplete.

4. One copy of the completed "Child Abuse Reporting Form," (Attachment A, ODH form 333F) should then be filed in the administrative section of the client child's medical record.

5. A progress note should be made stating only "ODH Form 333F completed." The progress note is to be filed in the client child's medical record in the relevant clinical service section. For example, if the child was seen in the WIC Clinic and reported by a WIC staff person, then the progress note would be filed in the WIC section of the client child's medical record.

6. If the child is not a health department client, a medical record should be opened for that child and the "Child Abuse Reporting Form," (Attachment A, ODH Form 333F) should be filed in the administrative section of that medical record.

7. A progress note should be made stating only "(Attachment A, ODH Form 333F) completed." The progress note is to be filed in the medical record in a clinical service section.

8. A separate file should be established in each county health department to contain "Child Abuse Reporting Forms," (Attachment A, ODH Form 333F) related to child abuse reports made on behalf of children whose names are not known.

9. Approximately one week after the report was made; the "One Week Follow-Up" section of the "Child Abuse Reporting Form," (Attachment A, ODH Form 333F) should be completed. The form should be returned to its appropriate place in the child client's medical record AND a copy of the completed form should be sent to:

The Oklahoma State Department of Health
The Family Support & Prevention Service
1000 Northeast Tenth Street, 7th Floor
Oklahoma City, Oklahoma 73117-1299

Please state "CONFIDENTIAL" on the outside of the envelope.

10. The person making the report is responsible for informing the immediate supervisor, and/or district supervisor, who will, in turn, advise the local county health department administrator. This notification procedure is not a substitute for making a report. According to state law, reporting is an individual responsibility and the person who suspects abuse is the person who must make the report. The legal responsibility for reporting is not satisfied by merely reporting the suspicion to a supervisor.

III. Statutory Definitions

A. Abuse

"Abuse" means harm or threatened harm or failure to protect from harm or threatened harm to the health, safety, or welfare of a child by a person responsible for the child's health, safety or welfare, including but not limited to nonaccidental physical or mental injury, sexual abuse, or sexual exploitation. Provided, however, that nothing contained in this act shall prohibit any parent from using ordinary force as a means of discipline including, but not limited to, spanking, switching, or paddling.

1. "Harm or threatened harm to the health or safety of a child" means any real or threatened physical, mental or emotional injury or damage to the body or mind that is not accidental including but not limited to sexual abuse, sexual exploitation, neglect or dependency.

2. "Sexual abuse" includes but is not limited to rape, incest, and lewd or indecent acts or proposals to a child, as defined by law, by a person responsible for the health, safety, or welfare of a child.

3. "Sexual exploitation" includes but is not limited to allowing, permitting, or encouraging a child to engage in prostitution, as defined by law, by a person responsible for the health, safety, or welfare of a child, or allowing, permitted, encouraging, or engaging in the lewd, obscene, or pornographic, as defined by law, photographing, filming, or depicting of a child in those acts by a person responsible for the health, safety, and welfare of the child.

B. Neglect

"Neglect" means:

1. The failure to provide any of the following:

   a. Adequate nurturance and affection, food, clothing, shelter, sanitation, hygiene, or appropriate education,

   b. Medical, dental, or behavioral health care,

   c. Supervision or appropriate caretakers, or

   d. Special care made necessary by the physical or mental condition of the child,

2. The failure to protect a child from exposure to any of the following:

   a. The use, possession, sale, or manufacture of illegal drugs,

   b. Illegal activities, or

   c. Sexual acts or materials that are not age-appropriate, or

3. Abandonment.

IV. References

Title 10A O.S. § 1-1-105
Title 10A O.S. § 1-2-101

V. Action

The Deputy Commissioner for Community and Family Health Services is responsible for ensuring the annual review of this administrative procedure.

Family Support & Prevention Services is responsible for the annual review and revision of this administrative procedure.

Any exceptions to this administrative procedure require prior written approval of the Commissioner.

The procedure is effective immediately as indicated.

VI. Attachments

Attachments	Title	Location
Attachment A	Child Abuse Reporting Form (ODH Form 333F)	Attached

Tvcn jucz Fn bjm | QsjouQpsn

OKLAHOMA STATE DEPARTMENT OF HEALTH
SUSPECTED CHILD ABUSE/NEGLECT REPORT FORM

I understand that the Oklahoma State Department of Health policy requires me, as a mandated reporter, to promptly contact the Oklahoma Department of Human Services or call the statewide 24-hour hotline number (1-800-522-3511) to make a report of suspected child abuse and/or neglect in good faith and in accordance with the law of the state of Oklahoma. I understand that this form (333-F) does not replace a call to OKDHS, but is to be used to document adherence to policy, to be sent to OKDHS for hardcopy documentation, and to provide quality assurance.

This written report documents an oral report made to OKDHS on (Date)___/___/___, (Time)___:___ ☐am ☐pm
to (Person accepting the report)_____ Referral #_____.

IF THIS SITUATION POSES IMMINENT DANGER, WAS LAW ENFORCEMENT CALLED? ☐ Yes ☐ No
WAS THIS REPORT MADE ANONYMOUSLY? ☐ Yes ☐ No

Reporter Information

Reporter's Name:_____ Position/Title:_____

Phone number: ___-___-___ Fax number: ___-___-___ County: _____

E-mail address? _____

At which health department or contract agency do you work (also specify city)? _____

At the time of this incident, for which program or clinic were you working?

☐ Children First ☐ Early Intervention ☐ Immunization clinic ☐ Start Right/OCAP ☐ Well-child clinic

☐ Child Guidance ☐ Family Planning ☐ Maternity Clinic ☐ STD clinic ☐ WIC

☐ Administrative staff, multiple programs/clinics ☐ Other:

Child Information

Name: _____ DOB/Age: _____ Race/Ethnicity: _____ Gender: ___

Is this child physically or developmentally disabled? ☐ Yes ☐ No IF YES → Please describe: _____

Address or location of child at the time of the report? _____

Family/Caretaker Information

List each person's name and relationship to child (if known):	Age	Race/Ethnicity	Gender	Disabled? Explain:
1. Parent/Caretaker:			☐	
2. Parent/Caretaker:			☐	
3. Sibling/Other:			☐	
4. Sibling/Other:			☐	
5. Sibling/Other:			☐	

What is the primary language spoken in the home? ☐ English ☐ Spanish ☐ Other (specify):_____

Home Address: _____ Telephone: ___-___-___

_____ Alternative phone: ___-___-___

Finding Directions: _____

Out of Home Care

Is the child in out-of-home care? Check type:

☐ Unknown/Not Applicable ☐ OKDHS custody ☐ Foster family home ☐ Relative's home

☐ Childcare center or school ☐ Family friend ☐ Group home or institution ☐ Other:_____

Address: _____ Telephone: ___-___-___

_____ Alternative phone: ___-___-___

Who are the person(s) responsible for the child at this location? _____

Name of school or childcare/daycare center: _____

Incident Information

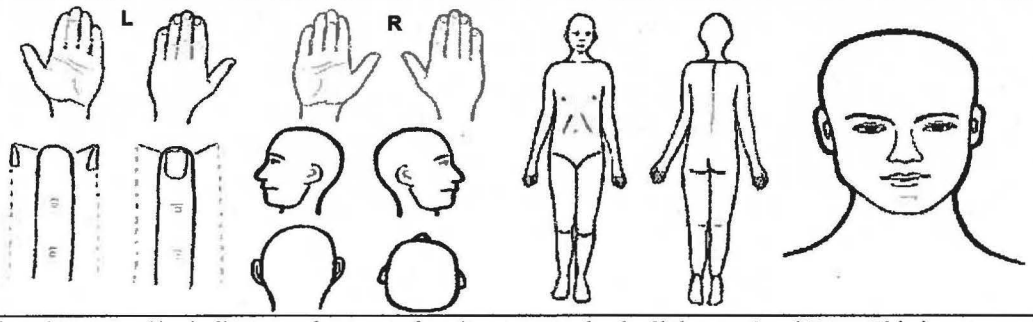
Please classify the type(s) of suspected maltreatment you are reporting (check all that apply):

☐ Physical abuse ☐ Sexual abuse ☐ Emotional or psychological abuse ☐ Neglect

Is domestic or intimate partner violence in the home? ☐ Yes:_____ ☐ No ☐Unknown
Is alcohol or a controlled dangerous substance involved? ☐ Yes:_____ ☐ No ☐Unknown
Are there dangers in the home (i.e. dogs, weapons, meth lab, etc.)? ☐ Yes:_____ ☐ No ☐Unknown

Incident Information, continued

Please describe the nature and extent of the child's injuries, neglect or endangered condition (indicate sites on body map):



Alleged types and/or indicators of suspected maltreatment; check all that apply. (Note: This is not an exhaustive list)

☐ Abrasions/laceration	☐ Exposure to domestic violence	☐ Inadequate clothing	☐ Substance abuse by caretaker
☐ Age-inappropriate sexual behavior	☐ Failure to obtain medical attention	☐ Inadequate or dangerous shelter	☐ Threat of harm
☐ Bite marks	☐ Failure to protect	☐ Inadequate physical care	☐ Vaginal penetration/intercourse
☐ Bone fracture (not skull)	☐ Failure to provide adequate nutrition	☐ Lack of supervision	☐ Wounds/cuts/punctures
☐ Bruises/welts	☐ Failure to thrive	☐ Mental trauma	☐ Other:_____
☐ Burns/scalds	☐ Fondling	☐ Pornography	☐ Other:_____
☐ Exposure to adult sexuality	☐ Head trauma	☐ Skull fracture	☐ Other:_____

Identify any child or adult who gave an explanation of the child's injury/condition and the date; What did the child or adult say happened?

How do you know this child? How long have you known him/her? When did you last see the child, and what was his/her condition? Does the child have any injuries now?

When did the incident occur (time, date, location)? Did you witness the incident?

Other pertinent information, including the name and address of others who may be willing to provide information about this case:

One Week Follow-Up

DHS Caseworker:_____ Phone number: ____-____-____ County:_____

Was this report: ☐ Accepted ☐ Screened out ☐ Don't know

Was this report assigned for: ☐ Investigation ☐Assessment ☐ No ☐ Don't know

What priority was assigned by DHS (if known)? ☐ Priority 1 (urgent) ☐ Priority 2

Notes: _____

_____

Have you had any problems or concerns interfacing with the local OKDHS / child welfare agency in making this report?

☐ Yes ☐ No → If YES please describe: _____

Reporter's Signature: _____ **Today's date:** ____/____/____

Instructions
ODH Form 333F
Suspected Child Abuse/Neglect Report Form

Purpose:
To comply with OSDH Policy and Procedure regarding mandated reported of suspected child abuse and/or neglect (child maltreatment)

NOT ALL INFORMATION MAY BE KNOWN. PLEASE INCLUDE AS MUCH INFORMATION AS POSSIBLE.

REFERRAL INFORMATION:

Date: Enter the date the oral report was made in (mm/dd/yyyy) format
Time: Enter the time the call was made to the DHS office.
TO: Enter the name of the person at DHS who accepted the report.
Referral Number: Ask for a referral number for this report and enter the number in the space provided **(this is a critical piece of information for follow-up).**
Imminent Danger: Indicate by checking yes or no if the child is in imminent danger based on your assessment.
Anonymous Report: Indicate by checking yes or no if the reporter made this report to OKDHS anonymously (did not give his/her name). **If the report was made anonymously, the reporter will not be able to obtain the follow-up information.**

REPORTER INFORMATION:

Reporter's Name: Enter the name of the person making the report.
Position/Title: Enter the name of title of the person making the report.
Phone/Fax Number: Enter the phone number and fax number of the person making the report.
County: Enter the name of the County in which the person making the report resides.
E-mail address: Enter the e-mail address of the person making the report if applicable.
County Health Department: Enter the name of the County Health Department or contract agency where the person who made the report is employed and the name of the city in which he/she works.
Program: Indicate which clinic the person making the report was working at the time of the incident.

CHILD VICTIM INFORMATION:

Name: Enter the name of the child to whom the suspected maltreatment
DOB/Age: Enter the DOB of the child if known, or if the DOB is not known, enter the age (or approximate age if not known) of the child. If approximating, please write an "A" after the age.
Race/Ethnicity: Enter the race of the child if known
Gender: Enter the gender of the child
Developmental Disability: Check the box to indicate if the child is disabled. If the child has a disability, specify the type of disability if known or describe the disability.

FAMILY/CARETAKER INFORMATION:

Parent/Caretaker: Enter the name of the parent or caretaker for this child and their relationship to the child. Enter the age, race and gender for each caretaker. If the caretaker is disabled in any way, explain the disability in the space provided.

Sibling; Enter the name (this includes step brother/s and step sister/s), age, race, and gender of each sibling. If the sibling is disabled in any way, explain the disability in the space provided.
Primary Language: Indicate the primary language spoken in the home, if the primary language is not English or Spanish, check other and enter the primary language in the space provided.
Home Address: Enter the mailing address where the child resides.
Telephone: Enter the phone number including area code where the caretaker can be reached.
Finding Directions: Enter the specific finding directions to the caretaker's residence. Be specific.
Alternative Phone Number: Enter another phone number where the caretaker can be reached.

OUT OF HOME CARE

Out of Home Care Type: Indicate the type of "out of home care" by checking the appropriate box. If the type of care is not listed, check other and specify the type of care in the space provided.
Home Address: Enter the "out of home care" facility mailing address.
Telephone: Enter the "out of home care" facility phone number including area code.
Finding Directions: Enter the "out of home care" facility finding directions.
Alternative Phone Number: Enter an alternate number for the "out of home care" facility if available.
Name of school or childcare/daycare center: Enter the name of the daycare center or childcare center the child/ren attend.

INCIDENT INFORMATION

NOTE: If Additional space is needed, document on plain paper or on a progress note and attach to 333F.

Types of maltreatment: Indicate the type of maltreatment by checking the appropriate box for each type of maltreatment that applies.
Domestic or Intimate Partner Violence: If domestic violence or intimate partner violence is occurring in the home check yes and specify the type of violence (ex. throwing items, threatened with weapon, use of weapon in domestic dispute)
Alcohol or controlled substance: If alcohol or controlled substances were present regarding this incident, check yes. In the space provided specify any significant information regarding the use of these items.
Danger to a worker: If there are circumstances that may put a caseworker at risk for harm when providing a home visit check yes. In the space provided specify the type of potential danger (i.e. dogs, weapons, potential meth lab)
Describe the nature of incident: In the space provided give detailed information to explain what you saw, heard, and smelled, etc. and indicate on the body map any injuries noted.
Alleged types of abuse: Check the appropriate box/es to indicate the type/s of suspected maltreatment. If there are any types of maltreatment not listed check other and specify in the space provided the specific type of maltreatment.
Explanation by any child or adult: In the space provided, document the child or adult's explanation of the incident and specify who gave the information. If the child has any injuries now, explain this also.

Incident time: In the space provided document the time (use military time or be sure to indicate am or pm), if the specific time is not known indicate if the incident occurred in the am or pm. Document the date (mm/dd/yyyy) the incident occurred if known. Document the location in which the incident took place (ex. child's home, _____ Park, maternal grandmother's home).
Other Information: Document any other pertinent information not yet specified.

ONE-WEEK FOLLOW-UP

DHS Caseworker: Enter the name of the caseworker assigned to this case:
Phone Number: Enter the phone number where the caseworker can be reached.
County: Enter the name of the county where the caseworker is headquartered.
Report: Indicate the status of the report as accepted, screened out, or don't know
Assigned: If the report was accepted, indicate what occurred by checking the appropriate box.
Priority: Check the appropriate box to indicate if a priority was assigned to this report.
Notes: document any significant information obtained in the space provided.
Difficulties with OKDHS: Check yes if there were any problems interfacing with DHS regarding this case. In the space provided specify the type of problem.
Reporter's Signature: Sign your name and title in the space provided.
Today's date: Enter the date (mm/dd/yyyy) the report was made to OKDHS.

ATTACHMENT P
MINIMUM SERVICE NUMBERS

Formula:
- **Number of families x 46 weeks of service x 75% completion rate**
- **i.e.: 15 families x 46 weeks x .75 = 518 home visits per year**
- **Contractors are not limited to these minimums**

Proposed Funding Amount	Proposed Minimum Number of Families to Receive a Home Visit Per Week/Year	Proposed Number of Completed Home Visits Per Fiscal Year
$150,000	15/40	518
$175,000	18/46	621
$200,000	20/53	690
$225,000	23/60	794
$250,000	25/66	863
$275,000	28/73	966
$300,000	30/80	1,035
$325,000	33/86	1,139
$350,000	35/93	1,208
$375,000	38/100	1,311
$400,000	40/106	1,380
$425,000	43/113	1,484
$450,000	45/120	1,553
$475,000	48/126	1,656
$500,000	50/133	1,725

ATTACHMENT Q
SAMPLE

OKLAHOMA STATE DEPARTMENT OF HEALTH
COMMUNITY AND FAMILY HEALTH SERVICES
FAMILY SUPPORT AND PREVENTION SERVICE
MIECHV PROGRAM
PROPOSED SUMMARY BUDGET

Bidder Name: _____ Date: _____
Bidder Contact:_____ Phone: _____

Bidder Address: _____

Requested Dollar Amount: $_____

Summary Budget Request:

Budget Line Item	Amount Requested OSDH		TOTAL
Personnel/Salaries			
Fringe Benefits			
Travel/Training			
Supplies			
Contractual			
Admin Costs/IDC			
Other			
Total			

SOLICITATION REQUEST

☐ Request for Quote ☐ Request for Proposal ☐ Request for Bid **Dispatch via Print**

Request Quote ID.	Date	Buyer	Page
3400001190	05/01/2013	Kathy Hallum (580)	1
Payment Terms	**DateTime Quote Open**	**Closing**	
0 Days	05/05/2013 11:57 AM	10/01/2013 03:00 PM	

Requisition Number Reference: From Req ID - 3400015959

Department of Health

OKLAHOMA STATE DEPT OF HEALTH
SHIPPING & RECEIVING
1000 NE 10TH ST
OKLAHOMA CITY OK 731171299

Ship To: OKLAHOMA STATE DEPT OF HEALTH
ACCOUNTS PAYABLE
1000 NE 10TH ST
OKLAHOMA CITY OK 731171299

Vendor: NAME
Address:_____
Address:_____
City:_____ST:____ ZIP:_____

Bill To: OKLAHOMA STATE DEPT OF HEALTH
ACCOUNTS PAYABLE
1000 NE 10TH ST
OKLAHOMA CITY OK 731171299

Supplier Responses

Line	Cat CD / Item # - Descr		Qty.	UOM	Unit Cost	Ext. Cost
1	85101508 /	MIECHV Parents as Teachers (PAT) Home Visitation Services	1	EA	_____	_____

The purpose of this Request for Proposal (RFP) is to solicit bid proposals regarding the implementation of home visitation services using the Parents as Teachers model in Muskogee County in an effort to expand the continuum of home visitation services within the county.

This contract shall begin on Date of Award and terminate on September 29, 2013 with the option to renew for two (2) additional one-year periods. Renewal shall be contingent upon the needs of the OSDH, the Contractor¿s performance and available funding.

Freight Terms: FOB DEST **Ship Via:** COMMON

Lead Time: _____

Supplier Remarks:

COMMENTS:

This is NOT AN ORDER
All returned quotes and related documents must be identified with our request for quote Number.

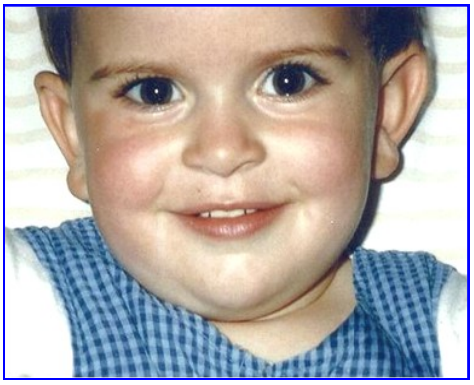
Authorized Signature

Parents as Teachers Program

Evaluation Forms Manual

In Compliance with the National
Maternal, Infant, Early Childhood Home Visiting Program (MIECHV) Benchmarks

SFY 2013



Family Support & Prevention Service

Office of Child Abuse Prevention

1000 NE 10th Street

Oklahoma City, OK 73117

Phone: 405.271.7611

Fax: 405.271.1011


Oklahoma State Department of Health

start right

TABLE OF CONTENTS

TABLE OF CONTENTS
Alphabetical

Family Support & Prevention Services Staff
(405) 271-7611

Annette Jacobi, JD Chief of Service Ph. (405) 271-7611 ext. 56701 annettej@health.ok.gov

Child Abuse Training & Coordination (CATC)	
Pat Damron, M.Ed. LPC CATC Coordinator Ph. (405) 271-7611 ext. 56702 patriciaAD@health.ok.gov	Lisa Williams Program Manager Ph. (405) 271-7611 ext. 56722 lisaw@health.ok.gov
Lisa Slater Administrative Assistant Ph. (405) 271-7611 ext. 56730 lisakj@health.ok.gov	
Children First (C1)	
Mildred Ramsey, R.N., M.P.H Director Ph. (405) 271-7611 ext. 56706 mildredr@health.ok.gov	Sarah Flora, R.N., B.S.N. Nurse Manager Ph. (405) 271-7611 ext. 56704 sarahf@health.ok.gov
Janice Mouser, R.N., B.S.N. Nurse Manager Ph. (405) 271-7611 ext. 56705 janicem@health.ok.gov	Linda Wise Administrative Assistant Ph. (405) 271-7611 ext. 56700 lindakw@health.ok.gov
Community Base Child Abuse Prevention Grant (CBCAP)	
Sherie Trice, M.S., CCPS CBCAP Grant Coordinator Ph. (405) 271-7611 ext. 56727 sheriet@health.ok.gov	
Maternal Infant Early Childhood Home Visitation (MIECHV)	
Kathie Burnett, M.S. MIECHV Grant Coordinator Ph. (405) 271-7611 ext. 56724 kathieb@health.ok.gov	Boudu Bingay, M.P.H. MIECHV Program Evaluator Ph. (405) 271-7611 ext. 56707 boudub@health.ok.gov
Brittany Berry Administrative Officer Ph. (405) 271-7611 ext. 56703 brittanyb@health.ok.gov	
Start Right	
Chris Fiesel, M.L.A. Programs Manager Ph. (405) 271-7611 ext. 56732 chrisf@health.ok.gov	Suzy Gibson, M.S. MCH Consultant Ph. (405) 271-7611 ext. 56925 susaneg@health.ok.gov
Persephone Starks, M.S.	Ruth Neville

MCH Consultant Ph. (405) 271-7611 ext. 56717 Persephone@health.ok.gov	Administrative Assistant Ph. (405) 271-7611 ext. 56733 ruthw@health.ok.gov
Strengthening Families	
Grace Kelley, MSW Strengthening Families Coordinator gracek@health.ok.gov	

Acknowledgements

The following individuals are acknowledged for their efforts and insight regarding the development of the Evaluation t ! ¢ Forms Manual:

David Bard, Ph.D., Associate Professor
Center on Child Abuse and Neglect
Department of Pediatrics
University of Oklahoma Health Sciences Center

Lana Beasley, Ph.D., Assistant Professor of Research
Center on Child Abuse and Neglect
Department of Pediatrics
University of Oklahoma Health Sciences Center

Brittany Berry
MIECHV Administrative Officer
Family Support and Prevention Service
Oklahoma State Department of Health

Boudu Bingay, M.P.H.
MIECHV Program Evaluator
Family Support and Prevention Service
Oklahoma State Department of Health

Kathie Burnett, M.S.
MIECHV Grant Coordinator
Family Support and Prevention Service
Oklahoma State Department of Health

Chris Fiesel, M.L.A.
Program Manager - Start Right
Office of Child Abuse Prevention
Family Support and Prevention Service
Oklahoma State Department of Health

Sarah Flora, R.N., BS.N.
Nurse Manager - Children First
Family Support and Prevention Service
Oklahoma State Department of Health

Suzy Gibson, M.S.
Consultant - Start Right
Office of Child Abuse Prevention
Family Support and Prevention Service
Oklahoma State Department of Health

Robn Green, MPH
HIPAA Privacy Officer
Oklahoma State Department of Health

Jennifer L. Han, Ph.D., CHES
Community Assessment & Evaluation Specialist
Community Epidemiology and Evaluation
Oklahoma State Department of Health

Annette Jacobi, JD
Chief of Service
Family Support and Prevention Service
Oklahoma State Department of Health

Miriam McGaugh, PhD
Epidemiologist
Community Development Service
Oklahoma State Department of Health

Janice Mouser, R.N.
Nurse Manager - Children First
Family Support and Prevention Service
Oklahoma State Department of Health

Jose Munoz, Spanish Interpreter/Translator
Office of Minority Health
Oklahoma State Department of Health

Ruth Neville,
Start Right Administrative Assistant
Family Support and Prevention Service
Oklahoma State Department of Health

Arthur Hamie Owora, Research Coordinator
Center on Child Abuse and Neglect
Department of Pediatrics
University of Oklahoma Health Sciences Center

Mildred Ramsey, R.N., M.P.H.
Director - Children First
Family Support and Prevention Service
Oklahoma State Department of Health

Acknowledgements

Jane Silovsky, Ph.D., Associate Professor
Center on Child Abuse and Neglect
Department of Pediatrics
University of Oklahoma Health Sciences Center

Persephone Starks, M.S.
Consultant – Start Right
Family Support and Prevention Service
Oklahoma State Department of Health

Cari Thompson
Community Health Services
Oklahoma State Dept of health

Angela Watkins - MBA, MPH
Epidemiologist
Community Epidemiology & Evaluation
Oklahoma State Department of Health

Lisa Williams, Programs Manager
Child Abuse Training & Coordination
Family Support and Prevention Service
Oklahoma State Department of Health

Thomas Wilson, MPH
Sponsored Program Coordinator
Center on Child Abuse and Neglect
Department of Pediatrics
University of Oklahoma Health Sciences Center

Linda Wise, Administrative Assistant
Children First
Family Support & Prevention Service
Oklahoma State Department of Health

Citations

1. Cox, J. L., Holden, J. M. & Sagovsky, R. (1987) Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 150, 782 - 786. (Found on page 79)
2. Magura S; Moses BS. (1986). Outcome measures for child welfare services: Theory and applications. Washington, DC: Child Welfare League of America. (Found on page 90)

Why Collect Data?

Goals

The goal of data collection is to gain insight into our program, create a system of measurement to ensure program fidelity and to discover outcomes created by the processes of the programs.

- Provide an electronic and physical record of services received by clients:
  - Data are entered into data system and used for program evaluation
  - Physical forms are filed in the client's chart for historical use/reference in accordance with OSDH Records Management guidelines

- Serve as tools for management and accountability:
  - Mean number of completed visits
  - Mean ratio of completed/expected visits per protocol
  - Mean visit time
  - Mean proportion of time spent on content domains, e.g., personal health, environmental health, life course development, maternal role, and family and friends

- Assist in tracking families' progress in attaining program goals:
  - Change in women's health habits during pregnancy and after birth
  - Mean birth weights and gestational age of infants
  - Percent of children (birth to two years) with completed immunizations
  - Number of emergency room visits and hospitalizations for injuries and ingestions for children birth to two years
  - Number of women who initiated breast-feeding
  - Mean number of months women participated in workforce
  - Mean number of months for use of public programs, e.g., TANF, Food Stamps, Medicaid

- Assist in providing feedback to individual home visitors on strengths and areas for improvement:
  - Visit Implementation Scale
  - Supervision Progress Report

- Assist in planning quality improvements to enhance program implementation and outcomes attained:

  - Compare local program implementation to target goals set by National Center for Children, Families and Communities and identify areas for quality improvement.

Description of the Flow of Data

1. Home visitors are responsible for complete data collection and submission for Primary Caregiver/Identified Child.

2. Home visitor will follow the data collection schedule in order to not overload the client with multiple forms on the same visit.

3. The home visitor will perform a thorough **review** of all forms to ensure that they are filled out completely and accurately. This step is very important for maintaining the quality of data and minimizing time spent in resolving potential data questions later.
   - ✓ Make sure the Primary Caregiver's name is recorded accurately.
   - ✓ Clarify all unclear responses. Make sure it is clear which response category is checked.
   - ✓ Make sure numerical responses are legible.
   - ✓ All questions that are skipped, as part of an established skip pattern, should be left blank (no option is checked or slashed).
   - ✓ There should be no missing data (unless noted by the skip pattern or that the client refused to answer the question)[1].
   - ✓ If a question was omitted, call the PCG to obtain the information or plan to get it on the next home visit.

4. The home visitor has 24 hours to give the completed forms to the clerk. If there is not a clerk: The home visitor has 24 hours to give the completed forms entered into database.

5. The clerk or home visitor should review the forms for completeness and check the data collection schedule to determine if forms are missing. The clerk is not to fill in missing data, but return the incomplete form to the home visitor or the home visitor's supervisor.

6. The clerk or home visitor has one week to enter the data into the data system.

7. The clerk or home visitor files the paper (physical) form in the PCG chart.

8. The program evaluator monitors quality of data and program implementation on an ongoing basis. Program Evaluator makes data available for continuous quality improvement involving frequent contact with program staff and feedback on progress, process and outcomes data.

[1]How to deal with "I don't know" type responses will be addressed in the next section.

Data Management Flow-Chart

Home Visitor (HV) administers the forms according to the schedule.

⇓

HV performs field edit (proofs) of data.

⇓

HV gives support staff completed forms within 24 hours of data collection.

⇓

Home visitor or support staff reviews forms for completeness. If form is not complete, support staff returns forms to HV.

⇓

Support staff enters data into the data system within one week of receiving forms and files paper (physical) forms in client's chart.

⇓

Program Evaluator monitors quality of data and program implementation on an ongoing basis.

⇓

Program Evaluator makes data available for continuous quality improvement involving frequent contact with program staff and feedback on progress, process and outcomes data.

Basic Interviewing and Data Collection Techniques

Role of the Home Visitor

The home visitor has a vital role in assuring that the goals of the evaluation are attained. In addition to maintaining records about the services provided, the home visitor collects information that helps describe the family's risk characteristics and progress toward program goals.

Data collection for evaluation purposes is similar to the assessment phase of the home visiting process. It requires many of the social skills home visitors use daily such as courtesy, tact, polite assertiveness, and careful listening. It differs in that it requires a structured and specialized format to assure consistency across families, home visitors, and sites. Collecting program evaluation data requires special skills such as neutrality, knowledge of interviewing techniques, and an understanding of the evaluation goals and record keeping forms.

Remain Neutral

It is of utmost importance that the facts and opinions that families' give are their own. Home visitors must be very careful to avoid behavior, conscious or unconscious, spoken or unspoken, which could affect the way a family answers questions.

- **Attitude**
  Approach the family with a positive, self-assured, but matter-of-fact manner when asking questions. Friendliness (not familiarity) is an asset.

- **Read questions slowly**
  Remember that this may be the family's first exposure to the question. If she doesn't understand, simply read the question again. Don't try to explain in your own words.

- **Ask questions in neutral conversational tone**
  Only those words underlined should be emphasized. Do not use intonation that may change the meaning of the question or bias the response. Tailor the question to the family; for example, use the child's name as in the following question: Has (child's name) had a blood test for lead poisoning?

Maintain Consistency

The home visitor must read to the family the questions exactly as they are written on data collection forms. Only when the questions are asked in the same way can the data be combined to give a true picture of the experience, thoughts, actions, and feelings of the people questioned. At times a family with limited education may need help in understanding the question. Try rereading the question slower. If the home visitor must rephrase or paraphrase the question to promote family understanding, be sure to keep the intent of the original question.

- **Ask questions exactly as they are written**
  Much time and thought has gone into the construction of the data collection forms to make sure that questions collect the information they are intended to collect.

- **Ask questions in the order indicated**
  Questions are ordered in a certain way to prevent answers to some questions from influencing answers to others. If the family begins to talk about events related to questions that occur later in the questionnaire, do not skip ahead. Say, "We will be getting to that in a few minutes." Skipping ahead may cause you to omit some questions.

- **Be sure the family hears the entire question before answering**
  If a family interrupts to answer, politely ask her to wait until you have read the entire question. At times, you may need to reread the question if the family was talking as you were reading.

- **Do not explain words in a question unless you feel the family cannot grasp the intent of the question**
  The family may ask you to explain the words in a question or part of a question. As a general rule, you should try not to offer your own explanation because it may bias the family's response. Some families may ask for an explanation in order to figure out the "socially desirable" response. Simply repeat the question slowly and encourage the family to answer according to her situation. If you feel that a family cannot grasp the intent of the question, you may try paraphrasing the question using simpler words, but be sure that you reflect the original intent of the question.

Follow Designated Skip Patterns

There are many skip instructions throughout the questionnaires. The skip pattern directs you to omit a question or sequence of questions, depending upon the family's response to a question. **CAREFULLY FOLLOW ALL SKIP PATTERNS** to avoid asking questions which are not relevant for the family. Failure to follow skip patterns results in confounding data.

Assure Confidentiality of Data

Persons working in jobs and professions that deal with the experiences, thoughts, actions, and feelings of people have a moral duty to those people to keep the information provided confidential. Home visitors often ask some questions that they would not think of asking a close friend, questions that may be perceived as "too personal." You will find that families are willing to answer these questions, and even to offer you information that she would not tell a close friend or relative. It is important for families to speak honestly. Home visitors must assure families that all information they provide will be treated confidentially (with the only exception being the mandated reporting of current possible child abuse and neglect).

This means:

- No names are used for data analyses. Numbers, not names, when processed, identifies data.
- Data are published in the form of summary statistics only.
- Home visitors do not discuss data or personal observations about families with anyone not associated with the project, or in the presence of persons not associated with the project (without permission of the family).
- Family information is maintained in a locked file when not in use.

Suggested Discussion Script:

Can I talk to you about confidentiality and how we plan on protecting all the information that is discussed in our visits?

I want to start off by saying that I am a guest in your home and you can freely ask me to leave at any time. Every piece or the whole program is completely voluntary, in other words; it's up to you, to be involved. Most everything we discuss here is completely confidential, meaning no one besides those you give permission to will have access. The only exceptions are when we witness a dangerous act against your child or against you. That process that we are required by law to do.

Use of Probes
A probe is a general technique used for obtaining more complete information when a family does not thoroughly answer a question. A probe should always be neutral, and should not suggest answers. There are several neutral probes which appear as part of a normal conversation that can be used to stimulate a fuller, clearer response.

- **An expression of interest and understanding**
  By saying things such as "uh-huh" or "yes," the home visitor indicates that the response has been heard, that it is interesting, and that more is expected.

- **An expectant pause**
  The simplest way to convey to a PCG that you know she has begun to answer the question, but has more to say, is to be silent. The pause allows the family to gather their thoughts.

- **Examples of probe phrases**
  - **To clarify**
    "What do you mean exactly?"
    "What do you mean by …?"
    "Could you please explain that a little? I don't think I understand."
  - **To specify**
    "When in particular do you have in mind?"
    "Could you be more specific about that?"
    "Tell me about that…" (who, what, where, when, why)
  - **To seek relevance**
    "I see. Well, let me ask you again." (Repeat question.)
    "Would you tell me how you mean that?"

The following are rules of probing that will help you avoid biasing the family's answers.

- **Don't ask whether a person means this or that.**
  This suggests only one of two possible answers, even though there may be many possibilities about which the family is thinking.

- **Don't try to sum up in your own words.**
  Avoid summing up what the family has said in your own words. This may suggest to the family that your idea of her feelings is the "right answer."

- **Don't ask whether the family meant something specific by a certain word.**
  This suggests one answer, when she might have another one in mind.

Handling the "I don't know" response

When a family responds, "I don't know," they may be conveying a number of different things. For instance:

- The respondent doesn't understand the question and says, "I don't know" to avoid saying s/he doesn't understand.
- The respondent is thinking the question over, and says, "I don't know" to fill the silence and give them time to think.
- The respondent may be trying to evade the question because they feel uninformed, afraid of giving a wrong answer, or because the question seems too personal.
- The respondent may really not know the information or have an opinion on the question asked.

Try to decide which of the above explanations may be the case. Don't be in a rush to settle for a "don't know" reply. If you sit quietly, the respondent will usually think of what to say. Silence and waiting are the best response for a "don't know" response. If you feel respondent has answered "I don't know" out a fear of admitting ignorance, you may want to reassure the PCG by saying, "There's really no correct answer."

Many of the questions ask about recall of events over time. The "I don't know" response will often mean, "I don't remember." You may assist the family with recall by conceptualizing the timeframe. For example, when asking a PCG whose infant is six months old, "How many months have you received food stamps since the birth of your infant?" You might note that the number of months would have to be six or less.

Always try at least once to obtain a reply to an "I don't know" response, before accepting it as the final offer. Be careful, however, not to antagonize families or force an answer if they state again that they don't know.

Recording Families Responses
Many of the questions provide you with response categories. Check the one that applies. Some answers require multiple responses depending on what is checked.

- **For some questions, response categories will need to be read to the PCG, e.g.,**
  How often do you usually see or talk to the baby's biological father?
  - ☐ Not at all
  - ☐ Less than once a week
  - ☐ At least once a week but not daily
  - ☐ Daily

- **Yes/No questions do not need the response categories read.**

When questions elicit numerical responses, be sure to write the number legibly on the form. Dates are to be recorded according to month, day, and year. Use numbers for the month, not alphabetic abbreviations (e.g., June 7, 2000 is recorded as 06/07/2000).

Should a PCG refuse to answer a question, there is a question at the end of some forms for the home visitor to record the refusal. Make a note on the form so that it is clear why there is no response. Otherwise, you may be asked to obtain missing data at a subsequent visit.

Closing the Interview
Thank the PCG for their participation in providing the requested information. Make every attempt to close on a pleasant note and to make the PCG feel that the interview has been valuable. After data collection is completed, the home visitor may need to seek clarification and document, using the Home Visit Form, some of the facts the PCG provided regarding domestic violence, mental health issues, etc.

Forms Schedule

Specific Visits	Pregnancy and Identified Child	Complete at enrollment or on the 1st home visit after birth	*Complete Based on Child's Age*
	Primary Caregiver Wellness	Complete on the 2nd home visit; follow-up every 6 months	
	Edinburgh Postnatal Depression Scale (EPDS) (English & Spanish)	Complete when the baby is **2 weeks, 4 weeks and 6 weeks** or, for older infants, complete once before the baby turns 12 months	*Complete Based on Child's Age*
	Relationship Assessment	Complete at the 4th home visit; follow-up every 6 months	
	Child Well-being Scale	Complete 1 month after the child's birth or 1 month after enrollment if the child was older than 1 month at intake; follow-up at every 6 months or immediately following end of services	*Complete Based on Child's Age*
	Family Support Plan	Complete within 45 days of enrollment date; follow-up every 6 months or following completion of goals whichever comes first	
	Identified Child Health Form	Complete within 2 months of enrollment or after birth; follow-up every 6 months	*Complete Based on Child's Age*
	**Immunization Log or OSIIS	Complete at least at the 1st visit after birth and then at the following monthly intervals: 2, 4, 6, 9, and 18.	*Complete Based on Child's Age*
	Home Safety Form	Complete within 2 months of enrollment; follow-up every 6 months	
	ASQ	Complete based on the child's age in months at the following intervals: 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months	*Complete Based on Child's Age*
	ASQ:SE	Complete based on the child's age in months at the following intervals: 6, 12, 18, 24, 30, 36, 48, 60 months	*Complete Based on Child's Age*
As Needed	*PCG HV Documentation	Completed after a home visit that focused on issues dealing with PCG	
	Authorization to Release Information	Complete before sharing participant information; participant's signature is required. See OSDH website for additional information: http://www.ok.gov/health/Organization/HIPAA_Privacy_Rules/Oklahoma_Standard_Authorization_Forms.html	
	Critical Incident Form	Form must be completed and FSPS staff (Program Consultant, Program Manager or Chief) called within 24 hours of discovery of incident	
	333 F Form (copy)	Complete immediately following making a verbal report to the OKDHS Child Abuse Reporting Hotline (Note: Instructions/Policy are in manual.)	

Forms Schedule

Healthy Families America - Family Prevention and Support Service – Oklahoma State Department of Health

CATEGORY	FORM NAME	ADMINISTRATION
Pre-visit	Referral Form: Community OR Referral Form: Provider	Completed by community partner to refer family to program OR Completed by program for direct referrals
	Participant Activity Form	Complete to activate participant in data base or to change status
	Screening Form	Complete once for every referral to the program
	Participant Activity Form	Complete to activate participant in data base or to change status
Initiation of Services *(Assessment Visit)*	HIPAA Privacy Notice (rights) Consent to Receive Services	Read and review with participant (Consent form below must also be completed.) Complete with participant; participant's signature is required.
	Family Assessment	Complete once for every assessment
	Participant Activity Form	Complete to change participant's status in data base
Enrollment	Primary Caregiver Enrollment	Complete once on the first home visit or intake (not the assessment)
	Participant Activity Form	Complete to change participant's status in data base
Used Every Visit	Home Visitation Form	Complete for every home visit including no shows and cancellations
	Home Visitation Documentation ▪ Prenatal ▪ Infant ▪ Toddler ▪ Preschooler ▪ *PCG	Complete one after every home visit as appropriate for the child's age: ▪ during the prenatal period ▪ during the child's infant period from the child's birth to 12 months ▪ during the child's toddler period from 1 to 3 years (12 to 36 months) ▪ during the child's Preschool period from 36 months up to 6 years ▪ Completed after a home visit that focused on issues dealing with PCG
	Service Utilization Form	Complete to document new referrals or update status of past referrals
Used in Between Visits	Supplemental Interaction Form	Complete after any significant interaction with a family that is not a home visit.

Forms Schedule

Update	Primary Caregiver Renewal Form	Complete 6 months from the enrollment date; follow-up every 6 months	
Repeated	ASQ	Complete based on the child's age in months at the following intervals: 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months	*Complete Based on Child's Age*
	ASQ:SE	Complete based on the child's age in months at the following intervals: 6, 12, 18, 24, 30, 36, 48, 60 months	*Complete Based on Child's Age*
	**Immunization Log or OSIIS	Complete at least at the 1st visit after birth and then at the following monthly intervals: 2, 4, 6, 9, and 18.	
	Primary Caregiver Wellness	Follow-up every 6 months from original completion date	
	Relationship Assessment	Follow-up every 6 months from original completion date	
	Family Support Plan	Follow-up every 6 months or following completion of goals whichever comes first	
	Identified Child Health Form	Complete within 2 months of enrollment or after birth; follow-up every 6 months	*Complete Based on Child's Age*
	Home Safety Form	Follow-up every 6 months from original completion date	
	Child Well-being Scale	Follow-up at every 6 months from original completion date and immediately following end of services	
End of Service	Child Well-being Scale	Complete immediately following end of services	
	Participant Activity Form	Complete to indicate in the data base that participant is no longer receiving services	
Staff	Staff and Volunteer	Complete once for every staff member and volunteer	

*PCG HV Documentation – This is a documentation form that is used on an as needed basis. The PCG HV Documentation form is to be used for a home visit that focuses on issues dealing with the PCG. It can be the only documentation form completed for a visit or it can be used in conjunction with a documentation form that is appropriate for the child's age.

Immunization Log or OSIIS – Either the Immunization Log **or OSIIS form must be included in the family file folder. Use the Home Visitation Form to enter immunization data.

07/10/2012

COMMUNITY REFERRAL FORM

Fill this form out if you would like someone to contact you with more information about home visitation services.

GENERAL CONTACT INFORMATION:

Today's Date: _____/_____/_____ Date of Birth: _____

First Name: _____ Last Name: _____

In which city do you live? _____ In which county do you live? _____

Please provide a phone number where you can be safely contacted:

1: (_____) _____-_____ 2: (_____) _____-_____

Can we leave a message? ☐ Yes ☐ No Email address_____

What is the best time to contact you?	What language do you primarily speak?
☐ Early morning	☐ English
☐ 8:00-11:00 a.m.	☐ Spanish
☐ 11:00-3:00 p.m.	☐ American Sign Language
☐ 3:00-6:00 p.m.	☐ Other: _____
☐ Evening	

1. Are you pregnant with your first child?
   ☐ Yes
   ☐ No

2. What is your due date? ___/___/_____(mm/dd/yyyy)

3. Are you currently receiving prenatal care? ☐ Yes ☐ No 4. Are you already raising children? ☐ Yes ☐ No

5. If yes, how old is/are your child (ren)?

Name of child:	Date of Birth

6. Where did you hear about our programs? _____

7. Name of person accepting referral: Last: _____ First: _____

Thank you for completing this form, a program representative will be in contact soon.

HOME VISITATION REFERRAL FORM – Community

Purpose

The Home Visitation Referral Form – Community gathers referral information on candidates who have interest in home visiting program services. The form is used to screen for eligibility and to identify risk factors. This form is specifically used by the provider when there is **no** wait list.

General Instructions

- **Whose form:** Enrollee, potential Primary Caregivers
- **When:** Given to anyone who would like services from the program
- **What:** The form is entered into the database to systematically collect information about the prospective Primary Caregivers and create a process of determining risk.
- **File:** Home Visitation Referral Form is filed at the PAT program site. If the candidate enrolls in the program, the referral form is filed in the family file folder. If the candidate is not enrolled in the program, the family should be referred to another home visiting program, if available, and/or to other resources in the community.

Top Box Item Instructions

- **Date:** Note the date of the referral using the mm/dd/yyyy format.
- **City/County:** Note the city and county in which the program is located.
- **Provider Name:** Note the name of the program.
- **First, Last Name and Date of Birth:** Note the first, last name and date of birth of the candidate (primary caregiver).
- **Best way to contact:** Note the best candidate's preference for method of communication to establish contact.
- **Phone number 1:** Ask what phone number is the safest and best to use to establish contact by phone?
- **Phone number 2:** Ask what is second safest and best phone number to use to contact the candidate by phone? Note: It is important to get a second phone number, this could be a neighbor, a friend or any trusted individual that could take a message and deliver it to the candidate.
- **Can we leave a message?** Ask if it is acceptable to leave a message either on an answering machine or with anyone who might answer the phone. Note: Services are confidential and not always perceived as helpful by everyone. Asking this will limit the possible harm done by our interactions and might increase the chances of further contact.
- **Special instructions when calling:** Ask if there are any special instructions for making contact. Note: Examples might include not saying the name of the program or asking for someone by another name or in a specified language.
- **Email address:** Ask for the complete email address, spelling out each character. Note: Explain to the family how their email will be used and that is will not be shared with any other entity.
- **What is the best time to contact?** Record the candidate's preference for time to contact.
- **What language do you primarily speak?** Record the candidate's primary language or the language of preference.

Home Visitation Form – Community:

1. **Are you pregnant with your first child?** Record if the candidate is pregnant with the first child. Note: If the response is "no", skip to question 4.

2. **What is your due date?** Record date the candidate's baby is due using the mm/dd/yyyy format.

3. **Are you receiving prenatal care?** Record the candidate's response regarding receiving prenatal care.

4. **Are you already raising children?** Record the candidate's response regarding raising children.

5. **What are the names and dates of birth of the children the candidate is raising?** Record candidate's responses the name and birthdates of the children the candidate is raising.

GENERAL CONTACT INFORMATION: Date: / / City/County

HOME VISITATION REFERRAL FORM – Provider: _____

First Name: _____ Last Name: _____ DOB:_____

Best way to contact? ☐ Phone ☐ Text ☐ Email ☐ They will visit office

1: (_____) _____-_____ 2: (_____) _____-_____

Can we leave a message? ☐ Yes ☐ No Special Instructions when calling: _____

Email:_____

Address:_____

What is the best time to contact you?	What language do you primarily speak?
☐ Early morning ☐ 8:00-11:00 a.m. ☐ 11:00-3:00 p.m.	☐ English ☐ Spanish
☐ 3:00-6:00 p.m. ☐ Evening	☐ Am. Sign Language ☐ Other: _____

*1. Are you pregnant with your first child?
☐ Yes → Skip to question 4
☐ No

*2. What is your due date? _____/_____/_____ (mm/dd/yyyy)

*2a. How many weeks along are you: _____

3. Are you currently receiving prenatal care? ☐ Yes ☐ No 4. Are you already raising children? ☐ Yes ☐ No → Skip to question 6

5. How many people in the house hold? _____ 6. How many children are you raising? _____

7. What are the name(s) of child(ren):	Date of Birth(s):
a.	
b.	
c.	
d.	

8. Marital Status:

☐ Never Married ☐ Married ☐ Living Together	☐ TANF ☐ Social Security ☐ Medicare
☐ Separated ☐ Divorce ☐ Widowed	☐ Medicaid ☐ WIC

9. Do you receive?

10. Working Status:

☐ Full Time Homemaker ☐ Full Time(37 hours or more) ☐ Working Part Time (37 hours or less)	☐ Not looking for work ☐ Unemployed - disabled
☐ Self-Employeed ☐ Student ☐ Unemployed	☐ Working more than one job

11. Ever had a report on a child in your home sent to DHS, Child Protective services or child welfare? ☐ Yes ☐ No

12. Have you ever received parenting help from:

☐ Home Visitor ☐ Nurse ☐ Social Worker	☐ Counselor ☐ Minister
☐ Psychologist ☐ Psychiatrist	☐ Other Religious Figure

13. Ever want or receive help for a:

☐ Excessive Drug/Alcohol use ☐ A mental Health Situation	☐ A Personal Health Situation ☐ Marriage or Family Problems ☐ Child Difficulties
☐ Domestic Violence	☐ Emotional Problems

14. Reason for calling/why they want service:

_____

_____

15. Who made the referral: Name: _____ Phone:_____ Address:_____

HOME VISITATION REFERRAL FORM – Provider

Purpose

The Home Visitation Referral Form – Provider gathers referral information on candidates who have interest in our program services. The form is to screen for eligibility and to discover a risk. This for is specifically used by the provider in cases of waiting lists or when the program feels a need to filter out participants.

General Instructions

- **Whose form:** Enrollee, potential Primary Caregivers
- **When:** Given to anyone who would like services from your program, especially when there is a chance of a waiting list
- **What:** The form systematically collects information about the prospective Primary Caregiver and creates a process of determining risk.
- **File:** Home Visitation Referral Form is filed at the PAT program site providing referral services. If the candidate enrolls in the program the referral form is filed in the family folder. If the candidate is not enrolled in the program you will need to offer a referral to another program.

Top Box Item Instructions

- **Date:** Please note the date of the referral
- **City/County:** Please note the city and county that the program is in
- **Provider Name**
- **First, Last name and Date of Birth** of the candidate
- **Best way to contact:** Please note the best way to contact
- **Phone number 1:** Please ask; what is the safest and best way to contact you by phone?
- **Phone number 2:** Please ask; what is second safest and best to contact the candidate by phone? It is important to get a second phone number, this could be a neighbor, a friend or any trusted individual that could take a message it get it to the candidate.
- **Can we leave a message?** Our services are not always perceived as helpful by everyone. Asking this will limit the possible harm done by our interactions and might increase the chances of further contact.
- **Special instruction when calling:** Maybe not saying the name of the program or asking for someone by another name or in a specified language.
- **Email address:** Please have them spell out their email address and remind them we will not use their email address maliciously.
- **Address:** Please note the candidate's address.
- **What is the best time to contact?** Record the best time to contact.
- **What language do you primarily speak?**

Home Visitation Form – Provider:

1. **Are you pregnant with your first child?** Record if the candidate is pregnant with their first child.

2. **What is your due date?** Record their due date.

2a. **How many weeks along are they?** If they don't know the answer to this question you can ask them: When you went to your medical provider, how far along in your pregnancy did he/she say you were? What was that date or when was that?

3. **Are you receiving prenatal care?** Record if they have received any prenatal care.

4. **Are you already raising children?** Record if they are raising children. If the candidate is not raising any children please skip to question 8 on the form.

5. **How many people in the household?** Record the number of people in the household.

6. **How many children are you raising?** Record how many children they are raising.

7. **What are the names and dates of births** of the children in the household.

8. **Marital Status:** Please record their current marital status.

9. **Do you receive?** Please ask if they receive each of the following: TANF, Social Security, Medicare, Medicaid or WIC.

10. **Working Status:** Record their working status, try and be as specific as possible.

11. **Ever had a report on a child in your home sent to DHS, Child Protective Serive or Child Welfare?** Please ask each question separately.

12. **Have you ever received parenting help from:** Please ask if they have had support from any of the following: Home Visitor, Nurse, Social Worker, Counselor, Minister, Psychologist, Psychiatrist or other Religious Figure.

13. **Ever want or received help for:** Please name all of the following: Drug/Alcohol use, mental health situation, personal health situation, marriage or family problems, child difficulties, domestic violence or emotional problems?

14. **Reason for calling/why they want services:** Record any other information regarding why they want services.

15. **Who made the referral?** Record the Name, Phone and Address of the person who made the referral. This helps is keep track of where our referrals are coming from.

PARTICIPANT ACTIVITY FORM

First name: _____ Last Name: _____ DOB (mm/dd/yyyy): ___/____/_____

Date (mm/dd/yyyy): _____/_____/_____ FSW Name: _____

Please choose only one option:

☐ P1. Enrollment status
- ☐ a. Referred for screening
- ☐ b. Screening not completed
- ☐ c. Screening negative
- ☐ d. Screening positive, not referred for assessment
- ☐ e. Screening positive, referred for assessment
- ☐ f. Assessment negative
- ☐ g. Assessment positive, not enrolled
- ☐ h. Assessment positive, enrolled
- ☐ i. Assessment not completed

☐ P2. Change of adult participating in program

a. Please indicate reason:
- ☐ a. Child not living with PCG
- ☐ b. PCG Death
- ☐ c. PCG lost legal custody
- ☐ d. Military deployment
- ☐ e. Other: _____

b. Relationship of new PCG to child:
- ☐ a. Father
- ☐ b. Grandmother
- ☐ c. Foster parents
- ☐ d. Other: _____

☐ P3. No further participation by the PCG
- ☐ a. Client declined further participation (Choose one)
  - ☐ i. Returned to work or school
  - ☐ ii. Receiving services from other program
  - ☐ iii. Pressure from family members
  - ☐ iv. Refused new home visitor
  - ☐ v. Incarcerated
  - ☐ vi. Met program goals
  - ☐ vii. Met personal goals
  - ☐ viii. Other: _____
- ☐ b. Moved out of area, no further participation
- ☐ c. Unable to locate
- ☐ d. Excessive cancellations/no show appointments
- ☐ e. Child no longer in PCG's home (Formal arrangement)
- ☐ f. Child no longer in PCG's home (Informal arrangement)
- ☐ g. PCG / Child death, no further participation
- ☐ h. Child adopted, no further participation

☐ P4. Child reached 6th birthday

☐ P5.Miscarriage/Fetal/Infant/Child death:

a. Date of Death (mm/dd/yyyy): _____/_____/_____

b. Specify primary cause of death:
- ☐ a. Abortion
- ☐ b. Miscarriage
- ☐ c. Fetal/Stillbirth
- ☐ d. Natural Causes
- ☐ e. Abuse or Neglect
- ☐ f. Accident
- ☐ g. Other _____

☐ P6. Client temporarily suspends participation
- ☐ a. Out of town
- ☐ b. Baby hospitalized
- ☐ b. PCG hospitalized
- ☐ c. Schedule conflict
- ☐ d. Other: _____

☐ P7. Returned to program / service area

☐ P8. Transfer to new service area

Previous HFA Program: _____
Previous PAT Program: _____
Current HFA Program: _____
Current PAT Program: _____

☐ P9. DHS notified of potential abuse or neglect
- ☐ a. Reported by FSW
- ☐ b. Reported by Other: _____

☐ P10. Program unable to provide services (specify)
- ☐ a. FSW is not available
- ☐ b. Unable to accommodate schedule
- ☐ c. Other: _____

☐ P11. New family support worker

Previous FSW name: _____
New FSW name: _____

☐ P12. Child begins program; choose one:
- ☐ a. Infant born
- ☐ b. Child enrolled

P13. Is this a MIECHV client? Yes ☐ No ☐

P14: Is this client: HFA ☐ PAT ☐

Instructions for Participant Activity Form

Purpose

The Participant Activity Form "begins and ends" an individual as an participant. It indicates who is involved in the program and, if not involved, why not. The form also records the participant's enrollment status, change of participant, when a participant quits the program and when a participant completes the program. The form identifies significant changes that might impact outcomes, such as change of primary caregiver (PCG), report of possible child maltreatment, and change of family support worker (FSW).

General Instructions

- **Whose form:** A person who is referred to or becomes a program participant.
- **When:** Complete each time there is a change of status for a specific PCG or child. Check only ONE status change option for a specific date.
- **What:** The form records changes in enrollment status and changes in active involvement of the PCG/child in the program.
- **File:** The Participant Activity Form is filed in the family folder at the program site that is providing services.

Top Box Item Instructions

Note:
You must complete all fields listed in the top box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Identified Child Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create a unique id that will link all the family forms to one id.

First name / Last name / DOB: The PCG's / child's first and last names and date of birth.

Date: The date that the indicated activity change occurred. Record the date in mm/dd/yyyy format.

FSW name: The first and last name of the FSW assigned to this family.

Item Instructions

Note:

- You must complete services and enter all other forms related to the family before entering a Participant Activity Form that withdraws a family from the PAT program.

- To attain program goals, it is important to retain families until their goals are attained. As a guideline, 12 weeks of consistent effort may be needed to establish a working relationship and engage families in the program prior to changing the Participant Activity Form from active to inactive or withdraw status.

- Every time that a participant undergoes any activity change that is listed on this form, complete the form, putting the date that the activity change occurred.

- If an activity status option (P1, P2, etc.) has multiple parts, be sure to put a response for each part. (Ex: P2a and P2b)

Item	Description	Activity Status
P1	Enrollment Status	
P1a	Referred for screening	Inactive
P1b	Screening not completed	Inactive
P1c	Screening negative	Inactive
P1d	Screening positive, not referred for assessment	Inactive
P1e	Screening positive, referred for assessment	Inactive
P1f	Assessment negative	Inactive
P1g	Assessment positive, not enrolled	Inactive
P1h	Assessment positive, enrolled	Active
P1i	Assessment not completed	Inactive
P2	Change of Adult Participating	Change PCG/Active
P3	No further participation by PCG	
P3a	Client declined further participation	Inactive
P3b	Moved out of area, no further participation	Inactive
P3c	Unable to locate	Inactive
P3d	Excessive cancellations/no show appointments	Inactive
P3e	Child no longer in PCG's home (Formal arrangement)	Withdraw/case closed
P3f	Child no longer in PCG's home (Informal arrangement)	Withdraw/case closed
P3g	PCG/Child death, no further participation	Withdraw/case closed
P3h	Child adopted, no further participation	Withdraw/case closed
P4	Child reached 6th birthday	Withdraw/case closed
P5	Miscarriage/Fetal/Infant/Child Death	Active
P6	Client temporarily suspends participation	Inactive
P7	Returned to program / service area	Active
P8	Transfer to new service area	Transfer/Active
P9	DHS notified of potential abuse or neglect	Active
P10	Program unable to provide services	Inactive
P11	New family support worker	Active
P12	Child begins program, choose born or enrolled	Active
P13	Indicate if the PCG is a MIECHV participant	Active
P14	Indicate if the PCG is a HFA or a PAT participant. (PAT is HFA.)	Active

SCREENING FORM

Today's Date (mm/dd/yyyy): ____/____/_____ First Name: _____ Last Name: _____

DOB (mm/dd/yyyy): _____/____/_____ Gender: ☐Female ☐Male

S1. Disability: ☐ Deaf ☐ Wheelchair ☐ Blind ☐ Other ☐ None

S2. Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other

S3. Race:
Please check all that apply.
☐American Indian/Alaskan Native ☐Native Hawaiian/Pacific Islander
☐Asian ☐White
☐Black/African American ☐Other, specify:_____

S4. Are you Hispanic or Latino: ☐Yes ☐No

S5. Are you currently married: ☐Yes ☐No

S6. Are you currently enrolled in school: ☐Yes, Please indicate last grade completed _____
☐No, Please indicate last grade completed or GED _____

S7. Street Address: _____ S8. City: _____

S9.County: _____ S10. State: _____ S11. Zip Code: _____

S12. Phone 1: (_____)_____-_____
☐Home ☐Cell ☐Message ☐Work ☐Pager

S13. Phone 2: (_____)_____-_____
☐Home ☐Cell ☐Message ☐Work ☐Pager

Referral Information

S14. Referral Source:

☐Department of Human Service	☐WIC	☐School
☐Hospital	☐Head Start	☐Faith-Based Organization
☐Indian Health Service	☐Babyline	☐Child care provider
☐Children First	☐Self-Referral	☐Doctor's office
☐SNAP	☐Friend	☐TANF
☐Community Connector	☐ParentPro	☐Other, specify_____

Screening Information

S15. Are you or will you be a first-time parent? ☐Yes
☐No If no, how many children do you have? _____

S16. Are you pregnant? ☐Yes, What is your due date (mm/dd/yyyy): ___/____/_____
☐No, What is the date of your baby's birth (mm/dd/yyyy): ___/____/_____

S17. If you are pregnant (before 29 weeks) with your first child, you may be eligible for the Children First Program.

a. Were you referred to Children First? ☐Yes ☐No ☐ Unknown or N/A
b. If yes, were services available from Children First? ☐Yes ☐No ☐ Unknown or N/A

S18. If your baby is already born, does the baby have any birth defect or developmental concerns (ex: prematurity)? ☐Yes ☐No

a. If yes, were you referred to SoonerStart? ☐Yes ☐No ☐ Unknown or N/A
b. If yes, were services available from SoonerStart? ☐Yes ☐No ☐ Unknown or N/A

Risk Factor Screening Record

	(+)	(-)	( )
S19. Teen, Single, Separated, Divorced, or Widowed*	True	False	Unknown
S20. Late or no pre-natal care, poor compliance*	True	False	Unknown
S21. Abortion unsuccessfully sought or attempted*	True	False	Unknown
S22. Partner unemployed	True	False	Unknown
S23. Inadequate income	True	False	Unknown
S24. Unstable housing	True	False	Unknown
S25. No phone	True	False	Unknown
S26. Education under 12 years	True	False	Unknown
S27. Inadequate emergency contacts	True	False	Unknown
S28. History of substance abuse	True	False	Unknown
S29. History of abortions	True	False	Unknown
S30. Relinquishment for adoption sought or attempted	True	False	Unknown
S31. Marital or family problems	True	False	Unknown
S32. History of or current depression	True	False	Unknown
S33. History of psychiatric care	True	False	Unknown

The screening is considered positive if two or more factors are true for the parent. Additionally, the screen is positive if <u>any</u> of the asterisked (*) factors are true or if there are seven or more unknowns.

Screening Outcome

S34. Was the screening positive? ☐Yes ☐No

S35. Was a referral made for assessment? ☐Yes ☐No, Reason code: _____
(If 9 or 10) Details: _____

Reason Coding:

1. Person not interested
2. Person does not feel need for the program
3. Person did not return phone calls
4. Program was unable to contact family for assessment
5. Person moved/plans to move out of the state
6. Person could not be located (wrong address, etc.)
7. Person requested additional time and never followed up
8. Person lives outside of program service area
9. Person currently participating in another program **(Give name as details)**
10. Other, **give details**_____
11. The pregnancy ended in a miscarriage
12. The pregnancy ended in an adoption
13. The pregnancy ended in an abortion
14. Schedule conflict (too busy, work conflict, etc.)
15. Referred to Children First
16. Referred to SoonerStart
17. Program has full caseload
18. Person did not provide specific reasons
19. Child Protective Services is currently involved with the family

Program Worker who conducted the screening: _____

Instructions for Screening Form

Purpose

The Screening Form gathers initial information on potential PAT program participants. The screening is a fast, inexpensive method to group those who probably are at risk from those who probably are not at risk. This form collects preliminary information on the candidate's enrollment eligibility, contact information, interest in enrollment and demographics. Characteristics of those who enroll in the program are compared to those who do not enroll to help modify the evaluation, education and promotion of the program.

More than one screening per candidate is allowed by site only if there is a change in the candidate's situation over time that warrants a new screening. For example a candidate that screened negative initially may have a change in the risk factors that would result positive if screened again. A referral from a source such as a hospital or Children First does not constitute a screening. A screening is to be counted only when the PAT screening form is filled out completely and entered in to the OCAPPA database.

General Instructions

- **Whose form:** Candidates who have been referred to the PAT program, both those that enroll and those that do not enroll.
- **When:** Complete when the first contact or referral is made to the PAT program.
- **What:** Gather as much information as possible on the individual when the referral is being made.
- **File:** The screening form is filed at the PAT program site that is providing screening service. If the candidate enrolls in the program, the screening form is filed in the family folder.

Top Box Item Instructions

Note:
You must complete all fields listed in the gray box. Ensure the information pertaining to the candidate (potential primary caregiver-PCG) is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, misspells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create unique identification criteria that will link all the family forms to one identification criteria.

Today's Date: The date on which the screening was conducted. Use mm/dd/yyyy format.

First Name / Last Name / DOB: The candidate's first and last names and date of birth (potential PCG).

Gender: Check the appropriate box indicating the candidate's gender.

Item Instructions

S1: Check the appropriate box indicating the type of disability the candidate currently experiences. Note that "None" is a possible choice.

S2: Check the appropriate box indicating the language the candidate currently speaks or uses.

S3: Check the appropriate box, indicating race of the candidate. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the candidate.

S4: Check the appropriate box indicating whether the candidate is Hispanic or Latino.

S5: Check the appropriate box indicating the marital status of the candidate.

S6: Check the appropriate box indicating whether the candidate is enrolled in school. Do not include short courses for job skills or job training.

"Yes" box checked: record the last grade the candidate completed.

"No" box checked: record the last grade the candidate completed.

- If the candidate has graduated from high school or has obtained a GED, enter "12" as the last grade completed.
- If the candidate has completed more than high school, add the number of years additional education completed to 12, and record that total.

S7: Record the street address of the candidate. Include the apartment number if applicable.

S8: Record the city in which the candidate resides.

S9: Record the county in which the candidate resides.

S10: Record the state in which the candidate resides.

S11: Record the candidate's zip code.

S12: Record the telephone number, including area code, of the primary phone where the candidate can be reached. Check the appropriate box indicating the type of telephone for this number.

S13: Record the telephone number, including area code, of the secondary phone where the candidate can be reached. Check the appropriate box indicating the type of telephone for this number.

S14: Check the appropriate box indicating the type of agency, program or person who initiated the referral.

- Select self-referral if the candidate saw the promotional material and called the program on his/her own accord.
- If the candidate was given the promotional materials by a particular service such as WIC, then that service would be the referral source.

- If the agency or program that made the referral is not represented in the list, check the "Other" box and record the specific referral source.

S15: Check the appropriate box indicating whether the candidate is or will become a first-time parent. If the "No" box is checked, record the number of children the candidate currently has.

S16: Check the appropriate box indicating whether the candidate is currently pregnant. If the "Yes" box is checked, record the expected due date. If the "No" box is checked, record the date of the most recent infant's birth. Use mm/dd/yyyy format for recording dates.

S17: Determine whether the candidate is pregnant (29 weeks or fewer) with her first child.

a) If yes, check the appropriate box indicating whether the candidate was referred to Children First.
b) If yes, check the appropriate box indicating whether services were available from Children First.

S18: Check the appropriate box indicating whether the candidate's child has any birth defect or if there are developmental concerns.

a) If the "Yes" box is checked for S18, check the appropriate box indicating whether the candidate was referred to SoonerStart.
b) If the "Yes" box is checked for S18a, check the appropriate box indicating whether services were available from SoonerStart.

Risk Factor Screening Record

For items S19 through S33, circle the appropriate response indicating whether each item is true, false or unknown for the candidate.

S19: If the candidate is a teen or marital status is single, separated, divorced, or widowed, then mark "True".

S20: If the candidate's prenatal care did not begin within the first 12 weeks of pregnancy, then mark "True". If the candidate has not received any prenatal care, then mark "True". If the candidate has missed prenatal appointments or if medical advice has not been followed, then mark "True".

S21: If candidate considered having an abortion for this pregnancy, then mark "True".

S22: If the candidate's partner (husband, live-in boyfriend, or domestic partner) is unemployed, then mark "True".

S23: If the candidate receives public aid such as Medicaid, food stamps, or TANF, is employed but does not have medical insurance, or expresses concern about finances, then mark "True".

S24: If the candidate does not list a home address, is uncertain of having a home, or lists an address of a homeless shelter (or equivalent), then mark "True".

S25: If the candidate does not have a home phone or a cell phone, then mark "True".

S26: If the candidate did not complete 12 years of education, then mark “True”.

S27: If the candidate does not list any immediate family emergency contacts (must include names, relationship, and telephone number), then mark “True”.

S28: If the candidate excessively uses or used alcohol or drugs, then mark “True”.

S29: If the candidate has had two or more total induced terminations of pregnancy, or one induced termination of pregnancy within the previous 12 months of the current pregnancy, then mark “True”.

S30: If the candidate considered adoption for this pregnancy, then mark “True”.

S31: If there is any indication of discord among family members of the candidate, then mark “True”.

S32: If the candidate reports depression or if program worker conducting the screening indicates it is warranted, then mark “True”.

S33: If the candidate has had or is currently receiving psychiatric care, then mark “True”.

The screening is considered positive if two or more factors are true for the parent. Additionally, the screen is positive if S19, S20, or S21 are true or if there are seven or more unknowns.

Screening Outcome

S34: Check the appropriate box indicating whether the screening is positive.

S35: Check the appropriate box indicating whether a referral was made for assessment. If the “No” box is checked, record the appropriate reason code from the list on the Screening Form. If reasons 5 or 19 are recorded, provide details for the situation. If the “Other” reason is chosen, record the specific reason that a referral was not made for assessment.

Program Worker who conducted the screening: Record the name of the program worker who conducted the screening.

Oklahoma State Department of Health
HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

It is the policy of the Oklahoma State Department of Health (OSDH) to keep all of your medical and personal information confidential. We will only use or disclose your information for the following reasons:

Treatment: We will share your medical information with other medical providers who are involved in your care (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others. We also participate in Electronic Health Information Exchange, such as the Cherokee County Health Information Network. For instance, if you are getting maternity services from us, we will share your Protected Health Information (PHI) with the doctor who delivers your baby.

Payment: We may use and disclose PHI when it is needed to receive payment for services provided to you. For example, if you have Medicaid benefits, we will release the minimum information necessary for the Medicaid program to pay us.

Health Care Operations: We will use and disclose PHI when it is needed to make sure we are providing you with good service. For instance, we may review your records in order to make certain quality service was given.

Other uses or disclosures of your PHI that may occur include:

- If you have given us permission in writing to release part of your information;
- When ordered to do so by a valid court order;
- When cases of child abuse or neglect are investigated;
- Immunization information is shared with schools and childcare centers;
- When business associates of OSDH, such as community clinics, sign agreements to protect your privacy;
- The SoonerStart Program shares information with the State Department of Education;
- When required by state law. For instance, when reporting injuries and disease as required by the Public Health codes or to prevent the spread of diseases such as tuberculosis (TB) or when reporting suspected child abuse or neglect to the Department of Human Services.
- We can share your information with anyone as necessary, consistent with Oklahoma law and the Oklahoma State Department of Health's policies and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious and imminent threat to the health and safety of a person or the public.
- Also, when services are provided to children less than 18 years of age, information will be shared with the state Joint Oklahoma Information Network (JOIN). This is done to help us improve the services given to children. However, no one can use your child's information unless you have given permission in writing.
- In the case of a severe disaster we can disclose your information. For example, if, as a result of a tornado you are displaced and in need of health care, you may need ready access to health care and the means of contacting family and caregivers. We can disclose your information for the following reasons:

Emergency Coordination: We will share your medical information with other medical providers who are involved in your care to coordinate your care with others (such as emergency relief workers or others that can help in finding you appropriate health services).

Notification: We can share your information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for your care of your location, general condition, or death. For example, if it is necessary, we may notify the police, the press, or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to your location and general condition.

Your Rights
You have the right to:

- Receive a list of persons or organizations, other than those listed above, to whom we released your information.
- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits.
- Ask that we not contact you at home.
- Inspect and copy your medical records except in cases involving certain psychotherapy notes.
- Amend incorrect information in your medical record.
- Revoke your written permission for release of information.
- Receive a paper copy of this privacy notice.

Our Responsibilities
Federal law requires the Oklahoma State Department of Health and its entities to:

- Maintain the confidentiality of your protected health information.
- Provide you with a copy of this notice.
- Abide by the terms of this notice.
- Only change this notice as permitted by federal rules.
- Provide you with a way to file complaints regarding privacy issues.

For further information regarding this notice and your rights, or to report any complaints regarding privacy issues, contact:

HIPAA Privacy Officer
Community Health Services
Oklahoma State Department of Health
1000 NE Tenth Street
Oklahoma City, OK 73117-1299
405/271-5585
privacyofficer@health.ok.gov

You may also report complaints directly to the Secretary of Health and Human Services at the following address:

The U.S. Department of Health and Human Services, the Office of Civil Rights
1301 Young Street, Suite 1169, Dallas, TX 75202
Telephone: (214)767-4056, (214)767-8940 (TDD)

Departamento de Salud del Estado de Oklahoma
Notificación de Privacidad HIPPA

Esta notificación describe cómo se puede usar y revelar información médica sobre usted y cómo puede usted recibir acceso a esta información. Por favor lea cuidadosamente.

La política del Departamento de Salud del Estado de Oklahoma (OSDH) es mantener en forma confidencial toda su información médica y personal. Solamente utilizaremos o revelaremos su información por las siguientes razones:

Tratamiento: Compartiremos su información médica con otros proveedores médicos que estén involucrados en su atención **(**incluyendo hospitales y clínicas), para referirlo a tratamiento y para coordinar su atención con otros. También participamos con el Electronic Health Information Exchange (Intercambio Electrónico de Información de la Salud) tal como el Cherokee County Health Information Network (Red Información de la Salud del Condado de Cherokee). Por ejemplo, si usted está recibiendo nuestros servicios de maternidad, compartiremos su Información de Salud Protegida (PHI- por sus siglas en inglés) con el médico que atienda su parto.

Pago: Podríamos usar y revelar PHI cuando sea necesario recibir pago por los servicios que le fueron proporcionados. Por ejemplo, si usted cuenta con beneficios de Medicaid, daremos a conocer la mínima información necesaria para que el programa de Medicaid nos pague.

Manejo del Cuidado para la Salud: Utilizaremos y daremos a conocer PHI cuando sea necesario para asegurarnos que le estamos proporcionando un buen servicio. Por ejemplo, podemos revisar su expediente para asegurarnos que se le haya ofrecido un servicio con calidad.

Otros usos o revelación de su PHI que pueden ocurrir incluyen:

- Si usted nos ha dado permiso por escrito para dar a conocer parte de su información;
- Cuando se nos ordena hacerlo mediante una orden válida de la corte;
- Cuando se investigan casos de abuso o negligencia infantil;
- Se comparte información de inmunizaciones con las escuelas y centros de guarderías infantiles;
- Cuando los negocios asociados con OSDH, tales como las clínicas comunitarias, firman convenios para proteger su privacidad.
- El programa SoonerStart comparte información con el Departamento de Educación del Estado.
- Cuando la ley estatal lo requiere. Por ejemplo, cuando se reportan lesiones y enfermedades de acuerdo a los requisitos de los códigos de Salud Pública o para prevenir la propagación de enfermedades como la tuberculosis (TB), o cuando se reportan sospechas de abuso o negligencia infantil al Departamento de Servicios Humanos (DHS).
- Podemos compartir su información con cualquiera conforme sea necesario, de acuerdo a la ley de Oklahoma y a la política y procedimientos del Departamento de Salud del Estado de Oklahoma, si pensamos que existe peligro inminente. Por ejemplo, daremos a conocer la información mínima necesaria si creemos que evitará o disminuirá una amenaza seria o inminente a la salud o seguridad de algún individuo o del público.
- Además, cuando se les proporcionan servicios a los niños menores de 18 años de edad, la información se compartirá con la Joint Oklahoma Information Network (Red de Información Conjunta de Oklahoma), (JOIN- por sus siglas en inglés). Esto se hace con el propósito de ayudarnos a mejorar los servicios que se le dan a los niños. Sin embargo, nadie puede usar la información de su niño(a) a menos que usted haya otorgado su permiso por escrito.
- Podemos revelar su información en el caso de una catástrofe. Por ejemplo, si como resultado de un tornado usted se encuentra desplazado y en necesidad de atención médica, puede necesitar acceso rápido de atención médica y los medios para comunicarse con familiares y personas a su cuidado. Podemos revelar su información por las siguientes razones:

Coordinación de Servicios de Urgencia: Compartiremos su información médica con otros proveedores de atención médica que estén involucrados en su cuidado para coordinarlo con otros (como miembros de equipos de socorro u otros que puedan ayudar a localizar los servicios de asistencia apropiados para usted).

Notificación: Podemos compartir su información según sea necesario para identificar, localizar y dar aviso a miembros de la familia, custodios, o cualquier otra persona que sea responsable de su cuidado para informarles en dónde se encuentra, de su condición en general, o de su muerte. Por ejemplo, si es necesario podemos notificar a la policía, a la prensa, o al público en general hasta el punto necesario para que ayuden a localizar, identificar o de otra manera notificar a los miembros de la familia y a otros en dónde se localiza usted y de su condición general.

Sus Derechos
Usted tiene el derecho de:

- Recibir una lista de las personas u organizaciones, aparte de las mencionadas arriba, a quienes les hayamos proporcionado su información.
- Solicitar limitaciones de cómo se debe utilizar o revelar su información; sin embargo, no estamos obligados a observar dichos límites.
- Pedir que no lo contactemos en su casa.
- Revisar y hacer copias de sus archivos médicos, excepto en casos de que se trate de anotaciones psicoterapéuticas.
- Corregir la información incorrecta en su expediente médico.
- Revocar su permiso escrito para la divulgación de su información.
- Recibir una copia en hoja de papel de este aviso de privacidad.

Nuestra Responsabilidad
La ley Federal requiere que el Departamento de Salud del Estado de Oklahoma y sus entidades:

- Mantenga la confidencialidad de su información de salud protegida.
- Le proporcione una copia de esta notificación.
- Acate los acuerdos de este aviso.
- Cambie esta notificación solamente de acuerdo al reglamento federal.
- Le proporcionen una manera de presentar quejas respecto a asuntos de privacidad.

Para más información con respecto a esta notificación y a sus derechos, o para reportar alguna queja relacionada a asuntos de privacidad, comuníquese a:

HIPAA Privacy Officer
Community Health Services
Oklahoma State Department of Health
1000 NE Tenth Street
Oklahoma City, OK 73117-1299
405/271-5585
privacyofficer@health.ok.gov

También puede reportar las quejas directamente al Secretario de Salud y Servicios Humanos a la siguiente dirección:

The U.S. Department of Health and Human Services, the Office of Civil Rights
1301 Young Street, Suite 1169, Dallas, TX 75202
Teléfono: (214)767-4056, (214)767-8940 (TDD)

Consent for Service
Consentimiento para Servicio

Name_____ **Date of Birth**_____
Nombre: Printed Name of Client - Escriba el nombre del cliente Fecha de nacimiento

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health and its entities/contractors. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

Yo, el suscrito, doy consentimiento para los servicios que estoy solicitando del Departamento de Salud del Estado de Oklahoma y sus entidades/contratistas. Yo entiendo que los riesgos y beneficios por esos servicios me serán explicados y tendré la oportunidad de hacer preguntas.

I also understand that:
También entiendo que:

- The information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management and billing purposes. However, my name and other personally identifiable information will not be released without my written permission;
- La información referente a mí y a los servicios que recibiré serán ingresados a los sistemas de manejo de información del OSDH y pueden ser usados para el programa de evaluación, manejo y propósitos de pagos. Sin embargo mi nombre no será dado sin my autorización por escrito;

- I will not be denied service because of my inability to pay;
- No se me negaran los servicios debido a mi incapacidad de pagarlos;

- I may refuse service at any time.
- Yo puedo rehusar los servicios en cualquier momento.

I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Statement as required by the Health Information Portability and Accountability Act.

Reconozco que he recibido una copia de la Nota de Privacidad del Departamento de Salud del Estado de Oklahoma, tal como es requerido por el Acta de Contabilidad y Portabilidad del Seguro de Salud.

Self (Yo mismo)
Other (Specify) - Otro(Especifique)

_____ _____
Printed Name of Consenter — Relationship to Client
Escriba el nombre de la persona dando consentimiento — Relación con el cliente

_____ _____
Signature of Consenter — Date
Firma de la persona dando consentimiento — Fecha

_____ _____
Additional Signature (if required) — Date
Firma adicional (si es requerido) — Fecha

FAMILY ASSESSMENT FORM

First Name: _____ *Last Name:* _____ *DOB (mm/dd/yyyy):* ____/____/_____

Today's Date (mm/dd/yyyy): ____/____/_____ Assessment Worker Name: _____

Family Stress Checklist

Scoring: *0 - normal; 5 - mild; 10 - severe; unk - unknown*

Index of Stresses	Mother				Father				Other			
FA1. Childhood history	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA2. Troubled history	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA3. CPS involvement	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA4. Coping skills	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA5. Stressors/concerns	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA6. Potential for violence	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA7. Expectations of infant	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA8. Discipline of infant	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA9. Perception of new infant	0	5	10	unk	0	5	10	unk	0	5	10	unk
FA10.Bonding/attachment issues	0	5	10	unk	0	5	10	unk	0	5	10	unk
TOTAL SCORE												
TOTAL UNKNOWNS												

A score of 25 or higher qualifies as a positive assessment.

Assessment Outcome

FA11. Outcome and Disposition

☐Positive, offered home visitation*
☐Positive, refused services
☐Positive, caseload full
☐Negative or positive, referred to other services **(Complete FA12**)**
☐Negative, referred to center-based activities **(Complete FA12**)**
☐Negative, no services or referrals given

FA12. **Specify referral: _____

Assessment Follow-up

FA13. *If assessment was positive and services were not initiated, check the reason for not initiating:

☐Person did not feel need for the program
☐Person did not return phone calls
☐Person moved/plans to move out of the state
☐Schedule conflict (too busy, work conflict, etc.)
☐ Referred on to another OCAP program site
☐Person could not be located (wrong address, etc.)
☐There was no HV available to provide services
☐All HV have full caseloads
☐Person did not keep the scheduled intake appointment(s)
☐Other: _____

Instructions for Family Assessment Form

Purpose

The Family Assessment Form gathers in-depth information on candidates who have positive screenings. Receiving assessment service from a PAT program makes the candidate a PAT program participant for that site if the candidate assesses positive. Assessments systematically identify families who would most benefit from intensive home visitation services. The form is a summary page for the results of the family assessment.

More than one assessment per candidate is allowed by site only if there is a change in the candidate's situation over time that warrants a new assessment. For example: first assessment completed but person does not enroll for home visitation. Person comes to the program again after several months to start home visits. Assess again to see if situation has changed (e.g. divorce, job change, domestic violence, etc). This can be done only before the identified child reaches 12 months of age.

Person is said to be a PAT participant once an assessment is completed. If home visits do not begin the case remains open in the OCAPPA database as an inactive family till the child ages out at 6 years i.e. the family can come back for HV at anytime during this period.

General Instructions

- **Whose form:** Family Assessment Worker or persons who are authorized to initially assess and are under interagency agreement.
- **When:** The assessment is completed on every positive screening and before services can begin.
- **What:** The form systematically collects information about the strengths and needs of the family for the purpose of developing a family support services plan. If the assessment is positive, the family can accept services.
- **File:** The Family Assessment Form is filed at the PAT program site providing assessment service. If the candidate enrolls in the program the Family Assessment Form is filed in the family folder.

Top Box Item Instructions

Note:
You must complete all fields listed in the top box. Ensure the information pertaining to the candidate (potential primary caregiver-PCG) is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, misspells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create a unique identification that will link all the family forms to one identification criteria.

First Name / Last Name / DOB: The candidate's first and last names and date of birth (potential PCG).

Today's Date: The date on which the assessment was conducted. Use mm/dd/yyyy format.

Family Assessment Worker Name: The first and last name of the FAW who conducted this interview.

Item Instructions

Family Stress Checklist

Provide score for mother, father on the following index of Stresses using the 0 - 10 scale, where a score of 0= normal; 5=mild; 10=severe; and unk=unknown.

FA1. Childhood History - Person being assessed was beaten or deprived as a child.

FA2. Troubled History – Person being assessed has a criminal, mental illness, or substance abuse history.

FA3. Child Protective Service Involvement – Person being assessed has been suspected of abusing in the past.

FA4. Coping Skills – Person being assessed displays low self-esteem, social isolation, or depression.

FA5. Stressors/Concerns – Person being assessed experiences multiple crises or stresses.

FA6. Potential for Violence – Person being assessed displays violent outbursts.

FA7. Expectations of Infant – Person being assessed has rigid and unrealistic expectations of child's behavior.

FA8. Discipline of Infant – Person being assessed uses harsh punishment towards the child.

FA9. Perception of New Infant – Person being assessed perceives baby/child as difficult and/or provocative.

FA10. Bonding/Attachment Issues – Person being assessed has the potential for a parent/child relationship at risk for bonding.

Total Score: Record the assessment score for mother, father and other. A score of 25 or higher is positive.

Total Unknowns: Record the number of unknowns for mother, father.

FA11. Outcome and Disposition: The family assessment is positive if any of the individual's assessments was positive. Record if the family assessment was positive, if services were offered, and if services were accepted.

FA12. Record the specific referral that was made for other or center-based services.

FA13. Check the appropriate box indicating if an assessment was positive and services were not initiated. If the "Other" reason is chosen, specify other.

PRIMARY CAREGIVER ENROLLMENT FORM

First Name: _____ Last Name: _____ DOB (mm/dd/yyyy): _____/_____/_____

Today's Date (mm/dd/yyyy): ____/____/_____ FSW Name: _____

1. Gender: ☐ Male ☐ Female

2. Which of the following is your race?
(Please check all that apply)

☐ American Indian/ Alaskan Native
☐ Asian
☐ Black/African American
☐ Caucasian
☐ Native Hawaiian/Pacific Islander
☐ Other, specify _____

3. Are you Hispanic or Latino? ☐ Yes ☐ No

4. Marital Status:
☐ Married ☐ Common law marriage ☐ Separated
☐ Single, never married ☐ Divorced ☐ Widowed

5. What is the highest level of school you have completed?
(Please choose one)

☐ 8th grade or less
☐ 9th-12th grade, no diploma
☐ High school graduate
☐ GED completed
☐ Some college, no degree
☐ Vo-tech certification
☐ Associate degree
☐ Bachelor's degree
☐ Post graduate

6. Are you currently enrolled in any kind of school, vocational or educational program? ☐ Yes ☐ No

7. Annual Household income:
(Please choose one)

☐ Under $5,000
☐ $5,000 - $14,999
☐ $15,000 - $24,999
☐ $25,000 - $34,999
☐ $35,000 - $44,999
☐ $45,000 and above
☐ Unknown

8. How many *adults* live in the home? _____ Adults

9. How many *children* live in the home? _____ Children

10. Who are the *other adults* who live in the home:

☐ None
☐ Father of child
☐ Stepfather of child
☐ Boyfriend/ not father of child
☐ Grandmother of the child
☐ Grandfather of the child
☐ Your aunt
☐ Your uncle
☐ Your sister
☐ Your brother
☐ Your friend
☐ Others, specify_____

11. Information about *all* children living in the home:

Name of child (First Name and Last Name)	Date of Birth (mm/dd/yyyy)	Gender (Female/Male)	Relationship to You (Biological Child, Adopted Child, Step-Child, Grandchild, Niece/Nephew, Unrelated, Other)

12. Do you have health care insurance that covers your health expenses? ☐ Yes ☐ No (If no, skip to 14)

13. What kind of health care insurance?
☐ Private Insurance ☐ Medicaid /SoonerCare ☐ Military
☐ Indian (I.H.S./Tribal Health Service) ☐ Other, specify: _____

14. Type of housing:
(Please choose one) ☐ Apartment ☐ Mobile Home ☐ Transitional/ homeless shelter ☐ Domestic violence shelter
☐ House ☐ Other, specify: _____

15. Do you rent or own your residence?
☐ Rent ☐ Own ☐ Live with someone else

16. Employment:
(Please choose one)
☐ Full time employed (35+ hours/week)
☐ Unemployed, but looking
☐ Part time employed (less than 35 hours/week)
☐ Unemployed, not looking
☐ Odd jobs/irregular employment
☐ Medical leave/disability
☐ Other, specify _____

17. Have you received education on preconception/inter-conception care topics, such as the importance of folic acid; the harmful effects of alcohol, smoking, and illegal drugs; medical check-ups?
☐ Importance of folic acid,
☐ harmful effects of alcohol,
☐ harmful effects of smoking,
☐ harmful effects of illegal drugs,
☐ importance of medical check-ups.
☐ No

18. How many live births have *you* had until now? _____ Live births

19. Where are these children living and how many?
☐ With you, # of children: _____ ☐ With someone else, # of children: _____

20. Are you currently expecting a baby? ☐ Yes ☐ No (If no, skip to 24)

21. If yes, how many weeks pregnant are you now? _____ Weeks

22. When is your due date (mm/dd/yyyy)? ___/___/_____

23. How many weeks pregnant were you when you began getting prenatal care for this pregnancy?
a. Number of weeks pregnant _____
b. Number of prenatal care visits so far _____
c. ☐ I have not gotten prenatal care for this pregnancy yet

24. Thinking back to *just before* you got pregnant with your *new* baby, how did you feel about becoming pregnant? **(Choose one answer)**

- ☐ I wanted to be pregnant sooner (Skip to 26)
- ☐ I wanted to be pregnant later
- ☐ I wanted to be pregnant then (Skip to 26)
- ☐ I didn't want to be pregnant then or at any time in the future (Skip to 26)

25. How much later did you want to become pregnant?

- ☐ Less than 1 year
- ☐ 1 year to less than 2 years
- ☐ 2 years to less than 3 years
- ☐ 3 years to less than 4 years
- ☐ 4 years or more

26. Are you or your partner doing anything now to keep from getting pregnant? (Some things people do to keep from getting pregnant include not having sex at certain times [rhythm], or withdrawal, and using birth control methods such as pill, condoms, cervical ring, IUD, having their tubes tied or their partner having a vasectomy.)

☐ Yes ☐ No (Skip to 28)

27. Which type of birth control method have you used in the last 6 months?

- ☐ Male condom
- ☐ Natural family planning, rhythm method
- ☐ Spermicides, jelly, foam, cream suppositories, vaginal cream
- ☐ Diaphragm
- ☐ Cervical cap
- ☐ Sponge
- ☐ Withdrawal method
- ☐ Birth control pills
- ☐ Patch
- ☐ Cervical ring
- ☐ Quarterly birth control shot (Depo-Provera)
- ☐ Monthly birth control shot (Lunelle)
- ☐ Progestrone IUD
- ☐ Non-progestrone IUD
- ☐ Emergency contraception
- ☐ Female condom
- ☐ Other: _____

28. What are your or your partner's reasons for not doing anything to keep from getting pregnant now? Choose 'Yes' if it is a reason, and choose 'No' if it is not.

1. I am not having sex	☐ Yes	☐ No
2. I want to get pregnant	☐ Yes	☐ No
3. I don't want to use birth control	☐ Yes	☐ No
4. My husband or partner doesn't want to use anything	☐ Yes	☐ No
5. I don't think I can get pregnant (sterile)	☐ Yes	☐ No
6. I can't pay for birth control	☐ Yes	☐ No
7. I am pregnant now	☐ Yes	☐ No
8. Other, Please tell us: _____	☐ Yes	☐ No

Instructions for Primary Caregiver Enrollment Form

Purpose

Primary Caregiver Enrollment form gathers demographic and initial pregnancy related information on the person who accepts program services. The form is to be completed prior to home visit services being rendered.

General Instructions

Whose form: The primary caregiver (PCG) form.
When: Completed after a positive screening and assessment, when the family joins the home visit program.
What: The form gathers information on the demographics and initial pregnancy related information.
File: This form is filed in the family folder at the program site that is providing services.

Top Box Item Instructions

Note:
You must complete all fields listed in the box at the top of the form. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create a unique identifier that will link all the family forms to one family ID.

First Name / Last Name / DOB: The PCG's first and last names and date of birth.

Today's Date: The date on which the form was completed. Use mm/dd/yyyy format.

FSW Name: The first and last name of the FSW assigned to this family.

Item Instructions

1: Check the appropriate box indicating the gender of the primary caregiver.

2: Check the appropriate box indicating the race of the primary caregiver. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the primary caregiver.

3: Check the appropriate box indicating whether the primary caregiver is Hispanic or Latino.

4: Check the appropriate box indicating the marital status of the primary caregiver.

5: Check the appropriate box indicating the highest level of education the primary caregiver has completed. Only choose one box.

6: Check the appropriate box indicating whether the primary caregiver is currently enrolled in school, a vocational program or an educational program.

7: Check the appropriate box indicating the primary caregiver's annual household income. Only choose one box.

8: Record the number of adults living in the home in which the primary caregiver resides.

9: Record the number of children living in the home in which the primary caregiver resides.

10: Check the appropriate boxes indicating all adults other than the primary caregiver that live in the home in which the primary caregiver resides. Check all boxes that apply. If the "Others" box is checked, please specify the relationship to the primary caregiver of the other person/people.

11: For all children living in the home in which the primary caregiver resides, record the first and last names, the date of birth in mm/dd/yyyy format, the gender, and the relationship of the child to the primary caregiver. Relationships include biological child, adopted child, step-child, grandchild, niece/nephew, unrelated, and other.

12: Check the appropriate box indicating whether the primary caregiver has health insurance that covers health expenses. If the primary caregiver does not have health insurance, skip to PC18.

13: Check the appropriate box indicating the type of health insurance the primary caregiver has. If the "Other" box is checked, indicate the specific type of health insurance.

14: Check the appropriate box indicating the type of housing in which the primary caregiver resides. Choose only one box. If the "Other" box is checked, indicate the specific type of housing.

15: Check the appropriate box indicating whether the primary caregiver rents or owns the home in which he/she resides.

16: Check the appropriate box indicating the primary caregiver's type of employment. Choose only one box. If the "Other" box is checked, indicate the specific type of employment.

17: Check the appropriate box indicate if the mother reports ever receiving education about preconception/interconception care topics, such as the importance of folic acid, effects of alcohol, tobacco and drugs, and importance of medical check-ups.

18: Record the number of live births the primary caregiver has had up to this point in time. If the primary caregiver has not had a live birth.

19: Check the appropriate box indicating the adult with which the primary caregiver's children currently live. Additionally, record the number of the primary caregiver's children that live with the primary caregiver and that live with someone else.

20: Check the appropriate box indicating whether the primary caregiver is currently pregnant. If the primary caregiver is not pregnant, skip to 24.

21: Record the number of weeks pregnant the primary caregiver is currently.

22: Record the expected due date of the primary caregiver. Use mm/dd/yyyy format.

23: Record the number of weeks pregnant the primary caregiver was when prenatal care began for the current pregnancy.

- 23a – Record the number of weeks pregnant for the primary caregiver
- 23b – Record the number of prenatal care visits the primary caregiver has attended thus far
- 23c – Check the box if the primary caregiver has not received any prenatal care for the current pregnancy.

24: Check the appropriate box describing the primary caregiver's feelings toward becoming pregnant at the time just before becoming pregnant with the current baby. Continue to 30 only if the box for "I wanted to be pregnant later" is checked; otherwise, skip to 26.

25: Check the appropriate box indicating how much later the primary caregiver would have liked to wait before becoming pregnant.

26: Check the appropriate box indicating whether the primary caregiver or his/her partner is using a method to prevent pregnancy. If "No" is checked, skip to 26.

27: Check the appropriate box indicating the type of birth control method the primary caregiver used within the previous 6 months. If the "Other" box is checked, indicate the specific type of birth control method used.

28: Check the appropriate "Yes" or "No" box indicating for each reason whether it was an issue for the primary caregiver and his/her partner to not use the birth control method. If the "Yes" box is checked for "Other", indicate the specific reason.

HOME VISITATION FORM		
PCG Last Name	PCG First Name	PCG DOB / /
Today's Date (mm/dd/yyyy) / /	Home Visitor Name	
Start Time: am / pm	End Time: am / pm	

HV1. Level of visit: ☐ 1-PN ☐ 1-SS ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ X

HV2. Was the visit? ☐ Completed ☐ No Show ☐ Cancelled by Family ☐ Cancelled by FSW

HV3. Next visit scheduled: Date_____/_____/_____ Time _____am/pm

HV4. Location: ☐Home ☐Doctor/Clinic ☐Employment ☐Family/Friend's Home ☐School
☐ Shelter:(name)_____ ☐Other_____

HV5. At visit: (check all that apply) ☐PCG ☐Husband/partner ☐Supervisor ☐Interpreter
☐PCG's mother ☐Identified Child ☐2nd Home Visitor ☐ HD Employee
☐ Father of Child ☐Other family ☐Other person at visit (specify)_____

HV6. Percent of time spent in each program area (**TOTAL = 100%**)**:**

Maternal Health_____% Child Heath & Development_____% Self-Sufficiency_____%

Family Safety_____% Positive Parenting & Parent Child Interaction_____%

HV7. Was parental education provided regarding prevention of child injuries? ☐Yes ☐No

HV8. Was an Intimate Partner Violence safety plan discussed, completed or reviewed today? ☐Yes ☐No

HV9. Was the family referred to appropriate services? ☐Yes ☐No **HV10. Did you complete the Service Utilization form?** ☐Yes ☐No

HV11. Was screening and education for special services provided? ☐ **Lead** ☐ **Depression** ☐**Other:**_____

HV12: **Since the last meeting/interaction was there an ER visit for the PCG**? ☐ Yes ☐ No

HV12a. Since the last meeting/interaction was there an ER visit for the Identified Child? ☐ Yes ☐ No **(If no on 12 & 12a; skip to HV14)**

HV13: If yes, what was the reason? Child:
☐ Non-Critical – ER visit due to non-critical incidences like ear/nose/throat infections, respiratory distress, fever, gastro-intestinal issues.
☐ Critical – ER visits due to critical incidences like injury from accident, physical trauma, poisoning, ingestion, bruising, wounds, severe bleeding.

HV13a: If yes, what was the reason? PCG:
☐ Non-Critical – ER visit due to non-critical incidences like ear/nose/throat infections, respiratory distress, fever, gastro-intestinal issues.
☐ Critical – ER visits due to critical incidences like injury from accident, physical trauma, poisoning, ingestion, bruising, wounds, severe bleeding.

HV14: Since the last meeting was there a non-ER related event that would be considered a critical incident? ☐Yes ☐No

HV14a. Was a Critical Incident Report completed? ☐Yes ☐No **HV14b**. Was a DHS report completed? ☐Yes ☐No

	Child 1	Twin
HV15. Immunizations currently up to date?	☐ Yes ☐ No	☐ Yes ☐ No
HV16. Most recent medical well child check-up?	☐ 1 – 2 wks ☐ 1 month ☐ 2 months ☐ 4 months ☐ 6 months ☐ 9 months ☐12 months ☐ 18 months ☐ 24 months ☐ 30 Months ☐36 Months ☐ 42 Months	☐ 1 – 2 wks ☐ 1 month ☐ 2 months ☐ 4 months ☐ 6 months ☐ 9 months ☐12 months ☐ 18 months ☐ 24 months ☐ 30 Months ☐36 Months ☐ 42 Months
HV17. Ages & Stages ☐ Adjusted for Prematurity	☐2 ☐4 ☐6 ☐8 ☐10 ☐12 ☐14 ☐16 ☐18 ☐20 ☐22 ☐24 After 24, which month are you reporting on? _____ Communication_____ Gross Motor_____ Problem Solving_____ Fine Motor _____ Personal Social_____	☐2 ☐4 ☐6 ☐8 ☐10 ☐12 ☐14 ☐16 ☐18 ☐20 ☐22 ☐24 After 24, which month are you reporting on? _____ Communication_____ Gross Motor_____ Problem Solving_____ Fine Motor _____ Personal Social_____
HV18. Ages & Stages: SE	☐6 ☐12 ☐18 ☐24 ☐30 ☐36 Score ☐ ☐48 ☐60	☐6 ☐12 ☐18 ☐24 ☐30 ☐36 Score ☐ ☐48 ☐60

Instructions for Home Visitation Form 2012

Purpose
The Home Visitation Form records each attempted visit, cancellation, and completed home visit.

General Instructions

- Whose form: Primary Caregiver (PCG) form
- When: This form should be used any time a scheduled home visit has been completed or attempted. This must be a face-to-face visit for the purpose of interaction between the home visitor and the PCG or an interaction between the home visitor and someone from the PCG's family (PCG's mother, spouse, boyfriend, etc.)
- What: The form provides information about the number of visits that a PCG receives, the duration and location of each visit, the participant's engagement in the visit and content of the visit.
- Complete and enter into the OCCAP (or equivalent) data base.
- File physical copy into PCG's file folder.

Item Instructions
HV1: Check the box that describes the level of the visit:

☑	LEVEL	HOME VISITATION SERVICE CRITERIA
	LEVEL 1P	During the Prenatal Service Level, the Family Support Worker will make 2 to 4 visits monthly according to the family's needs. The Home Visitor and Supervisor will determine the frequency of home visits during the prenatal period.
	LEVEL 1	Transition the family to Level 1 when parent(s) give birth to a baby. On Level 1, the Family Support Worker will make at least 1 home visit a week. Transition to Level 2 will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL 2	The Family Support Worker will make at least 1 home visit every other week. Transition to Level 3 will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL 3	The Family Support Worker will make at least 1 home visit per month. Transition to Level 4 will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL 4	The Family Support Worker will make at least 1 home visit every 3 months. Transition out of the Program will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL X	Level X or Creative Outreach is the level assigned to parents who have not engaged in services for 4 weeks; or have received visits but currently decline or are not available for visits; or for parents who have notified the Staff that they are temporarily out of the service area (for over 1 month) but plan to return and resume service. Transition to Level X will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of

		Service.
	LEVEL SS	Special Services is the level assigned to parents who are experiencing stress due to environmental circumstances; due to the physical health of the child; or have had a substantiated report of abuse or neglect. Transition to Level SS will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service. If additional assistance is needed, contact the Program Consultant.

HV2: Check one box that best describes the outcome and purpose of the visit.
1. Completed: A completed visit is when time is spent with the person that the home visitor intended to visit at a specific date and time.
2. No Show: A visit where the home visitor attempted to make a visit but for some reason was not able to conduct the visit (e.g., no response at home, PCG was not at home when the home visitor arrived, or PCG refused visit when the home visitor arrived at the home).
5. Cancelled by Family: Cancellation indicates that the family gave prior notice that the visit would not occur, for example, called or left a message that they would not be available for the visit. Enter the date the home visit was originally scheduled.
6. Canceled by Family Support Worker: Cancellation indicates that the home visitor gave a prior notice that the visit would not occur. For example, the family called or left a message to reschedule the visit. Enter the date the home visit was originally scheduled.

HV3: Enter the date and time of the next scheduled home visit.

HV4: Indicate the location where the home visit occurred. Indicate the name of the shelter; the PCG is residing at a shelter.

HV5: Indicate those present at the visit. If "other" is indicated, specify the role of the person present.

HV6: Estimate the relative proportion of time (0-100%) during the visit spent covering each of the five content domains listed. Make sure that the total amount of time equals 100%. If you spent no time in an area, score it "0" (zero). Given that the emphasis on a particular content domain within the home visit guidelines varies from visit to visit, it is not expected that you consistently record an equal amount of time spent on each program area. Generally, any discussion of health and human services arises because of a need identified in one of the other content domains, so a separate category for time spent discussing community resources is not included. For example, a PCG's interest in completing high school may lead to discussion of GED programs available to her and completing education falls within the "Self Sufficiency" domain. Apply discussions about community resources to one of the applicable content domains specified below:

> **1- Maternal Health:** To systematically assess each family prenatally or at birth for strengths and needs and provide appropriate information and referrals

2- Child Health & Development: To promote healthy child growth and development

3- Self-Sufficiency: To enhance family functioning by: establishing a trusting, nurturing relationship, improving the family's support system, and teaching problem-solving skills

4- Positive Parenting & Parent-Child Interaction: To promote positive parent-child relationships

5- Family Safety: To promote safe practices.

HV7. Indicate if parental education was provided regarding prevention of child injuries. Select "Yes" if education was provided to the PCG during the completed visit regarding safety topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety, playground safety, etc. Select "No" if injury prevention was not discussed during the visit.

HV8: Record whether or not an Intimate Partner Violence safety plan was discussed, completed or reviewed. A Intimate Partner Violence safety plan should only be completed by those who have had the training. Please provide a referral if you have not completed the Intimate Partner Violence Safety Plan Training.

HV9: Record whether or not the PCG was referred to appropriate services. Complete this process by noting the referral on the Service Utilization From.

HV10: Note whether or not a Service Utilization form was completed for the referral of appropriate services.

HV11: Record whether or not screening and education was provided for special services such as lead or depression. While there is a schedule for the Edinburgh Postpartum Depression Scale, the tool is also designed to use when needed. In addition, lead exposure is a topic that can be addressed at anytime.

HV12: Record whether or not there was an emergency room visit for the Primary Caregiver since the last home visit or interaction. An Emergency Room (ER) visit can be at an urgent care center if it is accessed like an ER where no ER's are available.

HV12a: Record whether or not there was an emergency room visit for the Indentified Child since the last home visit or interaction. Emergency Room (ER) visit can be an urgent care center if it is accessed like an ER where no ER's are available.

HV13. Indicate the reason for the ER visit. The purpose of this question is to discern if the ER visit was due to a Non-critical or Critical event.

Non-critical events – This question references events that are not associated with abuse and neglect. Non-critical events might become critical under extreme circumstance, especially if there is any harmful intent or a suspicious grouping of several events. Examples of non-critical ER visits include events like ear/nose/throat infections, respiratory distress, fever, and gastro-intestinal issues. Completing a critical incident is not required but could be completed if there is a concern that the non-critical event might become critical.

Critical Events – This question references events that are associated with abuse and neglect. ER visits due to critical incidents might include injury from accident, physical trauma, poisoning, ingestion, bruising, wounds, and severe bleeding. Critical events can become non-critical under certain circumstances. A critical incident report is required, but not limited to, the following circumstances:

- Severe injury to a PAT family member or the child of a PAT PCG;
- Severe illness of a PAT family member or the child of a PAT PCG;
- Death of a PAT family member or the child of a PAT PCG;
- Any harm that has come to a FSW by a PCG or someone connected to the PCG;
- Legal issues such as a subpoena;
- The child of a PAT PCG is placed in Department of Human Services (DHS) Custody;
- Issues or concerns related to Child Protective Services (CPS); and
- Any other significant event that may occur.

HV13a. HV13a is consistent with HV13, but the emergency room visit was for the Primary Caregiver.

HV14: Record whether or not there was a non-emergency room related critical incident. Examples of circumstances that are identified as critical incidents include the following:

- Severe injury to a PAT family member or the child of a PAT PCG;
- Severe illness of a PAT family member or the child of a PAT PCG;
- Death of a PAT family member or the child of a PAT PCG;
- Any harm that has come to a FSW by a PCG or someone connected to the PCG;
- Legal issues such as a subpoena;
- The child of a PAT PCG is placed in Department of Human Services (DHS) Custody;
- Issues or concerns related to Child Protective Services (CPS); and
- Any other significant event that may occur.

HV14a: If HV13, HV13a, or HV14 involved a critical incident, was a critical incident report completed?

HV14b. Was a Department of Human Services Report completed?

HV15: Indicate whether or not the parent reports that the child's immunizations are current. If there are twins, child 1 is the first-born; child 2 is the second-born. This needs to be recorded on the day the question is asked. Do not mark yes unless the immunization(s) has been completed. It is not enough for the parent to say the immunization(s) will be completed later that day or week. Check yes only if the vaccinations are up-to-date when the question is asked.

HV16. Indicate which well child check-up was most recently completed.

HV17. Ages and Stages Scores:
Each time an Ages and Stages tool is completed, report the scores on this form. The ASQ **MUST** be administered at **2 months, 4 months, 10 months, 16 months** and **22 months**. All other ASQ screenings may be performed as necessary.

The procedure for reporting scores is as follows:
- Specify whether the child was born prematurely and the gestational age was adjusted due to prematurity by checking the adjusted for prematurity box.
- Choose the month of the tool that was administered which should correspond to the child's age.
- Report the following ASQ subtest scores in the boxes provided:
    - Communication,
    - Gross Motor,
    - Fine Motor,
    - Problem Solving, and
    - Personal/Social.
- For TWINS, write the score for the first-born in the section labeled Child 1; write the score for the second-born in the section labeled Child 2.

HV18. For each Ages and Stages:Social-Emotional tool completed, report the scores on this form. The ASQ: SE **MUST** be performed at **6 months, 12 months, 18 months** and **24 months**.

The procedure for reporting scores is as follows:
- Choose the month of the tool that was administered which should correspond to the child's age.
- Report the total ASQ: SE score in the box provided.

Home Visitation Documentation—PRENATAL FORM

File Initials/No._____

Was the Visit:

☐ Completed ☐ Canceled by Family
☐ No Show ☐ Canceled by FSW

Previous Visit Follow-Up:

Parental Guidance Concerns:

Parental Guidance Concerns Addressed by FSW:

Guidance Topics: **X =** Discussion **H-PAT =** Handout (PAT**)** **H-S =** Handout (Supplementary**)** **D =** Demonstration **V** = Video

Abusive Head Trauma (Shaken Baby Syndrome)		Childcare		Father Involvement		Labor/Delivery	
Adequate Housing		Child Proofing		Fire Safety/Smoke Detectors		Adult Literacy	
Adoption		Crying Baby		Home Safety		Prenatal Care	
Birth Plan		Danger Signs		Infant Care/Safety		Relationship Skills	
Bottle Feeding/Formula Prep		Developing Fetus		Infant Cues		Smoking/2nd Hand	
Breast Feeding		Domestic Violence		Infant Supplies		Substance Use	
Car Seat Safety		Family Planning		Job Training		Transportation	

PAT Curriculum:

FSP Goals Addressed:

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Maternal Health (*Health habits, nutrition, exercise, substance abuse, mental health):*
Family Stability (Education, employment, family planning):

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Child Health and Development *(Immunizations, infant care; physical, social, emotional, & cognitive development):*
Positive Parenting & Parent Child Interaction *(Parenting efficacy, behavior, relationships):*
Family Safety *(Child Proofing, sleep position, car seats, domestic violence; fire, water, & weather safety):*
Additional Comments:

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

PRENATAL VISIT FORM—HOME VISITATION DOCUMENTATION

Purpose: The purpose of this form is to provide standardized documentation for home visit services in the OCAP Program during the prenatal period.

Use: This form is part of the OCAP record and should be completed by the Family Support Worker (FSW) after each visit during the prenatal period. File the original documentation in the Primary Caregiver (PCG) file folder.

Identified Population: Provide the file name/number of the PCG's File Folder.

Weeks Gestation: Provide the number of weeks pregnant as of the visit date, and due date of the identified child (IC).

Visit Date: Provide the date of the visit, including when the visit started and the length of the visit.

Visit Details: Information includes whether the visit was completed, the family was a no show, or canceled by either the FSW or Family; The level the family is on; Who was present at the visit, complete the "other" section for friends or extended family members; And the next visit scheduled.

Previous Visit Follow-up: Summarize any follow-up actions from previous home visit.

Parental Guidance Concerns: Use this section to document any concerns of the PCG. Be clear and specific in documentation in the additional notes.

Parental Guidance Concerns Addressed: Use this section to document any concerns address by the FSW. Be clear and specific in documentation in the additional notes.

Primary Care Provider (PCP): Provide name of physician, phone number, and next appointment date.

Guidance Topics: Document using X, H-PAT, H-S, D, or V to indicate what method was used to address the topic.

Additional Notes: Use this section to document any additional concerns during the home visit.

Parents As Teachers (PAT) Curriculum: Document curriculum used, and any handouts of information or activities that are to be reviewed by the PCG before the next home visit.

Family Support Plan (FSP) Goals Addressed: Use this section to document what goals were addressed, and what goals have been accomplished, or new goals that have been set.

Note: Any section that is not addressed should be marked with a line (———) and initialed. If the PCG made the decision to not respond, document the decision. ***DO NOT LEAVE BLANK SPACES.***

1. Maternal Health
2. Child Health
3. Family Stability
4. Positive Parenting & Parent Child Interaction
5. Family Safety

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Home Visitation Documentation—INFANT FORM

File Initials/No._____

Was the Visit:

☐ Completed ☐ Canceled by Family
☐ No Show ☐ Canceled by FSW

Previous Visit Follow-Up:

Parental Guidance Concerns:

Parental Guidance Concerns Addressed by FSW:

Guidance Topics: **X =** Discussion **H-PAT =** Handout (PAT) **H-S =** Handout (Supplementary) **D =** Demonstration **V** = Video

Abusive Head Trauma (Shaken Baby Syndrome)		Co-Sleeping/SIDS		Home Safety/Child Proofing		Smoke/2nd Hand	
Bath Safety		Crying/consolable or excessive		Immunizations		Sun Exposure	
Bottle feeding/Formula Prep		Dental Hygiene//Bottle Tooth Decay		Infant Cues		Temperament	
Breast Feeding		Family Planning		Infant Care/Infant Supplies		Toy Safety	
Car Seat/Safety		Fire Safety/Smoke Detectors		Lead Exposure		Walkers	
Child Care		First Aid/CPR/Burns/Scalds		Setting Routines		Weight Gain	
Choking		Growth/Development		Sleep/Night Waking		Well-Baby Exam	

Parent Child Interaction: *(What did you observe happening between the parent and child on the home visit?)*

PAT Curriculum:

FSP Goals Addressed:

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Maternal Health (*Health habits, nutrition, exercise, substance abuse, mental health):*
Family Stability *(Education, employment, family planning):*

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Child Health and Development *(Immunizations, infant care; physical, social, emotional, & cognitive development):*
Positive Parenting & Parent Child Interaction *(Parenting efficacy, behavior, relationships):*
Family Safety *(Child Proofing, sleep position, car seats, domestic violence; fire, water, & weather safety):*
Additional Comments:

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

INFANT VISIT FORM—HOME VISITATION DOCUMENTATION

Purpose: The purpose of this form is to provide standardized documentation for home visit services in the OCAP Program during the infancy period from 0 to 12 months.

Use: This form is part of the OCAP record and should be completed by the Family Support Worker (FSW) after each visit during the infancy period. File the original documentation in the Family File Folder.

Identified Population: Provide the file name/number of the Family File Folder.

Visit Date: Provide the date of the visit, including when the visit started and the length of the visit.

Visit Details: Information includes whether the visit was completed, the family was a no show, or canceled by either the Family Support Worker (FSW) or Family; The level the family is on; Who was present at the visit, complete the "other" section for friends or extended family members; And the next visit scheduled.

Primary Care Provider (PCP): Provide name of physician, and next appointment date (i.e., well baby check-up, immunizations, or sick care). This section is only completed if the identified child (IC) has an appointment. If not, mark through this section with a line (————) and initial.

Previous Visit Follow-up: Summarize any follow-up actions from previous home visit.

Parental Guidance Concerns: Use this section to document any concerns of the PCG. Be clear and specific in documentation in the additional notes.

Parental Guidance Concerns Addressed: Use this section to document any concerns address by the FSW. Be clear and specific in documentation in the additional notes.

Guidance Topics: Document using X, H-PAT, H-S, D, or V to indicate what method was used to address the topic.

Additional Notes: Use this section to document any additional concerns during the home visit.

Parent Child Interaction: Document observations of PCG and IC interacting during the home visit.

Parents As Teachers (PAT) Curriculum: Document the curriculum used and any handouts of information or activities that are to be reviewed by PCG before the next home visit.

Family Support Plan (FSP) Goals: Use this section to document what goals were addressed, and what goals have been accomplished, or new goals that have been set.

Note: Any section that is not addressed should be marked with a line (————) and initialed. If the PCG made the decision to not respond, document the decision. ***DO NOT LEAVE BLANK SPACES.***

1. Maternal Health
2. Child Health
3. Family Stability
4. Positive Parenting & Parent Child Interaction
5. Family Safety

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Home Visitation Documentation—TODDLER FORM

File Name/No._____

Was the Visit:

☐ Completed ☐ Canceled by Family
☐ No Show ☐ Canceled by FSW

Previous Visit Follow-Up:

Parental Guidance Concerns:

Parental Guidance Concerns Addressed By FSW:

Guidance Topics: **X =** Discussion **H-PAT =** Handout (PAT) **H-S =** Handout (Supplementary) **D =** Demonstration **V** = Video

Biting		Early Literacy		Immunizations		Smoke/2nd Hand	
Burns/Scalds/Falls		Family Planning		Lead Exposure		Tantrums	
Car Seat Safety		Fire Safety/Smoke Detectors		Nutrition		Temperament	
Child Care		First Aid/CPR		Outdoor Safety		Toilet Learning	
Choking		Growth/Development		Poisons		Toy Safety	
Dental Hygiene//Bottle Tooth Decay		Gun Safety		Self-feeding/Weaning		Trauma	
Discipline/Limit Setting/Routines		Home Safety		Sleep/Night Waking		Water Safety	

Parent Child Interaction:

PAT Curriculum:

FSP Goals Addressed:

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Maternal Health (*Health habits, nutrition, exercise, substance abuse, mental health):*
Family Stability *(Education, employment, family planning):*

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Child Health and Development *(Immunizations, infant care; physical, social, emotional, & cognitive development):*
Positive Parenting & Parent Child Interaction *(Parenting efficacy, behavior, relationships):*
Family Safety *(Child Proofing, sleep position, car seats, domestic violence; fire, water, & weather safety):*
Additional Comments*:*

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

TODDLER VISIT FORM—HOME VISITATION DOCUMENTATION

Purpose: The purpose of this form is to provide standardized documentation for home visit services in the OCAP Program during the toddler period from 12 to 36 months (1 year to 3 years).

Use: This form is part of the OCAP record and should be completed by the Family Support Worker (FSW) after each visit during the toddler period. File the original documentation in the Family File Folder.

Identified Population: Provide the file name or number of the Family File Folder.

Visit Date: Provide the date of the visit, including when the visit started and the length of the visit.

Visit Details: Information includes whether the visit was completed, the family was a no show, or canceled by either the FSW or Family; The level the family is on; Who was present at the visit, complete the "other" section for friends or extended family members; And the next visit scheduled.

Primary Care Provider (PCP): Provide name of physician, and next appointment date (i.e., well-child check-up, immunizations, or sick care). This section is only completed if the identified child (IC) has an appointment. If not, mark through this section with a line (————) and initial.

Previous Visit Follow-up: Summarize any follow-up actions from previous home visit.

Parental Guidance Concerns: Use this section to document any concerns of the PCG. Be clear and specific in documentation in the additional notes.

Parental Guidance Concerns Addressed: Use this section to document any concerns address by the FSW. Be clear and specific in documentation in the additional notes.

Guidance Topics: Document using X, H-PAT, H-S, D, or V to indicate what method was used to address the topic.

Additional Notes: Use this section to document any additional concerns during the home visit.

Parent Child Interaction: Document observations of PCG and the IC interacting during the home visit.

Parents As Teachers (PAT) Curriculum: Document the curriculum used and any handouts of information or activities that are to be reviewed by PCG before the next home visit.

Family Support Plan (FSP) Goals: Use this section to document what goals were addressed, and what goals have been accomplished, or new goals that have been set.

Note: Any section that is not addressed should be marked with a line (————) and initialed. If the PCG made the decision to not respond, document the decision. ***DO NOT LEAVE BLANK SPACES.***

Logic Model Goals

1. Maternal Health
2. Child Health
3. Family Stability
4. Positive Parenting & Parent Child Interaction
5. Family Safety

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Home Visitation Documentation—PRESCHOOL FORM

File Initials/No._____

Was the Visit:

☐ Completed ☐ Canceled by Family
☐ No Show ☐ Canceled by FSW

Previous Visit Follow-Up:

Parental Guidance Concerns:

Parental Guidance Concerns Addressed by FSW:

Guidance Topics: **X =** Discussion **H-PAT =** Handout (PAT) **H-S =** Handout (Supplementary) **D =** Demonstration **V** = Video

Birth Certificate		Early Literacy		Immunizations		Smoke - Passive	
Biting		Family Planning		Lead Exposure		Tantrums	
Burns/Scalds/Falls		Fire Safety/Smoke Detectors		Nutrition		Television/Computers	
Child Care		First Aid/CPR		Outdoor Safety		Temperament	
Choking		Growth and Development		Poisons		Toileting	
Dental Hygiene		Gun Safety		School Enrollment		Toy Safety (Including Wheeled Toys)	
Discipline/Limit Setting/Routines		Home Safety		Sleep		Water Safety	

Parent Child Interaction: *(What did you observe happening between the parent and child on the home visit?)*

PAT Curriculum:

FSP Goals Addressed:

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Maternal Health (*Health habits, nutrition, exercise, substance abuse, mental health):*
Family Stability *(Education, employment, family planning):*

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

Logic Model Goals

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Child Health and Development *(Immunizations, infant care; physical, social, emotional, & cognitive development):*
Positive Parenting & Parent Child Interaction *(Parenting efficacy, behavior, relationships):*
Family Safety *(Child Proofing, sleep position, car seats, domestic violence; fire, water, & weather safety):*
Additional Notes:

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

PRESCHOOL VISIT FORM—HOME VISITATION DOCUMENTATION

Purpose: The purpose of this form is to provide standardized documentation for home visit services in the OCAP Program during the preschool period from 36 months up to 6 years.

Use: This form is part of the OCAP record and should be completed by the Family Support Worker (FSW) after each visit during the preschool period. File the original documentation in the Family File Folder.

Identified Population: Provide the file name or number of the Family File Folder.

Visit Date: Provide the date of the visit, including when the visit started and the length of the visit.

Visit Details: Information includes whether the visit was completed, the family was a no show, or canceled by either the FSW or Family; The level the family is on; Who was present at the visit, complete the "other" section for friends or extended family members; And the next visit scheduled.

Primary Care Provider (PCP): Provide name of physician, and next appointment date (i.e., well child check-up, immunizations, or sick care). This section is only completed if the identified child (IC) has an appointment. If not, mark through this section with a line (————) and initial.

Previous Visit Follow-up: Summarize any follow-up actions from previous home visit.

Parental Guidance Concerns: Use this section to document any concerns of the PCG. Be clear and specific in documentation in the additional notes.

Parental Guidance Concerns Addressed: Use this section to document any concerns address by the FSW. Be clear and specific in documentation in the additional notes.

Guidance Topics: Document using X, H-PAT, H-S, D, or V to indicate what method was used to address the topic.

Additional Notes: Use this section to document any additional concerns during the home visit.

Parent Child Interaction: Document observations of PCG and IC interacting during the home visit.

Parents As Teachers (PAT) Curriculum: Document the curriculum used and any handouts of information or activities that are to be reviewed by PCG before the next home visit.

Family Support Plan (FSP) Goals: Use this section to document what goals were addressed, and what goals have been accomplished, or new goals that have been set.

Note: Any section that is not addressed should be marked with a line (————) and initialed. If the PCG made the decision to not respond, document the decision. ***DO NOT LEAVE BLANK SPACES.***

Logic Model Goals

1. Maternal Health
2. Child Health
3. Family Stability
4. Positive Parenting & Parent Child Interaction
5. Family Safety

Use this section to document the **Logic Model Goals** that were addressed on the Home Visit. **Not every topic will be discussed during each visit. Document only the topics that were discussed during the visit, and are relevant to the family and their current life situation.** This section is part of the Logic Model, therefore the goals listed should be a part of the home visitation, whether it be in the form of discussion (X), Handouts (H-PAT), Handout Supplement (H-S), Demonstration (D), or Video (V).

Home Visitation Documentation—PCG (Primary Caregiver)

File Initials/No._____

Was the Visit:

☐ Completed ☐ Canceled by Family
☐ No Show ☐ Canceled by FSW

Previous Visit Follow-Up:

PAT Curriculum:

FSP Goals Addressed:

Observations/Progress Notes:

Observations/Progress Notes (Continued):

FSW Signature:_____ Date:_____

Supervisor Initials:_____ Date:_____

PCG Primary Caregiver—HOME VISITATION DOCUMENTATION

Purpose: The purpose of this form is to provide standardized documentation for home visit services in the OCAP Program during the duration of home visitation services. This form is used in conjunction with the Infant, Toddler, & Preschool Forms. This form is to be used on an as needed basis when documenting information about the Primary Caregiver (PCG), such as family crisis (i.e. domestic violence, referrals, drugs, alcohol) or any other situation in the family discussed on that particular home visit.

Use: This form is part of the OCAP record and should be completed by the Family Support Worker (FSW) after a visit that focuses on issues dealing with the PCG. This form is to be used as long as the family is enrolled in the home visitation services. File the original documentation in the Family File Folder.

Identified Population: Provide the file name or number of the Family File Folder.

Visit Date: Provide the date of the visit, including when the visit started and the length of the visit.

Visit Details: Information includes whether the visit was completed, the family was a no show, or canceled by either the FSW or Family; The level the family is on; Who was present at the visit, complete the "other" section for friends or extended family members; And the next visit scheduled.

Primary Care Provider (PCP): Provide name of physician, and next appointment date. (i.e., well-woman check-up, mammograms, or sick care). This section is only completed if the PCG has an appointment. If not, mark through this section with a line (————) and initial.

Previous Visit Follow-up: Summarize any follow-up actions from previous home visit.

Observation/Progress Notes: This section is to be used when documenting information about the PCG, such as family crisis (i.e. domestic violence, referrals, drugs, alcohol) or any other situation in the family discussed on that particular home visit.

Parents As Teachers (PAT) Curriculum: Document the curriculum left with the parent and any handouts of information or activities that are to be reviewed by PCG before the next home visit. When a family is in crisis, it is understandable if the PAT Lesson is not addressed, however in order for the home visit to count, you have to at least leave the PAT handouts with the PCG for her/him to review before the next scheduled home visit.

Family Support Plan (FSP) Goals: Use this section to document what goals were addressed, and what goals have been accomplished, or new goals that have been set. If you were unable to address the FSP goals, be sure to document the reasons why in this section (i.e. PCG was in crisis, FSP were not relevant at this time).

Note: Any section that is not addressed should be marked with a line (————) and initialed. If the PCG made the decision to not respond, document the decision. ***DO NOT LEAVE BLANK SPACES.***

SERVICE UTILIZATION FORM

PCG First Name: _____ Last Name: _____ DOB (mm/dd/yyy): ___/____/_____

Child First Name: _____ Last Name: _____ DOB (mm/dd/yyyy): ___/____/_____

Today's Date (mm/dd/yyy): ____/____/_____ FSW Name: _____

Stage of Service Utilization					
1	Family referred	5	Waiting to receive service	9	No transportation to service
2	Service Initiated – Ongoing	6	No service available in area	10	Refused referral
3	Service Initiated – Resolved	7	Service in area full	11	Other
4	Referred but no action taken	8	Referred but cannot afford service		

Please choose the most recent status of referral

PCG	C	Service	PCG	C	Service
		Financial Assistance			**Developmental Services**
		1. Medicaid / SoonerCare			30. Sooner Start/Early Intervention
		2. TANF / Welfare			31. Child Guidance
		3. Food Stamps/SNAP			31a. Children First/ Nurse Family Ptship
		4. Social Security/ SSI			32. Counseling/Therapy for children
		5. Rent / Utility Assistance			**Educational Programs**
		Nutritional Services			33. GED, Alternative HS, etc.
		6. WIC			34. Education Beyond High School
		7. Lactation Services			35. ESL Classes
		Crisis Intervention			36. Literacy Program
		8. Domestic/Interpersonal violence			37. Parenting Class
		9. Child Welfare / DHS Referral			38. Childbirth Education Class
		9a. DHS report			39. Fatherhood groups
		9b. Critical Incident Report			40. Family Expectations
		Health Care Services			41. Head Start
		10. Indian Health Services (HIS)			42. Pre-Kindergarten programs
		11. Maternity Clinic			**Charitable Services**
		12. Immunizations			43. Clothing (ex: baby clothes, blankets, diapers)
		13. PCP – PCG			44. Furniture (ex: cribs, bassinets)
		14. PCP – Child			45. Food (including formula)
		15. Lead Screening			**Other**
		16. Dental			46. Relationship Counseling (ex: OMI)
		17. Hearing			47. Respite
		18. Vision			48. Child Support
		19. Speech			49. Legal Services
		20. Family Planning			50. Adoption Services
		Injury Prevention			51. Childcare
		21. Car Seat			52. Job Training
		22. Bike helmet			53. Housing
		23. Smoke alarm			54. Transportation
		24. Water Safety Devices			55. Circle of Parents
		25. Gun locks			56. Parents as Teachers (PAT)
		Substance Use / Mental Health			57. Other: _____
		26. Mental Health Treatment or Therapy			58. Other: _____
		27. Alcohol Treatment			59. Other: _____
		28. Drug Treatment			60. Other: _____
		29. Smoking Cessation			61. Other: _____

Instructions for Service Utilization Form

Purpose

The purpose of the Service Utilization Form is to document the services to which PAT families are referred, the participant's action taken on a referral, whether the participant was able to access and utilize the service, and the ultimate result of the referral.

General Instructions

- **Whose form**: The PCG / child's form.
- **When**: This form is completed at each home visit.
- **What**: The form gathers information on each stage of a participant's utilization of a particular service to which he or she was referred while participating in the PAT program. The stages include initial referral, actions taken or not taken by the participant, availability and accessibility of services, initiation of service, and conclusion of service.
- **File**: This form is filed in the family folder at the PAT program site providing services.

Top Box Item Instructions

Note:
You must complete all fields listed in the Top box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Identified Child Form". Avoid alternate names, misspells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the Top box will be used to create a unique identification that will link all the family forms to one identification criteria.

PCG First Name / Last Name / DOB: The PCG's first and last names and date of birth.

Child First Name / Last Name / DOB: The Child's first and last names and date of birth.

Today's Date: The date on which the referral was made. Use mm/dd/yyyy format.

FSW Name: The first and last name of the FSW assigned to this family.

Item Instructions

There are columns for the Primary Caregiver (PCG) and the child (C). Determine if the service is for the PCG or the child, and then record the option in the PCG or child's column next to the service to indicate the stage of service utilization.

Only record the referrals and follow-up status of those referrals that were given to the participant by the PAT Family Support Worker.

Only continue to record the participant's status on a particular service until the referral/service has been resolved. Options for resolving a referral/service are 3,4,6,7, 8,9 and 10. However, if in the future, you refer the participant again to that same service, indicate the initial referral on this form and continue to record the participant's status with that service at every visit until it is resolved.

Stage of Service Utilization

Option 1. Use to indicate that an initial referral was made during the visit.

Option 2. Use to indicate the current use of a service.

Option 3. Use this to indicate that the participant is no longer receiving the service (record only once at the time services ended.

Option 4. Use to indicate that the participant has chosen to not take action on a previous referral (record only once to indicate the conclusion of the referral process).

Option 5. Use to indicate that the participant has acted on the referral but is waiting for services or for the first appointment.

Option 6. Use to indicate that a referral has been made or is needed, but the service is not available in the area.

Option 7. Use to indicate that a referral has been made, but the service is closed to new program participants (full) and there is no waiting list.

Option 8. Use to indicate that a referral was made and the participant has followed up on the referral, but that s/he cannot afford the service.

Option 9. Use to indicate that a referral was made and the service was available, but the participant cannot get to the service because of transportation issues.

Option 10. Use to indicate that a referral was made or offered, but the participant refused to accept the referral or to follow-up on it.

Option 11. Use this option to indicate the status of a referral ONLY if it is not listed among options 1-11 above.

PREGNANCY & IDENTIFIED CHILD FORM

PCG First Name: _____ Last Name: _____ DOB (mm/dd/yyyy): ___/___/_____

Child First Name: _____ Last Name: _____ DOB (mm/dd/yyyy): ___/___/_____

Today's Date (mm/dd/yyyy): ____/____/_____ FSW Name: _____

1. Gender of the child: ☐ Male ☐ Female

2. Birthweight: _____pounds _____ounces

3. Gestational age at birth: _____ weeks

4. Race of the child **(Please check all that apply)**:
   - ☐ American Indian or Native Alaskan
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Pacific Islander
   - ☐ White or Caucasian
   - ☐ Other, specify: _____

5. Is your child Hispanic or Latino? ☐ Yes ☐ No

6. Please describe the plurality of the birth:
   ☐ Single ☐ Twin ☐ Triplet ☐ Other, specify: _____

7. Did the child have to spend any time in the Neonatal Intensive Care Unit (NICU) because of problems?
   - ☐ Yes, he/she is still in the NICU
   - ☐ Yes → 7a. For how many days prior to discharge? _____ days
   - ☐ No

8. What is your relationship to the child?
   - ☐ Mother
   - ☐ Father
   - ☐ Grandmother
   - ☐ Grandfather
   - ☐ Aunt
   - ☐ Uncle
   - ☐ Foster Parent
   - ☐ Legal Guardian
   - ☐ Other: _____

9. *Just before* the mother got pregnant, did she have health insurance?
   - ☐ Yes, She had Medicaid
   - ☐ Yes, She had private health insurance
   - ☐ No, She did not have health insurance

10. How was the prenatal care paid for? **(Please check all that apply)**
    - ☐ Medicaid
    - ☐ Personal income (cash, check, or credit card)
    - ☐ Health insurance or HMO (including insurance from your work or your partner's work)
    - ☐ Indian Health Service or Tribal
    - ☐ Community or public health clinic
    - ☐ Other, specify: _____

11. How was the delivery paid for? **(Please check all that apply)**

- ☐ Medicaid
- ☐ Personal income (cash, check, or credit card)
- ☐ Health insurance or HMO (including insurance from your work or your partner's work)
- ☐ Indian Health Service or Tribal
- ☐ Community or public health clinic
- ☐ Other, specify: _____

12. How many prenatal care visits did the mother have during the pregnancy? _____ # of visits

13. In the *3 months before* the mother got pregnant, how many cigarettes did she 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
- ☐ None (0 cigarettes)

14. In the *last 3 months* of the mother's pregnancy, how many cigarettes did she 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
- ☐ None (0 cigarettes)

15. How many cigarettes does the mother smoke on an average day *now*? (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
- ☐ None (0 cigarettes)

16. During the *3 months before* the mother got pregnant, how many alcoholic drinks did she have in an average week? (A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.)

- ☐ 14 drinks or more a week
- ☐ 7 to 13 drinks a week
- ☐ 4 to 6 drinks a week
- ☐ 1 to 3 drinks a week
- ☐ Less than 1 drink a week
- ☐ I didn't drink then

17. During the *last 3 months* of the mother's pregnancy, how many alcoholic drinks did she drink in an average week? (A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.)

- ☐ 14 drinks or more a week
- ☐ 7 to 13 drinks a week
- ☐ 4 to 6 drinks a week
- ☐ 1 to 3 drinks a week
- ☐ Less than 1 drink a week
- ☐ I didn't drink then

18. During the *3 months before* the mother got pregnant, how many times did she use marijuana, cocaine, narcotics, or other drugs?

- ☐ Once a day
- ☐ Every other day
- ☐ Once a week
- ☐ Every other week
- ☐ Once a month
- ☐ More than once a month
- ☐ Less than once a month
- ☐ I didn't use drugs

19. During the *last 3 months* of the mother's pregnancy, how many times did she use marijuana, cocaine, narcotics, or other drugs?

- ☐ Once a day
- ☐ Every other day
- ☐ Once a week
- ☐ Every other week
- ☐ Once a month
- ☐ More than once a month
- ☐ Less than once a month
- ☐ I didn't use drugs

Instructions for Pregnancy and Identified Child Form

Purpose

The purpose of this form is to collect information on events during the pregnancy, delivery, and the birth of the child that may impact maternal and child health outcomes. This form also provides a link between the mother and child's data.

General Instructions

Who: The child's form. In case of multiple births, this form is to be completed for all live births in program
When: Completed at the first home visit after enrollment or birth. However, in case of neonatal death or if the infant dies before the first home visit, the Pregnancy & Identified Child Form should be completed when possible. Follow up a completed Pregnancy & Identified Child Form for a deceased child with a Participant Activity Form that updates the status of the deceased child in the database.
What: This form intakes the child into the program and begins the child's record in the program's database.
File: This form is filed in the family folder at the program site that is providing services.

Top Box Item Instructions

Note:
You must complete all fields listed in the top box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Index Child Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create a unique ID that will link all the family forms to one ID.

PCG First Name / Last Name / DOB: The PCG's first and last names and date of birth.

Child First Name / Last Name / DOB: The Child's first and last names and date of birth.

Today's Date: The date on which the referral was made. Use mm/dd/yyyy format.

FSW Name: The first and last name of the FSW assigned to this family.

Special Instructions for Multiple Births

There are some questions on this form that are pregnancy and mother-related (item 9 to 19). To keep from administering and entering these questions more than once for a mother:

- Complete and enter all the questions on the form i.e. 1 to 19 for the first –born child of a multiple birth.
- Complete and enter questions 1 to 8 for second – born of a multiple birth.

Item Instructions

1: Check the appropriate box indicating the gender of the child.

2: Record the birth weight of the infant in pounds (lbs) and ounces (oz).

3: Record the number of gestational weeks completed at the time of the delivery. For infants delivered more than 3 weeks prior to the mother's due date.

4: Check the appropriate box indicating the race of the child. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the child.

5: Check the appropriate box indicating whether the child is Hispanic or Latino.

6: Check the appropriate box indicating the number of infants delivered. If the "Other" box is checked, please specify the plurality of the birth.

7: Check the appropriate box indicating whether the infant spent any time in the Neonatal Intensive Care Unit at the time of birth.

7a: If the infant was in Neonatal Intensive Care Unit or any other care related to complications during birth at the hospital and has already been released, check the "Yes" box next to 7a and then record the specific number of days prior to discharge.

8: Check the appropriate box indicating the primary caregiver's relationship to the child.

9: Check the appropriate box indicating the type of health insurance the mother had just before becoming pregnant.

10: Check the appropriate box indicating how prenatal care was paid. Please check all boxes that apply. If "Other" has been checked, please specify method used to pay for prenatal care.

11: Check the appropriate box indicating how the child's delivery was paid. Please check all boxes that apply. If "Other" has been checked, please specify method used to pay for the child's delivery.

12: Record the number of prenatal care visits the mother had during the pregnancy of this child. Exclude the appointment for the pregnancy test.

13: Check the appropriate box indicating the number of cigarettes the mother smoked on an average day in the 3 months prior to becoming pregnant. Note that a pack contains 20 cigarettes.

14: Check the appropriate box indicating the number of cigarettes the mother smoked on an average day during the last 3 months of the pregnancy. Note that a pack contains 20 cigarettes.

15: Check the appropriate box indicating the number of cigarettes the mother smokes on an average day now. Note that a pack contains 20 cigarettes.

16: Check the appropriate box indicating the number of alcoholic drinks the mother had in an average week in the 3 months prior to becoming pregnant. Note that a drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

17: Check the appropriate box indicating the number of alcoholic drinks the mother had in an average week during the last 3 months of pregnancy. Note that a drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

18: Check the appropriate box indicating the number of times the mother used marijuana, cocaine, narcotics or other drugs in the 3 months prior to becoming pregnant.

19: Check the appropriate box indicating the number of times the mother used marijuana, cocaine, narcotics or other drugs during the last 3 months of pregnancy.

PRIMARY CAREGIVER WELLNESS FORM

First Name:_____ Last Name:_____ DOB (mm/dd/yyyy) _____/_____/_____

Today's Date:(mm/dd/yyyy): _____/_____/_____ FSW Name:_____

Reporting Time: ☐Intake ☐6 ☐12 ☐18 ☐24 ☐30 ☐36
Months from enrollment date ☐42 ☐48 ☐54 ☐60 ☐66 ☐72

1. Have you smoked at least 100 cigarettes in the past 2 years? (A pack has 20 cigarettes.)
   ☐ Yes
   ☐ No

2. Do you now smoke cigarettes every day, some days, or not at all? (One pack has 20 cigarettes.)
   ☐ Every day ☐ Number of cigarettes
   ☐ Some days ☐ Number of cigarettes
   ☐ Not at all (skip to #5)

3. In the last 48 hours, how many cigarettes have you smoked? By 48 hours I mean from (time and day of week) to (today and time). Number of cigarettes ☐

4. Do any of the following statements apply to you?
   a. I have quit smoking ☐ Yes ☐ No
   b. I am trying to quit smoking ☐ Yes ☐ No
   c. I have cut down on the number of cigarettes I smoke. ☐ Yes ☐ No

5. How many alcoholic drinks do you have in an average week? (A drink is: one glass of wine, one wine cooler, one 12-oz container of beer, on shot of liquor, one mixed drink)
   ☐ Less than 1 drink a week ☐ 7 to 13 drinks a week
   ☐ 1 to 3 drinks a week ☐ 14 or more drinks a week
   ☐ 4 to 6 drinks a week ☐ I don't drink

6. How often do you use marijuana, cocaine, narcotics, or other recreational drugs?
   ☐ Once a day ☐ Once a month
   ☐ Every other day ☐ Less than once a month
   ☐ Once a week ☐ I don't use drugs
   ☐ Every other week

These next questions are about the foods you usually eat or drink. Please tell me how often you eat or drink each 1, for example, twice a week, 3 times a month, and so forth. Include all the foods *you* eat, both at home and away from home.

7. How often do you drink fruit juices such as orange, grapefruit, or tomato?
   ☐ per day ☐ per week ☐ per month ☐ never

8. Not counting juice, how often do you eat fruit?
   ☐ per day ☐ per week ☐ per month ☐ never

9. How often do you eat green salad?
   ☐ per day ☐ per week ☐ per month ☐ never

10. How often do you eat potatoes not including french fries, fried potatoes, or potato chips?
☐ per day ☐ per week ☐ per month ☐ never

11. How often do you eat carrots?
☐ per day ☐ per week ☐ per month ☐ never

12. Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat?
(Example: A serving of vegetables at both lunch and dinner would be two servings.)
☐ per day ☐ per week ☐ per month ☐ never

13. During the past six months, other than your regular job, did you participate in any physical activities or exercises such as running, bicycling, vacuuming, gardening, heavy yard work or brisk walking for exercise? ☐ Yes ☐ No

14. In the past 6 months, how many times have you visited a hospital emergency room/urgent care center to receive care/treatment for yourself? ☐ times

Instructions for Primary Caregiver Wellness Form

Purpose
Primary Caregiver Wellness form tracks changes in the primary caregiver health behaviors as a result of program interventions. The form is to be completed every six months to measure the changes that have occurred since enrollment into the program.

General Instructions

Whose form: The Primary Caregiver Wellness form.
When: The form is completed at the 2nd home visit and followed-up every six months from the date of enrollment.
What: The form gathers information on the use of tobacco, alcohol and drugs, and nutrition and exercise habits.
File: This form is filed in the family folder at the program site that is providing services.

Top Box Item Instructions
NOTE: You must complete all fields listed in the box at the top of the form. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create a unique ID that will link all the family forms to one ID.

First Name / Last Name / DOB: The PCG's first and last names and date of birth.

Today's Date: The date on which this form was completed by the PCG or FSW. Use mm/dd/yyyy format.

FSW Name: The first and last name of the FSW assigned to this family.

Reporting Time: Check the box indicating the appropriate time frame (PCG intake or every 6 months calculated from the enrollment date). Many program outcomes are measured over time, and this field helps to determine time sequence.

Item Instructions

1: **Using the time frame of the past 2 years,** mark if the PCG has smoked at least 100 cigarettes (5 packs).

2: Check the appropriate box indicating if the PCG **currently** smokes every day, some days or not at all. If the PCG is a current smoker, record the number of cigarettes typically smoked per day.

3: **Using the time frame of the past 48 hours,** record the number of cigarettes the PCG has smoked. If cigarette use is reported in packs, recode the number of cigarettes. One half-pack is 10 cigarettes. Clarify time frames to assist PCGs with time orientation. For example, if the visit date is Tuesday around 2:00 PM, the 48-hour timeframe began on Sunday, around 2:00 until now (Tuesday, 2:00 PM).

PH4: Read each of the 3 statements to the PCG and mark whether s/he reports that each does (Yes) or does not (No) apply to her.

a. "I have quit smoking" means s/he has quit smoking at some point in the past, has not smoked since she quit and is not currently smoking.
b. "I am trying to quit smoking" means that s/he currently smokes and is taking some sort of action to try and quit.
c. "I have cut down on the number of cigarettes I smoke" means s/he smokes currently but has cut down on the number of cigarettes from the amount s/he smoked in the past.

5: Record the number of alcoholic drinks that are consumed by the PCG in an average week.

6: Record how often the PCG indicates usage of drugs. Although not listed, drugs include crystal methamphetamine, crack, and crank.

7: Record the consumption of fruit juices by the PCG per day, week or month (for example twice a week, three times a month etc.)

8: Record the consumption of fruit ***excluding fruit juices*** by the PCG per day, week or month (for example twice a week, three times a month etc.)

9: Record the consumption of green salad by the PCG per day, week or month (for example twice a week, three times a month etc.)

10: Record the consumption of potatoes ***excluding french fries, fried potatoes, or potato chips*** by the PCG per day, week or month (for example twice a week, three times a month etc.)

11: Record the number of times the PCG consumes carrots per day, week or month (for example twice a week, three times a month etc.)

12: Record the consumption of vegetables ***excluding carrots, potatoes, or salad*** by the PCG per day, week or month (for example a serving of vegetables at both lunch and dinner would be two servings.)

13: **Using the time frame of the past 6 months,** mark if the PCG has participated in any physical activities or exercises (For example running, bicycling, vacuuming, gardening, heavy yard work or brisk walk).

14: **Using the time frame of the past 6 months,** record the number of times the PCG has visited the hospital emergency room or urgent care center for treatment.

Edinburgh Postnatal Depression Scale

PCG _____DOB_____Weeks PP_____Date_____

As you have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **in the past 7 days**, not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ❑ As much as I always could
   - ❑ Not quite so much now
   - ❑ Definitely not so much now
   - ❑ Not at all

2. I have looked forward with enjoyment to things
   - ❑ As much as I ever did
   - ❑ Rather less than I used to
   - ❑ Definitely less than I used to
   - ❑ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ❑ Yes, most of the time
   - ❑ Yes, some of the time
   - ❑ Not very often
   - ❑ No, never

4. I have been anxious or worried for no good reason
   - ❑ No, not at all
   - ❑ Hardly ever
   - ❑ Yes, sometimes
   - ❑ Yes, very often

*5. I have felt scared or panicky for no good reason
   - ❑ Yes, quite a lot
   - ❑ Yes, sometimes
   - ❑ No, not much
   - ❑ No, not at all

*6. Things have been getting on top of me
   - ❑ Yes, most of the time I haven't been able to cope at all
   - ❑ Yes, sometimes I haven't been coping as well as usual
   - ❑ No, most of the time I have coped quite well
   - ❑ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty Sleeping
   - ❑ Yes, most of the time
   - ❑ Yes, sometimes
   - ❑ Not very often
   - ❑ No, not at all

*8. I have felt sad or miserable
   - ❑ Yes, most of the time
   - ❑ Yes, quite often
   - ❑ Not very often
   - ❑ No, not at all

*9. I have been so unhappy that I have been crying
   - ❑ Yes, most of the time
   - ❑ Yes, quite often
   - ❑ Only occasionally
   - ❑ No, never

*10. The thought of harming myself has occurred to me
   - ❑ Yes, quite often
   - ❑ Sometimes
   - ❑ Hardly ever
   - ❑ Never

Total Score: _____

Source: **Cox, J. L., Sagovsky, R, 1987 Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.**
*** notes a mark to simplify scoring**

SCORED - Edinburgh Postnatal Depression Scale – SCORED

[This page is to be used for scoring, not given directly to families.]

PCG _____DOB_____Weeks PP_____Date_____

As you have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **in the past 7 days**, not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all

2. I have looked forward with enjoyment to things
   - 0 As much as I ever did
   - 1 Rather less than I used to
   - 2 Definitely less than I used to
   - 3 Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - 3 Yes, most of the time
   - 2 Yes, some of the time
   - 1 Not very often
   - 0 No, never

4. I have been anxious or worried for no good reason
   - 0 No, not at all
   - 1 Hardly ever
   - 2 Yes, sometimes
   - 3 Yes, very often

*5. I have felt scared or panicky for no good reason
   - 3 Yes, quite a lot
   - 2 Yes, sometimes
   - 1 No, not much
   - 0 No, not at all

*6. Things have been getting on top of me
   - 3 Yes, most of the time I haven't been able to cope at all
   - 2 Yes, sometimes I haven't been coping as well as usual
   - 1 No, most of the time I have coped quite well
   - 0 No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty Sleeping
   - 3 Yes, most of the time
   - 2 Yes, sometimes
   - 1 Not very often
   - 0 No, not at all

*8. I have felt sad or miserable
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Not very often
   - 0 No, not at all

*9. I have been so unhappy that I have been crying
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, never

*10. The thought of harming myself has occurred to me
   - 3 Yes, quite often
   - 2 Sometimes
   - 1 Hardly ever
   - 0 Never

Source: **Cox, J. L., Sagovsky, R, 1987 Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale.** ***British Journal of Psychiatry*** **150:782-786.**

ESCALA DE EDINBURGO (Spanish Version)

PCG _____DOB_____Weeks PP_____Date_____

Como usted hace poco tuvo un bebé, nos gustaría saber como se ha estado sintiendo. Por favor SUBRAYE la respuesta que más se acerca a como se ha sentido en los últimos 7 días.
Or
Por favor haga un círculo alrededor de la respuesta que más se acerca a como se ha sentido en los últimos 7 días.

En los últimos 7 días:
1. He podido reír y ver el lado bueno de las cosas:
- ☐ Tanto como siempre
- ☐ No tanto ahora
- ☐ Mucho menos
- ☐ No, no he podido

2. He mirado al futuro con placer:
- ☐ Tanto como siempre
- ☐ Algo menos de lo que solía hacer
- ☐ Definitivamente menos
- ☐ No, nada

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
- ☐ Sí, casi siempre
- ☐ Sí, algunas veces
- ☐ No muy a menudo
- ☐ No, nunca

4. He estado ansiosa y preocupada sin motivo:
- ☐ No, nada
- ☐ Casi nada
- ☐ Sí, a veces
- ☐ Sí, a menudo

5. He sentido miedo o pánico sin motivo alguno:
- ☐ Sí, bastante
- ☐ Sí, a veces
- ☐ No, no mucho
- ☐ No, nada

En los últimos 7 días:
6. Las cosas me oprimen o agobian:
- ☐ Sí, casi siempre
- ☐ Sí, a veces
- ☐ No, casi nunca
- ☐ No, nada

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
- ☐ Sí, casi siempre
- ☐ Sí, a menudo
- ☐ No muy a menudo
- ☐ No, nada

8. Me he sentido triste y desgraciada:
- ☐ Sí, casi siempre
- ☐ Sí, bastante a menudo
- ☐ No muy a menudo
- ☐ No, nada

9. He estado tan infeliz que he estado llorando:
- ☐ Sí, casi siempre
- ☐ Sí, bastante a menudo
- ☐ Sólo ocasionalmente
- ☐ No, nunca

10. He pensado en hacerme daño a mí misma:
- ☐ Sí, bastante a menudo
- ☐ Sí, a menudo
- ☐ Casi nunca
- ☐ No, nunca

Total Score:_____

ESCALA DE EDINBURGO (Spanish Version)

Como usted hace poco tuvo un bebé, nos gustaría saber como se ha estado sintiendo. Por favor SUBRAYE la respuesta que más se acerca a como se ha sentido en los últimos 7 días.
Or
Por favor haga un círculo alrededor de la respuesta que más se acerca a como se ha sentido en los últimos 7 días.

Éste es un ejemplo ya completo:
Me he sentido contenta:
0 Sí, siempre
1 Sí, casi siempre
2 No muy a menudo
3 No, nunca

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas:
   0 Tanto como siempre
   1 No tanto ahora
   2 Mucho menos
   3 No, no he podido

2. He mirado al futuro con placer:
   0 Tanto como siempre
   1 Algo menos de lo que solía hacer
   2 Definitivamente menos
   3 No, nada

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   3 Sí, casi siempre
   2 Sí, algunas veces
   1 No muy a menudo
   0 No, nunca

4. He estado ansiosa y preocupada sin motivo:
   0 No, nada
   1 Casi nada
   2 Sí, a veces
   3 Sí, a menudo

5. He sentido miedo o pánico sin motivo alguno:
   3 Sí, bastante
   2 Sí, a veces
   1 No, no mucho
   0 No, nadaEn los últimos 7 días:

6. Las cosas me oprimen o agobian:
   3 Sí, casi siempre
   2 Sí, a veces
   1 No, casi nunca
   0 No, nada

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   3 Sí, casi siempre
   2 Sí, a menudo
   1 No muy a menudo
   0 No, nada

8. Me he sentido triste y desgraciada:
   3 Sí, casi siempre
   2 Sí, bastante a menudo
   1 No muy a menudo
   0 No, nada

9. He estado tan infeliz que he estado llorando:
   3 Sí, casi siempre
   2 Sí, bastante a menudo
   1 Sólo ocasionalmente
   0 No, nunca

10. He pensado en hacerme daño a mí misma:
   3 Sí, bastante a menudo
   2 Sí, a menudo
   1 Casi nunca
   0 No, nunca

Edinburgh Postnatal Depression Scale (EPDS)
Form No. 444

Purpose: The purpose of this form is to provide a standardized tool to assist in identifying mothers participating in OCAP home visitation service and suffering from signs of postnatal depression.

Use: This form is administered during postpartum (up to 1 year postpartum or when the baby is 12 months old) when signs or symptoms indicate.

PCG – Provide the name, initial, date of birth of mother.

Weeks PP – Provide the number of weeks postpartum or since birth of child.

Date – Provide the date the scale was administered.

The EPDS consists of 10 short statements, each with four responses. The mother checks the response that most closely matches how she has been feeling in the previous 7 days. Response categories are scored 0, 1, 2, and 3, according to the severity of the symptom. Items marked with an asterisk are reverse scored (i.e., 3, 2, 1, and 0). All 10 items must be completed. The total score is calculated by adding together the scores for each of the 10 items and should be documented on the "Healthy Families Parenting Inventory – Score Sheet". **Mothers with scores of 12 or above should be referred to their PCP or local resources. Mothers who answer question #10 " yes," should also be referred to their PCP or local mental health professional regardless of the total score. If the response is "yes, quite often," or similar, the referral should be made as soon as possible.**

Care should be taken to avoid the possibility of the mother discussing her answers with others. The mother should complete the EPDS herself, unless she has limited English or has difficulty reading. The EPDS will not detect mothers with anxiety disorders, phobias, or personality disorders.

Routing and Filing: The original copy of this form is filed in the PCG's family folder at the OCAP program site providing the home visitation service.

Jelinek M, Patel BP, Froehle MC, eds. 2002. *Bright Futures in Practice: Mental Health – Volume II. Tool Kit*. Arlington, VA: National Center for Education in Maternal Child Health.

Scoring and Other Information

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom. Items 3, 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect the copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression, a distressing disorder more prolonged than the "blues" (that occurs in the first week after delivery) but less severe than puerperal psychosis.

Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected, and it is possible that there are long-term effects on the family.

The EPDS was developed at health centers in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than 5 minutes.

The validation study showed that mothers who scored above a threshold 12-13 were likely to be suffering from a depressive illness of varying severity. Nevertheless the EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week, and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Instructions for users

1. The mother is asked to underline the response, which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women, or during pregnancy. The child health clinic, postnatal check-up, or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, *150*, 782-786.

This Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245. mike-ohara@uiowa.edu.

RELATIONSHIP ASSESSMENT FORM

First Name: _____ Last Name:_____ DOB (mm/dd/yyyy) _____/_____/_____

Today's Date (mm/dd/yyyy) _____/_____/_____ FSW Name: _____

Reporting Time: ☐Intake ☐6 ☐12 ☐18 ☐24 ☐30 ☐36

(Months from Enrollment Date) ☐42 ☐48 ☐54 ☐60 ☐66 ☐72

The following questions are about family and friends relationships. These questions may or may not describe your current or past partner.

RA1. Do you have a partner now?
- ☐ Yes, male
- ☐ Yes, female (Skip to RA3.)
- ☐ No (Skip to RA3.)

RA2. Is your current partner the biological father of this baby?
- ☐ Yes
- ☐ No
- ☐ Don't know

RA3. During the past 6 months or since the birth of the child, how often did the child's biological father spend time taking care of and /or playing with the child?
- ☐ Not at all
- ☐ Less than once a week
- ☐ At least once a week but not daily
- ☐ Daily

RA4. During the past 6 months, did the father figure /biological father participate in any program sponsored activity such as home visitations or family support events?
- ☐ Yes If yes, what were they?_____
- ☐ No

RA4a. Would you like more involvement of the biological father? ☐ Yes ☐ No

RA5. Since you became pregnant /or after the birth of your child, how much money has the child's biological father provided for you during a typical month? $_____

RA6. During the past 6 months or since the birth of the child, would you have had the kinds of help listed below if you needed them? Check all that apply:

a. Someone to help me if I were sick and needed to be in bed	☐ Yes	☐ No
b. Someone to talk with about my problems	☐ Yes	☐ No
c. Someone to loan me $50	☐ Yes	☐ No
d. Someone to take me to the clinic or doctor's office if I needed a ride	☐ Yes	☐ No
e. Someone to take care of my child	☐ Yes	☐ No
f. Someone to help me if I were tired and feeling frustrated with my child	☐ Yes	☐ No

RA7. Have you ever been emotionally or physically abused by your partner or someone important to you?

- ☐ Yes
- ☐ No

RA8. Within the last 6 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?

- ☐ Yes → By whom? (Check all that apply.)
  - ☐ Spouse
  - ☐ Ex-spouse
  - ☐ Boyfriend/ girlfriend
  - ☐ Ex-Boyfriend/ girlfriend
  - ☐ Other family member
  - ☐ Friend/acquaintance
  - ☐ Stranger
- ☐ No → (If no, go to RA15)

RA9. How many times were you physically hurt <u>in the last 6 months</u> (Temporary or lasting injuries)?

- ☐ None
- ☐ 1 or 2
- ☐ 3 to 5
- ☐ 6 or more

RA10. <u>In the last 6 months</u>, how many times did someone slap or push you?

- ☐ None
- ☐ 1 or 2
- ☐ 3 to 5
- ☐ 6 or more

RA11. <u>In the last 6 months</u>, how many times did someone punch, kick or cut you?

- ☐ None
- ☐ 1 or 2
- ☐ 3 to 5
- ☐ 6 or more

RA12. <u>In the last 6 months</u>, how many times did someone do something that burned you, severely bruised you, or broke a bone?

- ☐ None
- ☐ 1 or 2
- ☐ 3 to 5
- ☐ 6 or more

RA13. <u>In the last 6 months</u>, how many times did someone cause you to have a head, internal, or permanent injury?

- ☐ None
- ☐ 1 or 2
- ☐ 3 to 5
- ☐ 6 or more

RA14. In the last six months, how many times did someone use a weapon to hurt you? (Weapon is client's perception.)

- ☐ None
- ☐ One or two
- ☐ Three to five
- ☐ Six or more

RA15. Within the last six months, has anyone forced you to have sexual relations?

- ☐ Yes → If yes, by whom? (Check all that apply.)
  - ☐ Spouse
  - ☐ Ex-spouse
  - ☐ Boyfriend/ girlfriend
  - ☐ Ex-Boyfriend/ girlfriend
  - ☐ Other family member
  - ☐ Friend/acquaintance
  - ☐ Stranger
- ☐ No → (If no, go to RA17)

RA16. In the last six months, how many times were you forced to have sexual relations?

- ☐ None
- ☐ One or two
- ☐ Three to five
- ☐ Six or more

RA17. Are you afraid of any current or previous male partner or someone else important to you?

- ☐ Yes → If yes, by whom? (Check all that apply.)
  - ☐ Spouse
  - ☐ Ex-spouse
  - ☐ Boyfriend/ girlfriend
  - ☐ Ex-Boyfriend/ girlfriend
  - ☐ Other family member
  - ☐ Friend/acquaintance
  - ☐ Stranger
- ☐ No

Instructions for Relationship Assessment Form

Purpose
The purpose of the Relationship Assessment Form is to identify the PCG's partner status, the involvement of the baby's biological father, the social support available to the PCG, and the extent to which the PCG has experienced intimate partner violence.

General Instructions

Whose form: The primary caregiver (PCG) form. **NOTE: If the PCG is the baby's biological father, he will respond to the questions accordingly, often responding about his own involvement with his child.**
When: The form is completed at the 4th home visit and followed-up every six months from the date of enrollment.
What: The form gathers information on partner status, father involvement, social support, and intimate partner violence.
File: This form is filed in the family folder at the program site that is providing services.

It is important that you explain to clients at enrollment into the program if you are mandated to report domestic violence. It is important to clarify if mandated reporting requirements pertain only to current incidences of violence, e.g., during this pregnancy.

To assure the protection of the client as well as yourself, complete this form with the client in private. If other family members are routinely present during visits, you may need to think of creative ways of obtaining privacy in order to complete this form, e.g., suggesting to the client that she walk you to your car or calling the client to obtain information by telephone between visits.

If you are in doubt for any reason (even just an inner red flag) about the safety of completing this form with a client, please defer doing so until you can talk with your supervisor about your concerns.

If you feel you need to have more training in domestic violence issues, be sure to discuss this with your supervisor.

Do not consider that the time when you administer this form as the only time to discuss domestic violence with your client. Domestic violence should be addressed at appropriate times during home visits.

Top Box Item Instructions

Note:
You must complete all fields listed in the top box. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create a unique ID that will link all the family forms to one ID.

First Name / Last Name / DOB: The PCG's first and last names and date of birth.

Today's Date: The date on which this form was completed by the PCG or FSW. Use mm/dd/yyyy format.

FSW Name: The first and last name of the FSW assigned to this family.

Reporting Time: Check the box indicating the appropriate time frame (PCG intake or every 6 months calculated from the enrollment date). Many program outcomes are measured over time, and this field helps to determine time sequence.

Item Instructions

RA1. Indicate whether the PCG has a partner now and the partner's gender.

RA2. If applicable, indicate whether the PCG's partner is the baby's biological father.

RA3. Indicate how often the baby's biological father has spent taking care of and/or playing with the child **during the past 6 months or since the baby's birth.** *Note: If the PCG is pregnant, this question will not be applicable.*

RA4. Indicate whether the baby's father figure or biological father participated in any activity sponsored by your home visitation program, including home visitation or other events. Note what events they participated in.

RA4a. Indicate whether the PCG would like more involvement from the biological father.

RA5. Indicate how much money the baby's biological father has provided for the PCG during a typical month. **Please write a dollar amount.** If the baby's biological father lives with the PCG, include his whole monthly income. If he has only provided material items, ask the PCG to estimate the dollar value of those items.

RA6. For each item a – f, indicate whether the PCG had the kind of help indicated during the past 6 months or the birth of the child; circle "yes" if they had it and "no" if they did not.

A number of the following items inquire about the number of times clients may have experienced a certain type of violence. Please ask the question in an open-ended manner, use the response provided by the client, and check the appropriate response option. Do not just read all the possible response options.

RA7. Check whether a partner or someone important to her has ever emotionally or physically abused the client. DO NOT SKIP THE NEXT QUESTION

RA8. Check whether someone has physically hurt the client **in the past 6 months**. If "Yes", check all people whom the client says has physically hurt her. If "No," skip to ra15. *[Note: Choking is a type of physical injury.]*

RA9. Check how many times the client has been physically hurt **in the 6 months.**

RA10. Check how many times the client says somebody slapped or pushed her **in the past 6 months.**

RA11. Check how many times the client says somebody punched, kicked or cut her **in past the 6 months.**

RA12. Check how many times the client says somebody burnt her, severely bruised her, or broke her bones **in the past 6 months.**

RA13. Check how many times the client says somebody caused her to have a head, internal, or permanent injury **in the past 6 months.**

RA14. Check how many times the client says somebody used a weapon (client's perception) to hurt her **in the past 6 months.**

RA15. Check whether the client has been forced to have sexual relations by someone **in the last 6 months** If "Yes", check all people whom the client says have forced her to have sex with them. If "No," skip to RA17.

RA16. Check how many times the client says somebody forced her to have sexual relations with them **in the last 6 months.**

RA17. Check whether the client says she is afraid of any current or previous male partner or someone else important to her. If "1-Yes", check all people whom the client says she is afraid of.

NOTE: If there are any missing responses to any non-skipped question on this form in the database, it will be assumed that the client refused to respond.

Child Well-Being Scales

PCG First and Last Name: _____ DOB (mm/dd/yyyy) ____/____/_____

Child First and Last Name: _____ DOB (mm/dd/yyyy) ___/____/_____

Today's Date (mm/dd/yyyy): _____/_____/_____ FSW Name: _____

Reporting Time: (Months from enrollment date):

☐ Baseline (After 3-5 visits) ☐ 6 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 36 ☐ 42 ☐ 48 ☐ 54 ☐ 60

☐ End of Service

Are there any children in the home? Yes ○ No ○ If so, any children under 6 years? Yes ○ No ○	

A. Overcrowding (Check the most appropriate option that applies)	
0. Unknown- unable to observe	U
1. No overcrowding- space for family completely adequate; there is sufficient space for normally private activities for all family members.	①
2. Mild overcrowding- adult(s) and children have separate sleeping areas, but boys and girls ages 6-8 years may share same bed or up to 4 children may sleep in an average size bedroom; space can be made available for personal activities (homework, reading, play, etc.).	②
3. Moderate overcrowding- adult(s) and children age 5 or older may share same bedroom, or boys and girls ages 9-12 may share same bed; there is competition for space among family members for personal activities (people "get in each other's way").	③
4. Serious overcrowding- there is no segregation of sleeping areas; children and adults of all ages may share same bed; space is inadequate to pursue essential household functions in timely manner (cooking or cleaning often can't be done; proper sleep often impossible); there is almost no space to "move around;" fights and arguments about space may be common.	④

B. Household Sanitation (Check the most appropriate option that applies)	
0. Unknown	U
1. Appropriate- generally clean and orderly; pleasant to neutral odors; articles for daily living may be around (newspapers, books, coats not hung up); dishes washed; groceries properly stored.	①
2. Mildly inadequate- untidy, dusty, minor dirt buildup; stale, stuffy odors; garbage not kept in proper receptacle; home is not picked up, things are all over (but no "piles" of trash).	②
3. Moderately inadequate- dust and dirt are layered all over; bathroom has strong smells of urine/feces; dishes only washed when no clean ones are left; sheets and towels used after becoming dirty.	③
4. Seriously inadequate- home smells overwhelmingly of urine/feces/spoilage throughout; trash and junk piled up and layered on the floor so that it is difficult to get around; dishes are not washed; family eats off dirty dishes; vermin (roaches, etc.) throughout house; family sleeps on dirty mattresses, or on sheets that are black with dirt and soil.	④
5. Severely inadequate- household exhibits many of the conditions described above under "seriously inadequate;" as a result of this poor sanitation, at least one child is physically ill (e.g., intestinal disorder, food poisoning) requiring medical treatment.	⑤

C. Home Safety/ Child Access to Hazards (Check the most appropriate option that applies)	
0. Unknown	U
1. Appropriate – There are no obviously hazardous conditions in the home (see examples below).	①
2. Mildly inadequate – There are one or two hazardous conditions in the home, but child has not sustained injury as a result.	②
3. Moderately inadequate – There are many hazardous conditions in the home, but child has not sustained injury as a result.	③
4. Seriously inadequate - There are one or two hazardous conditions in the home, and child has sustained injury as a result, which may require medical treatment.	④
5. Severely inadequate - There are many hazardous conditions in the home, and child has sustained injury as a result, which may have required medical treatment.	⑤
Examples of Hazards are: Any of the following when accessible to young children: medicine (in bottles, tubes, inhalers, liquid, etc.) that are not child proof, detergents, cleansers, polishes, waxes, alcoholic beverages, beauty products, insecticides, paints, solvents, glues, petroleum products, fertilizers, drug paraphernalia, poisonous plants, combustibles (including lighters, matches), outlets/switches (without plates), space heaters/fireplaces/ fans/etc. (without appropriate screens or other protection), plastic bags, cords from window blinds, firearms, sharp objects, balconies/steps/windows (without protection), and drowning hazards (e.g., unattended bathtubs, buckets of water, ponds, pools). In addition, the following are home hazards: frayed cords or electrical cords, broken windows, holes in the floor, structural damage to the home, exposed insulation, missing steps, manufacturing met amphetamines, other home safety problems. See Administration on Instructions for the Child Well-being Scales for additional details on hazardous conditions.	
Check the most appropriate option that applies	
Does the family have any safety devices in place (e.g., covers over outlets, child proof caps on medications)? None ○ Some ○ Most ○	
Is the neighborhood a high drug/high crime area? Yes ○ No ○ Unknown ○	
Is the house on a busy street or are there other physical characteristics of the location that would lead to concerns about a child playing outside unsupervised? Yes ○ No ○ Unknown ○ Does not apply (no child in home) ○	

D. Clothing and Hygiene (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Child is clean and adequately clothed.	①
2. Inadequate clothing or hygiene, but this does not appear to affect child's functioning.	②
3. Inadequate clothing or hygiene limits child's functioning (e.g., unable to go outdoors because of lack of clothing, isolated by peers because of hygiene or appearance).	③
4. Inadequate clothing or hygiene likely to cause illness requiring medical treatment.	④
5. Illness requiring medical treatment due to inadequate clothing or hygiene (e.g., serious infection due to poor diaper care, intestinal disorder).	⑤

Child Well-Being Scales

E. Food/Nutrition Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Regular and nutritional meals provided.	①
2. Meals irregular and often not prepared, but child's functioning is not impaired.	②
3. Meals irregular and often not prepared, child's function is impaired (e.g., child is hungry and has difficulty concentrating in class).	③
4. Inadequate food provided, there is a substantial risk that the child will suffer from malnutrition (e.g., infant given diluted formula).	④
5. Child displays clinical symptoms of malnutrition; medical attention and/or rehabilitative diet required (e.g., weight loss, anemia, dehydration, etc.).	⑤

F. Physical Health Care (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Basic medical care provided.	①
2. Preventive medical care not provided (e.g., no regular checkups).	②
3. Medical care not provided for injury or illness causing avoidable distress.	③
4. Medical care not provided for injury or illness causing avoidable distress and interfering with child's functioning (e.g., chronic absence from school due to untreated illness).	④
5. Medical care not provided for injury or illness which could lead to permanent impairment or death (e.g., infant vomiting or diarrhea leading to dehydration).	⑤

G. Mental Health Care (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Parents anticipate and respond to child's emotional needs.	①
2. Inconsistent response to emotional distress (e.g., responds only to crisis situations).	②
3. Services or treatment not provided in response to emotional distress, child at substantial risk of severe emotional or behavioral problems (e.g., anxiety, depression, withdrawal, self-destructive behavior, child under 13 engaging in criminal activity).	③
4. Services or treatment not provided in response to emotional distress, child experiencing severe emotional or behavioral problems.	④

H. Developmental and Educational Care (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Child's developmental and educational needs are met.	①
2. Child's developmental and educational needs are inconsistently met (e.g., limited infant stimulation, child could benefit from remedial help in one or two subjects, child having academic difficulties due to poor school attendance).	②
3. Services or treatment are not provided in response to identified learning or developmental problems (e.g., learning disability diagnosed but caretakers refuse remedial help).	③
4. Child has suffered or will suffer serious/permanent delay due to inattention to developmental/educational needs (e.g., Non-Organic Failure to Thrive identified but caretakers refuse medical help).	④

Child Well-Being Scales

I. Money Management (Circle the most appropriate option that applies)	
0. Unknown	U
1. Appropriate- spends available money wisely, putting needs of the children first.	①
2. Mildly inadequate- usually spends available money appropriately, putting needs of children first; tends to "run short," not due to insufficient income.	②
3. Moderately inadequate- sometimes uses poor judgment regarding spending priorities; children sometimes lack essentials that the family could afford.	③
4. Seriously inadequate- frequently recurring monetary crises due to poor judgment, not insufficient income; children regularly deprived of necessities.	④

J. Parental Cooperation with Case Planning/Services (Check the most appropriate option that applies)	
0. Unknown	U
1. Appropriate- actively involved in case planning and utilizes services and/or treatment; keeps most appointments for services recommended for children and self (parent); missed appointments are due to satisfactory reasons (e.g., illness).	①
2. Mildly inadequate- not as fully or actively involved in case planning and/or services as recommended; misses some appointment without adequate reason.	②
3. Moderately inadequate- minimally involved in case planning, services, and/or treatment; clear pattern of resistance to assistance, frequently misses appointments without adequate reason.	③
4. Seriously inadequate- actively resists any agency contact or involvement; refuses or undermines services.	④

For this measure, the identified child will be the child who the parent(s) is/are most concerned about.	
K. Supervision (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply-children out of home	○
1. Adequate; provisions made to ensure child's safety, caretaker knows child's whereabouts and activities, clear limits set on activities.	①
2. Inconsistent; child is occasionally exposed to situations that could cause moderate harm (e.g., young school-aged child occasionally left alone, parents do not monitor whereabouts of adolescent who occasionally comes home late in evening).	②
3. Inadequate; child is often exposed to situations that could cause moderate harm, or there is a possibility that child could suffer serious harm (e.g., young school-aged children often left unsupervised, or infant occasionally left alone while sleeping).	③
4. Seriously inadequate; child is often exposed to situations that could cause serious harm (e.g., abandonment, home used as "crack house," & drugs left within reach of child, child often left to wander in dangerous neighborhood, toddler often exposed to hazardous situations).	④

L. Parental Positive Interactions with Child (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- parent currently has no contact with children.	○
1. Very accepting and affectionate- frequently and appropriately uses praise and affection towards the children; frequently talks with or plays with children on topics of interest to the children.	①
2. Fairly accepting and affectionate- few if any spontaneous praise or gestures of affection, but will describe child positively if asked; sometimes talks with or plays with children.	②
3. Not affectionate, but not openly rejecting or hostile- tends to describe and speak to children in emotionless, uncaring manner; allows physical contact, doesn't push children away, but rarely responds warmly.	③
4. Openly rejecting or hostile- consistently speaks to and about children in belittling, resentful, or angry way; usually does not allow children physical contact; tries to minimize or avoid necessary, functional contacts (e.g., feeding, dressing).	④

M. Parental Discipline (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Appropriate- uses developmentally appropriate consequences when children misbehave; does not use "put-downs", name calling, or harsh criticism.	①
2. Mildly inappropriate- uses appropriate consequences for misbehavior, but children are sometimes criticized harshly or "put-down unnecessarily."	②
3. Moderately inappropriate- disapproval is primary way of disciplining children, children rarely praised or rewarded for appropriate behavior; children severely punished or harshly criticized for misconduct or often "put-down."	③
4. Severely inappropriate-excessive and severe disapproval used, children's faults and shortcomings are clearly overemphasized; harsh criticisms and severe punishments are frequent and disproportionate to actual behavior.	④

N. Parental use of Clear Rules and Limit Setting (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Appropriate rules and limit setting- clear, specific rules for the children's behavior have been set and child has been told the rules; uses developmentally appropriate limits for misbehavior; gives appropriate consequences for misbehavior; approaches child's misbehavior with a firm, but understanding, manner.	①
2. Mildly inappropriate rules and limit setting- rules about some behavior (e.g., public behavior) are given from and enforced by the caregiver; rules are not consistently enforced and are not always appropriate for the child's age or developmental level.	②
3. Moderately inappropriate rules and limit setting- some limits are set on the child's behavior; misbehavior is rarely addressed or punished; parent "gives in" to child inappropriately.	③
4. Highly inappropriate- few limits are set on the children's behavior; misbehavior is ignored even if it might endanger the child; the caregiver expresses an inability to manage the child's behavior.	④

O. Parental Expectations of Children (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. Very realistic- has good understanding of age-appropriate behaviors; gradually encourages increasingly mature behavior, but takes care not to frustrate children.	①
2. Somewhat unrealistic, but open to improvement- has fair knowledge of age-appropriate behaviors, but children sometimes held to too high or too low a standard; is open to advice and guidance.	②
3. Unrealistic - has some knowledge of age-appropriate behaviors, but children frequently held to too high or too low a standard; is indifferent or angry when children cannot comply with demands or when they attempt exploratory behaviors.	③
4. Very unrealistic- has very poor understanding of age-appropriate behaviors or makes frequent, unrealistic demands of children despite some understanding.	④

P. Parental Consistency of Discipline (Check the most appropriate option that applies)	
0. Unknown	U
0. Does not apply- children out of home	○
1. High consistency- consistently follows through on promised rewards and punishments with children; rarely contradicts herself or himself; children know what to expect; punishments fit behaviors.	①
2. Moderate consistency- does not always follow through on restrictions; sometimes will contradict herself or himself, but makes corrective efforts when inconsistencies are brought to attention; punishments usually fit behaviors.	②
3. Marginal consistency- does not always follow through on restrictions; often will contradict herself or himself; children do not know what to expect; punishments often do not fit behaviors.	③
4. Low consistency- often reacts indiscriminately or inconsistently to children's behavior; punishments typically do not fit behavior.	④

Q. Parental Mental Health-Drug Use (Check the most appropriate option that applies)	
CCM-Please rate this based on your impressions, observations, and interactions with the family.	
0. Unknown	U
1. No drug use suspected.	①
2. Drug use suspected of others in the home.	②
3. Drug use of primary caregiver suspected.	③
4. Drug use of primary caregiver known in the past (reason for referral).	④
5. Primary caregiver is currently abusing drugs.	⑤
Check the most appropriate option that applies	
Has primary caregiver been referred for drug treatment? Yes ○ No ○	
Is primary caregiver currently in treatment for drug use? (NA meetings count as treatment.) Yes ○ No ○	
Is the primary care giver's drug use affecting child supervision, parenting skills or time spent with child? Unknown ○ Yes ○ No ○	

R. Parental Mental Health-Alcohol Use (Check the most appropriate option that applies)	
CCM-Please rate this based on your impressions, observations, and interactions with the family.	
0. Unknown	U
1. No alcohol use suspected.	①
2. Alcohol abuse suspected of others in the home.	②
3. Alcohol abuse of primary caregiver suspected.	③
4. Alcohol abuse of primary caregiver known in the past (reason for referral).	④
5. Primary caregiver is currently abusing alcohol.	⑤
Check the most appropriate option that applies	
Has primary caregiver been referred for alcohol treatment? Yes ○ No ○	
Is primary caregiver currently in treatment for alcohol use? (AA counts as treatment.) Yes ○ No ○	
Is the primary care giver's alcohol use affecting child supervision, parenting skills or time spent with child? Unknown ○ Yes ○ No ○	

S. Parental Distress (Check the most appropriate option that applies)	
CCM-Please rate this based on your impressions, observations, and interactions with the family.	
0. Unknown	U
1. Primary caregiver appears to be coping well and handles everyday stress and unexpected events in an appropriate manner.	①
2. Primary caregiver shows mild level of distress (mild symptoms, some difficulties in home or work, but generally functioning well).	②
3. Primary caregiver shows moderate level of distress (moderate symptoms, disruptive functioning in more than one area).	③
4. Primary caregiver shows severe level of distress (distress is debilitating and interferes with functioning at home, work, and the community).	④
Check the most appropriate option that applies	
Has primary caregiver been referred for individual treatment? Yes O No O	
Is primary caregiver currently in individual treatment for depression or anxiety or other mental health problems? Yes O No O	
Is primary caregiver currently prescribed medication for a mental health related problem? Yes O No O	

T. Caregiver-Partner - Conflict (Check the most appropriate option that applies)	
0. Unknown	U
1. Caregiver and partner resolve issues well. No concerning areas of conflict.	①
2. Minor difficulties with resolving conflict.	②
3. Conflict becomes heated at times or chronic low level conflict occurring	③
4. Domestic disputes/Conflict in the home is severe enough to cause minor harm to or fear in family members.	④
5. Caregiver and/or child have been harmed by or are experiencing significant fear associated with domestic violence in last month.	⑤

U. Caregiver-Partner – Control Issues (Check the most appropriate option that applies)	
0. Unknown	U
1. Balance of power adequate between caregiver and partner.	①
2. Caregiver or partner exhibits more power/control in the relationship than the other.	②
3. Caregiver or partner has been controlling that has caused restrictions in the other's choices, behaviors, and options.	③
4. Level of control partner/caregiver has caused minor problems for caregiver or family members.	④
5. Caregiver and/or child have been harmed by or are experiencing fear associated with power and control issues.	⑤
Check the most appropriate option that applies	
Has domestic violence been an issue for any of the caregivers in the family in the past? Yes O No O	
Has a caregiver been referred for domestic violence services? Yes O No O	
Has the caregivers followed up with domestic violence services? Yes O No O	

V. Caregiver Communication Skills (Check the most appropriate option that applies)	
0. Unknown	U
1. Caregiver has positive communication skills with others. Feelings are expressed in a calm way. Problems are addressed with problem solving skills.	①
2. Minor difficulties with communication noted.	②
3. Caregiver has difficulties communicating effectively routinely with others.	③
4. Primary caregiver has had frequent verbal arguments with others. This has caused problems for the family (e.g., loss of friendships, loss of jobs). Legal intervention has not occurred.	④
5. Primary caregiver has been in trouble with the law or had other major problems due to poor conflict resolution skills and aggressive behaviors.	⑤

W. Family Involvement in Services (Check the most appropriate option that applies)	
Was anyone else in the home/family other than the primary caregiver involved in services? **Yes** ○ **No** ○	
If **yes**, specify the relationship of the person involved to the primary caregiver? (Check all that apply)	
1. Spouse/Partner	○
2. Adult Child (ren)	○
3. Parents/Step parents	○
4. Brother/Sister	○
5. Grand Parents	○
6. Aunt/Uncle	○
7. Cousin	○
8. Friend (s)	○
9. Other (Specify) _____	○

Administration Instructions for the Child-Well Being Scales-Revised

*This measure is to be filled out by the home visitor for the family and the identified child, and the rating should reflect the answer that **BEST** describes the family or the home environment **right now**.*

This measure relies on the observation of many things, and therefore it would be best to be completed after a month or four home visits.

Before completing this measure, it is important that the home visitor becomes very familiar with all of the categories so s/he will know what to look for in the home.

A. OVERCROWDING

This scale examines the amount of available living space in relation to family size, privacy needs, sleeping arrangements for older children of the opposite sex, space to complete daily tasks, and room for all of the furniture a family of that size would need (e.g., not having a table to eat on because there isn't room for it).

B. HOUSEHOLD SANITATION

This scale examines the cleanliness of the home. It includes orderliness, amount of dust, garbage present, storage of perishable foods, cleanliness of bathroom and kitchen, and the presence of vermin.

C. HOME SAFETY/ACCESS TO HAZARDS

This scale examines physically dangerous conditions in the home, taking into account the number of dangerous conditions and whether or not a child has been injured as a result. Additional yes/no questions were added to assess the relative danger of the neighborhood related to drugs/crime and proximaty to major roads, etc.

D. CLOTHING AND HYGIENE

This scale measures the child(ren)'s clothing and cleanliness. For clothing, factors considered are amount, condition, and appropriateness (in terms of weather and age). Hygiene factors include cleanliness of body, hair, and teeth.

E. FOOD/NUTRITION

This scale asks specifically about the quantity and quality of food available to the children in the family and the health consequences of inadequate nutrition. This scale is not meant to imply that parents are being deliberate in not providing adequate food, but rather is meant to assess the current situation for the child(ren).

F. PHYSICAL HEALTH CARE

This scale assesses the adequacy of physical health care (and not physical health itself). Specifically, if an illness or injury occurred, is proper health care provided to prevent possible health consequences.

G. MENTAL HEALTH CARE

This scale assesses the adequacy of mental health care, taking into account the consequences of not providing this care.

H. DEVELOPMENTAL AND EDUCATIONAL CARE

This scale examines the degree to which the child(ren)'s developmental and educational needs are being addressed, in that young children at home are being adequately stimulated and children attending school are receiving any special services that they may require.

I. MONEY MANAGEMENT

This scale refers to the ability of the parent(s) to manage their income, including both budgeting and borrowing. A family on welfare may be managing their money well and still not be able to meet all of their needs. In this situation, money management skills would be adequate, although their income is not.

J. PARENTAL COOPERATION WITH CASE PLANNING/SERVICES

This scale looks at the parent(s)' behavior regarding planning and complying with OCS and other services, specifically how well they keep appointments, actively participate in case planning, making the maximum use of services offered, and adhering to the treatment plan.

K. SUPERVISION

This scale examines the amount and the quality of attention that is given to children when they are engaged in play or social activities. Factors considered in this category include location, characteristics of the child (e.g., age), parental concern or awareness of the activity that the children are engaged in, the potential for harm or danger in the act, and if actual injury occurred that can be attributed to poor supervision.

L. PARENTAL POSITIVE INTERACTIONS WITH THE CHILD

This scale examines the parent-child interaction, specifically at the presence of or lack of positive behaviors in the relationship. Specific behaviors to look for include praises, nonverbal signs of affection (pats on the head or back, hugs) frequency of discussions and playtime with children, and the lack of openly rejecting behavior.

M. PARENTAL DISCIPLINE

This scale examines how parents enforce rules and correct children's behavior. It addresses using appropriate consequences versus criticizing the child and being overly harsh in punishment.

N. PARENTAL USE OF CLEAR RULES AND LIMIT SETTING

In contrast to the "Parental Discipline" scale, this scale measures the level of limit setting versus permissiveness of parents. In other words, are clear, consistent limits set, or are there few rules or rules that are not enforced.

O. PARENTAL EXPECTATIONS OF CHILDREN

This scale focuses on the behavioral demands that the parent(s) places on the children based on their developmental level.

P. PARENTAL CONSISTENCY OF DISCIPLINE

This scale examines the extent to which parents are able to maintain a set pattern of discipline for the children. Factors considered include the children's understanding of the rules and consequences and the caregivers' follow through with rewards and punishments.

Q. PARENT MENTAL HEALTH - DRUG USE

This scale examines the HOME VISITOR's impression of the primary caregiver's possible difficulty with drug use and/or addiction.

R. PARENT MENTAL HEALTH - ALCOHOL USE

This scale examines the HOME VISITOR's impression of the primary caregiver's possible difficulty with alcohol use and/or addiction.

S. PARENT MENTAL HEALTH - PARENTAL DISTRESS

This scale examines the HOME VISITOR's impression of the primary caregiver's possible difficulty with depression, adjustment problems, or other mental illness.

T. DOMESTIC VIOLENCE

This scale assesses whether domestic violence is present in the home or is a significant issue for the family.

Tips for Completing the Child Well-Being Scales

Scales A, B, C, and **D** can be completed as a result of the **direct observation of the home and the family.**

A. OVERCROWDING

- Observe the home environment, type and amount of furniture, etc., how many bedrooms, etc.
- May have to directly ask about the sleeping arrangements: "Where do your children sleep?" "Who shares a bed?"
- Other questions may also be helpful: "Where do the children play?" "Where do the children do their homework?" "Where does _____ do (any other activity that the family may have)?"

B. HOUSEHOLD SANITATION

- Look at the amount of dust, garbage, and clutter in the home. Is this consistent across visits?
- Pay attention to any odors within the home.
- If you don't readily have a chance to observe the bathroom, make sure that you go and see it during one of the visits to the home.

C. HOME SAFETY/ACCESS TO HAZARDS

- Look around the home for the hazards and dangerous conditions listed on the CWBS item C.
- During your visits, you should investigate whether or not hazardous materials are stored under the sink or in other places that young children can reach.
- Obviously, other items may also be considered hazardous that are not included in the list of examples. Please include other items/situations that you encounter as hazardous in your rating and do not limit it to the items listed.
- Please also answer the three additional questions with regards to safety devices, neighborhood conditions, and other outside dangers.

D. CLOTHING AND HYGIENE

- Observe the condition of the child(ren)'s clothing and cleanliness.
- Cleanliness of the clothes is not necessarily a factor if this is due to not having enough changes of clothes or easy access to a means to washing the clothes, which is more a sign of poverty than neglect. Of course, extremely dirty clothes or clothes that have urine or excrement on them would be considered as inadequate.
    - Issues related to clothing include if involvement in normal activities is hindered and/or when the clothes do not offer adequate protection from the elements.
- Issues related to hygiene include body odor, tooth decay or chronic bad breath, and complaints of others (like the school).

PLEASE NOTE: A CHRONIC PROBLEM WITH LICE SHOULD BE CONSIDERED HERE.

Scales E through **J** can be answered through observation of the interaction with the parent(s) in the first few visits, and some direct questioning. CAREFUL CONSIDERATION TO UNDERSTAND WHAT IS CULTURALLY NORMATIVE AND ACCEPTABLE BEHAVIORS TO ILLUSTRATE THESE POINTS.

E. FOOD/NUTRITION

- Will require some questioning about meals.
- If child is in school or daycare, inquire about meals. "Does your child get meals provided at daycare/school?" Ask about a "typical day" and specifically ask about mealtimes: "What do you typically serve for breakfast/lunch/dinner?"

F. PHYSICAL HEALTH CARE

- Questions related to doctors and health care will be helpful to complete this scale. Information from the referral may also be important.

G. MENTAL HEALTH CARE

- Questions related to doctors and health care will be helpful to complete this scale. Information from the referral may also be important.

H. DEVELOPMENTAL AND EDUCATIONAL CARE

- Ask about school and any IEP plans that the child may be on or any special needs of the child in school.

I. MONEY MANAGEMENT

- Ask about the family's monthly bills and expenses and how decisions are made. Start with, "Tell me about your monthly budget." Follow up with questions such as "What bills do you pay first?" "Are you overdue on any bills?" "How do you pay for food? For clothes? For …?"
- You will need to determine if the family is trying to live beyond their means. Some families will not be able to make ends meet on their salary/income, and this is not in itself a sign of poor money management. The key is how they decide to manage the little money that they have.

J. PARENTAL COOPERATION WITH CASE PLANNING/SERVICES

- Observe your interaction with the parent(s). Have appointments been missed? Does the parent(s) ask questions or ask for help in specific areas?

Please consider only the identified child Many of these items can/should be observed. It also may be helpful to ask questions to get at attitudes towards discipline strategies and consistency (e.g., "How would you describe a good parent?" "What do you do well as a parent?" "How do you respond when your children misbehave?")

K. SUPERVISION

- Direct observations during the visit…where are the children while you are meeting with the parent? How often does the parent check on the children?
- Ask questions about children visiting friends, going out on their bikes, etc. Often can get at issues about children being left alone by asking the parent to describe a "typical day" and probes to see where the children are and who they are with when the parent(s) are not home.

L. PARENTAL POSITIVE INTERACTIONS WITH CHILD

- Observe parents verbal and nonverbal interactions with the child
- "How would you describe your child?"

M. PARENTAL DISCIPLINE

- "How do you respond when your child misbehaves?' and "Give an example of a typical discipline situation with your child."
- Observe situations in the home during your visit(s).

N. PARENTAL USE OF CLEAR RULES AND LIMIT SETTING

- Observe interactions and limits that parent(s) set during the visit. Are the limits appropriate given the child's age and cognitive/developmental level?
- Does the parent follow through on consequences? For example, if the parent told the child "If you come out here again, no snack later" and then the child comes out and the parent continues to issue the warning, or later gives the child a snack, the parent has not followed through on the discipline.
- Ask about any house rules and how they are enforced.

O. PARENTAL EXPECTATIONS OF CHILDREN

- Use information gathered for "clear rules and limit setting" and discussion of children to get a sense if parent(s) have a good understanding of developmentally appropriate behaviors and responsibility.

P. PARENTAL CONSISTENCY OF DISCIPLINE

- Direct observation of the family; any stories you hear about discipline in the family.
- Questions about discipline and consistency; "How do you respond when your child misbehaves?' and "Give an example of a typical discipline situation with your child."

Scales Q through **T** deal with the primary caregiver's mental health, specifically drug and alcohol use and depression.

Q. PARENT MENTAL HEALTH - DRUG USE

- HOME VISITOR gives impression of caregiver's functioning in this area and current involvement in treatment. Also, information about whether or not their drug use is impacting supervision and parenting of their children is requested.

R. PARENT MENTAL HEALTH - ALCOHOL USE

- HOME VISITOR gives impression of caregiver's functioning in this area and current involvement in treatment. Also, information about whether or not their alcohol use is impacting supervision and parenting of their children is requested.

S. PARENT MENTAL HEALTH - PARENTAL DISTRESS

- HOME VISITOR gives impression of caregiver's functioning in this area and current involvement in treatment.

T. CAREGIVER-PARTNER-CONFLICT

- The Home Visitor is asked to assess the extent that there is conflict between the caregiver and her partner.

U. CAREGIVER-PARTNER – CONTROL ISSUES

- The Home Visitor is asked to assess the extent that the partner is controlling in the relationship, such that the caregiver's friendships, outings, finances, etc. is being controlled by her partner.

V. CAREGIVER COMMUNICATION SKILLS

- The Home Visitor is asked to assess the communication skills of the caregiver. This assesses how much the caregiver is able to communicate well with others in their life so that

W. FAMILY INVOLVEMENT IN SERVICES

Family Support Plan (FSP)

PCG's Name:_____ DOB: (mm/dd/yyyy) ____/____/_____

Family Strengths:_____

	Goals	Action Steps; Tasks to be accomplished	Outcome/Date
Child Goals			☐ Completed Date:_____ ☐ Continued Date:_____ ☐ Not Relevant Date:_____
Family Goals			☐ Completed Date:_____ ☐ Continued Date:_____ ☐ Not Relevant Date:_____

Directions: Create 1st FSP within 45 days of enrollment which is from the day the PCG intake form was completed. Renegotiate FSP every six months.

Date FSP Due (initial FSP only)	**Date FSP Completed and Updated**	**FSP On Time?**
PCG Intake Date: ___ /___ /____	Completed Date: ___ /___ /____	_____ Yes _____ No
FSP Due Date: ___ /___ /____	6 Month Update: ___ /___ /____	If no, reason: _____

Primary Caregiver Signature:_____ Date:_____

FSW Signature:_____ Date:_____

Reviewed By Supervisor :_____ Date:_____

Plan de Apoyo Familiar (FSP, por sus siglas en inglés)

Nombre del(la) PCG:_____ DOB: (mm/dd/aaaa) ____/____/_____

Destrezas/Virtudes de la Familia:_____

	Metas	Pasos de Acción; Tareas a lograr	Logro/Fecha
Metas del Niño			☐ Completado Fecha:_____ ☐ Continuado Fecha:_____ ☐ No Relevante Fecha:_____
Metas de la Familia			☐ Completado Fecha:_____ ☐ Continuado Fecha:_____ ☐ No Relevante Fecha:_____

FSW— Trabajador de Apoyo Familiar
DOB— Fecha de Nacimiento

Instrucciones: Crear el 1er FSP a los 45 días de inscribirse, el cual es el día en que completó la forma inicial de PCG. Renueve el FSP cada seis meses.

Fecha de Vencimiento del FSP (FSP inicial únicamente)	**Fecha de Completado y Actualización del FSP**	**¿FSP a Tiempo?**
PCG Fecha de Inicio: ____ /____ /_____	Fecha de Completado: ____ /____ /_____	_____ Si _____ No
FSP Fecha de Vencimiento: ____ /____ /_____	6 Mes de actualización:____ /____ /_____	Si es No, razón:_____

Firma de la Persona Encargada del Cuidado:_____ Fecha:_____

Firma del FSW:_____ Fecha:_____

Revisado por Supervisor:_____ Fecha:_____

PCG— Persona Encargada del Cuidado
FSP— Plan de Apoyo Familiar

Family Support Plan (FSP)
Form Instructions

Initial or Follow-up FSP

- The Family Support Worker (FSW) will complete the plan in partnership with the family by providing the following information:
  - Primary caregiver's (PCG's) first and last name
  - Primary caregiver's (PCG's) date of birth (mm,dd,yyyy)
  - *Family Strengths* (with input from the family)
  - Starting from the left side record:
    - *Goals* in column one
    - *Action Steps* in column two
    - *Outcome/Date* in column three
      Choose one:
      -Date the goal was completed; or
      -Date it was decided the goal will be continued on the next FSP; or
      -Date it was decided the goal is no longer relevant and a new goal will be chosen for the next FSP.

  - **Reminder**: Make sure there is at least one goal for the identified child and one goal for the family.
  - **Reminder**: It's important to help the family set realistic goals. When setting goals it is important to consider the *mission.* What specifically does the family want to accomplish?
  - **Reminder**: When writing a goal, think about how the family will know it has been achieved or accomplished. How will you *measure* success?
  - **Reminder**: Include *mini* steps for each goal. Make each step small and achievable in a short period of time. The action steps guide the family helping them know what needs to be done step-by-step in order to accomplish the goal. When action steps are completed, acknowledge and celebrate the family's efforts.

  - *Date FSP Due*: This section is only required for the initial or first FSP.
    - Document the date the PCG Intake Form was completed which is the date of enrollment.
    - Document the date the initial FSP is due. The first plan needs to be in place 45 days after the enrollment which is the date the PCG Intake form was completed.
  - *Date FSP Completed and Updated*:
    - Document the date the FSP was actually completed.
    - Document the date when the next FSP is due. Follow-up FSP's need to be completed every 6 months.
  - *FSP on Time?*
    - Document if the FSP was completed by the date it was due.
    - If it was late, document the reason.
  - The PCG should sign and date the plan.
  - The FSW should sign and date the plan.

After the Visit

- Once the plan has been completed the FSW should take the plan back to the office and copy it.
    - At the next home visit, the FSW should take the family a copy of the plan.
    - The FSW should be sure the Supervisor has had an opportunity to review the plan.
    - The FSW should place the original support plan in the family file folder.
- Ask about the family's progress on at least one of their goals during every home visit. Document on the home visitation progress notes.

Supervisor Responsibility

- Review the plan making sure the goals -
    - Specify the family's mission or what they want to accomplish;
    - Include steps that are small and achievable in a short period of time;
    - Are stated in such a way that success is measureable.
- The Supervisor should sign and date the plan
- The original support plan should remain in the family file folder.

Closing Out The Plan

- Within six months, record the outcome of the goals in column three.
- Document and date the outcome by marking one of the following:
    - *Completed* -The date the goal was achieved.
    - *Continued* – The goal will be transferred to next FSP.
    - *Not relevant* – The goal is not relevant to the current situation and the family no longer wants to continue working on the goal.
- Record detailed outcome information in the home visitation progress notes.
- Place the original copy (white form) in the family file folder.
- Give a copy of the completed form to the family. Now the family has the entire support plan with the goals on the left side and the achievements on the right.
- Use the completed Family Support Plan to help guide the family in the development of the next FSP.

IDENTIFIED CHILD HEALTH FORM

PCG First Name: _____Last Name: _____ DOB (mm/dd/yyyy): ____/____/_____

Child First name: _____Last Name: _____ DOB (mm/dd/yyyy): ___/____/_____

Today's Date (mm/dd/yyyy): ___/___/_____FSW Name: _____

Time Frame: ☐Birth/Enrollment ☐6 ☐12 ☐18 ☐24 ☐30
(Child's age in months) ☐36 ☐42 ☐48 ☐54 ☐60 ☐66 ☐72

1. Does your child currently have health insurance?
☐ Yes ☐ No

2. What kind of health insurance?
☐ Private insurance
☐ Indian (I.H.S.)/Tribal Health service
☐ Other, specify: _____
☐ Medicaid/SoonerCare
☐ Military

3. Where do you usually take your child for routine check-ups (well-child care)?
☐ My child sees a health care provider only when s/he is sick
☐ Private doctor's office
☐ Hospital Clinic
☐ Hospital emergency room
☐ Health Department
☐ Community or free clinic
☐ Indian/Tribal Health service (HIS)
☐ Military facility
☐ Other: _____

4. **Most of the time**, where does your child go for care when he/she is sick? **(Check one.)**
☐ My child has not needed sick care
☐ Private doctor's office
☐ Hospital clinic
☐ Hospital emergency room
☐ Health department
☐ Community /free clinic
☐ Indian /Tribal Health Service (HIS)
☐ Military facility
☐ Other: _____

5. Has a health care provider ever said that your child has any of the following conditions?
Check Yes (Y) or No (N) for each.

1. Asthma	☐ Y	☐ N	6. Poor eye sight	☐ Y	☐ N
2. Croup, bronchitis, bronchiolitis	☐ Y	☐ N	7. Poor hearing	☐ Y	☐ N
3. Pneumonia	☐ Y	☐ N	8. Baby bottle tooth decay	☐ Y	☐ N
4. Developmental delay	☐ Y	☐ N	9. Other tooth decay / cavities	☐ Y	☐ N
5. Anemia (low blood iron)	☐ Y	☐ N	10. Lead poisoning	☐ Y	☐ N

6. Are your child's shots (immunizations) up-to-date? ☐ Yes ☐ No

7. How many hours per day, on average, is your child in the same room or car with someone who is smoking? (Please include time your child spends with baby-sitters, relatives, or anyone else who smokes)
☐ None
☐ 1 - 3 hours
☐ 4 – 6 hours
☐ 7 – 10 hours
☐ More than 10 hours a day

8. Which of the following statements best describes the rules about smoking *inside* your home?

- ☐ No one is allowed to smoke anywhere inside my home
- ☐ Smoking is allowed in some rooms or at some times
- ☐ Smoking is permitted anywhere inside my home

Ask item #9, 10, 11, and 12 for children less than 2 years:

9. Did you ever breastfeed or pump breast milk to feed the baby after delivery?

☐ Yes ☐ No (If no, skip to 11)

10. What were your reasons for not breastfeeding your baby? **(Check all that apply.)**

- ☐ I had too many household duties
- ☐ I didn't like breastfeeding
- ☐ I was embarrassed to breastfeed
- ☐ I went back to work or school
- ☐ I couldn't afford/ didn't have access to an effective pump
- ☐ My husband or partner didn't want me to breastfeed
- ☐ Other: _____

11. How old was your child when you introduced foods other than breast milk?
(Other foods include formula, cereal, baby food, juice, and cow's milk etc.)

- ☐ _____ months old
- ☐ Less than one month old
- ☐ I have not yet introduced any other food **(Skip to 17.)**

12. Until what age was your baby fed exclusively breast milk (no formula, cereal or other foods)?

_____ Weeks **OR** _____ Months

13. How much juice does your child drink each day? (One cup equals eight ounces)

- ☐ None
- ☐ Less than 1 cup
- ☐ 1 cup
- ☐ 2 cups
- ☐ 3 cups
- ☐ 4 or more cups

14. How much milk does your child drink each day? (One cup equals eight ounces)

- ☐ None
- ☐ Less than 1 cup
- ☐ 1 cup
- ☐ 2 cups
- ☐ 3 cups
- ☐ 4 or more cups

15. How much fruit does your child eat each day? (One cup equals two servings)

- ☐ None
- ☐ 1 serving
- ☐ 2 servings
- ☐ 3 servings
- ☐ 4 servings
- ☐ 5 or more servings
- ☐ More than 5 servings

16. How many vegetables does your child eat each day? (One cup equals two servings)

- ☐ None
- ☐ 1 serving
- ☐ 2 servings
- ☐ 3 servings
- ☐ 4 servings
- ☐ 5 servings
- ☐ More than 5 servings

Ask item # 17 and 18 for children one year or older:

17. On how many of the *past 7 days*, did your child participate in at least 20 minutes of physical activity, such as walking, going to the park, playing soccer, or running?

☐ None
☐ 1 – 2 days
☐ 3 – 4 days
☐ 5 – 6 days
☐ 7 days

18. On an *average weekday,* how many hours does your child spend watching TV, playing computer games, surfing the internet, or playing video games?

☐ None
☐ One hour or less per day
☐ 2 - 3 hours per day
☐ 4 – 5 hours per day
☐ 6 hours or more per day

19. What is the average number of hours per week that your child stays in child/daycare?

☐ My child is not in child/day care → Skip to CH22
☐ 1-9 hours/week
☐ 10-19 hours/week
☐ 20-29 hours/week
☐ 30-39 hours/week
☐ 40 hours or more per week

20. Is the child/ day care facility licensed?
(Child/ day care facility includes day care center and day care home)

☐ Yes ☐ No (If no, skip to 22)

21. What is the DHS star rating of the child/day care facility being used?

☐ 3 star
☐ 2 star
☐ 1 star plus
☐ 1 star

Ask item # 22 and 23 for children 6 months and older:

22. In the past 6 months, how many times have you taken your child to the hospital emergency room/urgent care center? _____

How many of those visits were for: Illnesses or infections_____

Injuries or ingestions _____

Accidents or poisonings _____

23. During the past 6 months, how many times has he/she been admitted to the hospital (that is, had to spend at least one night there)? _____

How many of those admissions were for: Illnesses or infections_____

Injuries or ingestions _____

Accidents or poisonings _____

Instructions for Indentified Child Health Form

Purpose
The purpose of this form is to gather information on changes in health insurance coverage, and child's general health, maternal breastfeeding, nutrition, physical activity, exposure to cigarette smoking; visits to emergency room/urgent care centers, and hospitalizations over time. This helps track child health and development outcomes in the program.

General Instructions

Whose form: The child's form. For multiple children, there should be one form completed for each multiple.
When: The form is completed 2 months from birth/enrollment and followed-up every 6 months according to the child's age.
What: Collects data on factors related to the child's health such as health insurance coverage, health conditions, health status, injuries, illnesses, ingestions, nutrition, exercise and exposure to cigarette smoke.
File: This form is filed in the family folder at the program site that is providing services.

Top Box Item Instructions

Note:
You must complete all fields listed in the top box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Identified Child Birth Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the top box will be used to create a unique ID that will link all the family forms to one ID.

PCG First Name / Last Name / DOB: The PCG's first and last names and date of birth.

Child First Name / Last Name / DOB: The Child's first and last names and date of birth.

Today's Date: The date on which the Child Health form was completed. Use mm/dd/yyyy format.

FSW Name: The first and last name of the FSW assigned to this family.

Reporting Time: Check the box indicating the appropriate time frame (Child birth/ enrollment or every 6 months calculated from the child's birth date). Many program outcomes are measured over time, and this field helps to determine time sequence.

Item Instructions

1. Indicate whether the child currently has health insurance (any type of health insurance, including private insurance, Medicaid, SoonerCare, etc.). If the child does not have any health insurance, skip to 3.

2. Read each type of insurance to the PCG and check those type of insurance which s/he says the child has.

3. Indicate where the PCG says s/he takes the child most often for routine well-child visits.

4. Indicate where the PCG says s/he takes the child most often for care when the child is sick.

5. Read the list of health conditions to the PCG and, for each, check whether a health care provider has ever said that the child has that condition. If Yes, check "Y" and if No, check "N."

6. Based on the FSW's assessment, check if the child is on schedule for recommended immunizations. If the child received a series of shots within the recommended age range, then the immunizations are current. If the child was outside the recommended age range when the shot was received or the shot was not given in the month it was due, then the child's immunizations are not current.

7. Indicate how many **hours per day**, on average, the child is in the same room or car with someone who is smoking.

8. Record the PCG's response to the statement that best describes the rules about smoking inside her/his home.

Ask item 9, 10, 11 and 12 only when the child is less than 2 years of age.

9. Record whether the mother of the child ever breast fed or pumped milk for the baby after delivery. If not, check "Yes" and skip to 11.

10. Record all the reasons that the PCG says are reasons she did not breastfeed her new baby. If she has a reason not in the list, check "Other" and describe using the PCG's words.

11. Record the child's age, if the PCG says that the child has been introduced to any other food than breast milk. If any other food has not been introduced yet, then skip to 17.

12. Record until what age the baby was fed exclusively breast milk, in weeks or months, rounding to the nearest whole figure.

13. Indicate the number of cups of juice that the PCG indicates the child drinks every day.

14. Indicate the number of cups of milk that the PCG indicates the child drinks every day.

15. Indicate the amount of fruit that the PCG indicates the child eats every day. (One cup equals two servings)

16. Indicate the amount of vegetables that the PCG indicates the child eats every day. (One cup equals two servings)

Ask item 17 and 18 only when the child is 1 year of age or older.

17. Using the time frame of the past seven days, indicate whether the PCG says that the child participated in physical activity for at least 20 minutes.

18. Record the number of **hours per day** that the PCG says the child spends in front of the TV or computer screen on an average weekday.

19. Record the average number of **hours per week** that the PCG says the child stays in child/daycare. If child is not in daycare, skip to 22.

20. Indicate if the PCG says the child/daycare facility is DHS licensed. If no, skip to 22.

21. Indicate PCG's response to the DHS star rating of the child/daycare facility being used.

Ask item 22 and 23 only when the child is 6 months of age or older.

22. Using the time frame of the past six months, indicate the number of times the child was taken to the ER. Specify the number of visits for illness or infections, injuries or ingestions; accidents or poisonings.

23. Using the time frame of the past six months, indicate the number of times the child was admitted to the hospital. Specify the number of admissions for illness or infections, injuries or ingestions; accidents or poisonings.

24. Please indicate which well-child visit you are reporting on.

25. Please indicate if you completed the visit.

IMMUNIZATION FORM

PCG First Name: _____Last Name: _____ DOB (mm/dd/yyyy): ____/____/_____

Child First name: _____Last Name: _____ DOB (mm/dd/yyyy): ___/____/_____

Today's Date (mm/dd/yyyy): ___/____/_____ FSW Name:_____

Instructions to FSW: Please indicate whether the child has or has not received each vaccine dose by checking "Yes" or "No" for each vaccine dose. If the child received a dose since the last time this form was completed, indicate the date given.

IM1. What was your source of information about the child's immunization status today? (Check one.)

☐ Written Record ☐ OSIIS
☐ Mother's self-report ☐ Other: _____

Vaccine	Dose		Date
IM2. Diptheria, Tetanus, Pertussis (DtaP)	**Yes**	**No**	**Date Given** (mm/dd/yyyy)
Has the child received Dose 1?	☐	☐	_____/_____/_____
Has the child received Dose 2?	☐	☐	_____/_____/_____
Has the child received Dose 3?	☐	☐	_____/_____/_____
Has the child received Dose 4?	☐	☐	_____/_____/_____
Has the child received Dose 5?	☐	☐	_____/_____/_____
Recommended schedule: 1st dose @ 2 mos.; 2nd dose @ 4 mos.; 3rd dose @ 6 mos.; 4th dose @ 15-18 mos.; 5th dose @ 4-6 years			
IM3. Hepatitis (HepB)	**Yes**	**No**	**Date Given** (mm/dd/yyyy)
Has the child received Dose 1?	☐	☐	_____/_____/_____
Has the child received Dose 2?	☐	☐	_____/_____/_____
Has the child received Dose 3?	☐	☐	_____/_____/_____
Recommended schedule: 1st dose @ birth.; 2nd dose @ 2 months; 3rd dose @ 6-18 months.			
IM4. H. Influenza type b (Hib)	**Yes**	**No**	**Date Given** (mm/dd/yyyy)
Has the child received Dose 1?	☐	☐	_____/_____/_____
Has the child received Dose 2?	☐	☐	_____/_____/_____
Has the child received Dose 3?	☐	☐	_____/_____/_____
Has the child received Dose 4?	☐	☐	_____/_____/_____
Has the child received PedvaxHIB or ComVax*?	☐	☐	_____/_____/_____
Recommended schedule: 1st dose @ 2 mos.; 2nd dose @ 4 mos.; 3rd dose @ 6 mos.; 4th dose @ 12-15 mos. (* If PedvaxHIB or ComVax (Merck) is administered at 2,4, &, 12 mos.; a dose @ 6 mos. is not required)*			
IM5. Inactivated Polio (IPV)	**Yes**	**No**	**Date Given** (mm/dd/yyyy)
Has the child received Dose 1?	☐	☐	_____/_____/_____
Has the child received Dose 2?	☐	☐	_____/_____/_____
Has the child received Dose 3?	☐	☐	_____/_____/_____
Has the child received Dose 4?	☐	☐	_____/_____/_____
Recommended schedule: 1st dose @ 2 months; 2n dose @ 4 months; 3rd dose @ 6-18 months; 4th dose @4-6 years.			
IM6. Measles, Mumps Rubella (MMR)	**Yes**	**No**	**Date Given** (mm/dd/yyyy)
Has the child received Dose 1?	☐	☐	_____/_____/_____
Has the child received Dose 2?	☐	☐	_____/_____/_____
Recommended schedule: 1st dose @ 12-15 mos.; 2nd dose @ 4-6 years.			
IM7. Varicella (Var)	**Yes**	**No**	**Date Given** (mm/dd/yyyy)
Has the child received Dose 1?	☐	☐	_____/_____/_____
Recommended schedule: 1st dose @ 12-18 mos.			
IM8. Hepatitis A (HepA)	**Yes**	**No**	**Date Given** (mm/dd/yyyy)
Has the child received Dose 1?	☐	☐	_____/_____/_____
Has the child received Dose 2?	☐	☐	_____/_____/_____
Recommended schedule: 1st dose @ 12-23 months; 2nd dose 6 months after 1st dose.			

Instructions for PAT Immunization Form

Purpose

The Immunization Form collects information on immunizations that the child has received for the purpose of describing the immunization status of children participating in PAT programs.

General Instructions

- **Whose form:** The child's form
- **When:** Administer this form following the immunization schedule. It should be completed at least at the first visit postpartum and when the child is 2 months, 4 months, 6 months, 15 months, and 18 months old.
- **What:** The form gathers information on the immunizations that the child receives.
- **File:** This form is filed in the family folder at the PAT program site that is providing services.

Item Instructions

IM1: Immunizations

Indicate where the source of information was obtained 1-written shot record, 2-mothers report, 3-OSIIS reports, 4-other. Written documentation is the preferable choice.

Vaccine, Dose, Date Given: If there is written documentation, copy the information completely onto the form. If there is another source available to complete the information other than the mother's self report, please use that source. Date given is extremely important in later data analysis to verify that the child was on schedule per shot, per series, or per recommended immunizations.

For each immunization dose, please check "Yes" if the child has received it and "No" if the child has not. Thus, every time this form is submitted for data entry, there should be a "Yes" or "No" checked for each vaccine dose on the page. For responses with a "Yes," record the date that the child received that dose of the vaccine.

Recommended Immunization Schedule	Dose	Child's Age
DtaP (Diphtheria, Tetnus, Pertussis	1	2 months
	2	4 months
	3	6 months
	4	15-18 months
	5	4-6 years
Hepatitis B	1	Birth
	2	2 months
	3	6-18 months
Hib (H. Influenza type b)	1	2 months
	2	4 months
	3	6 months
	4	12-15 months
Polio (Inactivated)	1	2 months
	2	4 months
	3	6-18 months
	4	4-6 years
MMR (Measles, Mumps, Rubella)	1	12-15 months
	2	4-6 years
Varicella (Chicken Pox)	1	12-18 months
Hep A (Hepatitis A)	1	12-23 months
	2	6 months after 1st

HOME SAFETY FORM

PCG First Name: _____ Last Name: _____DOB (mm/dd/yyyy): _____/_____/_____

Child First Name: _____Last Name: _____ DOB (mm/dd/yyyy): _____/_____/_____

Today's Date (mm/dd/yyyy): _____/_____/_____ FSW Name:_____

Time Frame: ☐Birth/Enrollment ☐6 ☐12 ☐18 ☐24 ☐30
(Child's age in months) ☐36 ☐42 ☐48 ☐54 ☐60 ☐66 ☐72

Instructions to FSW: Please complete this Home Safety form with the PCG, using direct observations when completing items as much as possible. "N/A" means Not Applicable or not inspected by the FSW.

SLEEP SAFETY (For children less than 1 year of age)

HS1. How often is baby placed on his/her back to go to sleep?
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

HS2. How often does baby share a sleeping surface with other people, adults or children?
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

HS3. Is baby's sleeping surface firm, free of blankets/pillows/stuffed animals or other items that could cover his/her face and block his/her nose & mouth? ☐ Yes ☐ No ☐ N/A

HS4. Are the bars on baby's crib 2-3/8" apart (or less)? ☐ Yes ☐ No ☐ N/A

HS5. Does the crib mattress fit snugly? (SAFE = no more than 2 fingers distance between mattress and crib railing)? ☐ Yes ☐ No ☐ N/A

HEAT SAFETY

HS6. How often are hot liquids and foods kept out of baby's reach?
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

HS7. How often do you or somebody else hold baby while cooking, carrying or eating hot liquids or food?
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

HS8. Is the hot water temperature set within recommended range (120° F)? ☐ Yes ☐ No ☐ N/A

SUPERVISION

HS9. At any time during the past month, has [child's name] been…
1. Left alone, unsupervised in a tub of water ☐ Yes ☐ No
2. Left in a bathtub to be watched by a sibling or other child? ☐ Yes ☐ No
3. Unsupervised near water (lake, pond, pool, etc.) for any amount of time? ☐ Yes ☐ No
4. Unsupervised near a bucket of water, open toilet, or other container of water? ☐ Yes ☐ No
5. Around or near water (lake, pond, pool, etc.) without a life jacket on? ☐ Yes ☐ No

HS10. Is there a pool, hot tub, pond or other body of water where the child lives? ☐ Yes ☐ No
IF YES: a. Is it protected by a self-closing, self-locking gate on all sides? ☐ Yes ☐ No ☐ N/A

FIRE SAFETY

HS11. Are all space heaters in safe condition and inaccessible to infant/toddler? (SAFE = stable, with protective covering, and at least 36 inches from containers, papers and furniture. Check cord and plug for fraying or exposed wires). ☐ Yes ☐ No ☐ N/A

HS12. Is there a fireplace, wall furnace or floor furnace where the child lives? ☐ Yes ☐ No
IF YES:
a. Does each heat source have a protective covering so the child cannot get near it? ☐ Yes ☐ No ☐ N/A
b. Is each heat source at a safe distance from cloth, paper, furniture or other flammable things? ☐ Yes ☐ No ☐ N/A

HS13. Is there a fire extinguisher in the home that has not expired? ☐ Yes ☐ No ☐ N/A

HS14. How many unobstructed exits does your house or apartment have, in case of fire or other emergency?

HS15. Have you made a fire escape plan for your home? ☐ Yes ☐ No ☐ N/A
(Ask mother/responder to describe to verify plan exists.)

HS16. How many smoke detectors are in the home? ☐

HS17. How many of the smoke detectors work? ☐

HS18. When were the batteries last changed? ☐ Months ago
☐ Months ago
☐ Months ago

CAR SAFETY

HS19. How often, when riding in a car, is [child's name] buckled in a car safety seat?
☐ All of the time
☐ Most of the time
☐ Some of the time
☐ None of the time

HS20. Is the infant/booster car seat properly installed? ☐ Yes ☐ No ☐ N/A

HS21. Is the infant/booster car seat appropriate for the child's age, weight & height? ☐ Yes ☐ No ☐ N/A

HS22. At <u>any time</u> during the past month, has [child's name] been left in a car alone? ☐ Yes ☐ No

HS23. Do you and visitors to your home make sure the child is in a safe place before moving their car? ☐ Yes ☐ No

FALL SAFETY

HS24. Is there a gate at the top of the stairs inside the home? ☐ Yes ☐ No ☐ N/A

HS25. Is there a gate at the bottom of the stairs? ☐ Yes ☐ No ☐ N/A

HS26. How many of the gates in home are of the accordion type? ☐

HS27. Are there any open or unguarded windows in rooms above the first floor that are within the child's reach? ☐ Yes ☐ No ☐ N/A

HS28. At any time during the past month, has [child's name] been…

a. Left alone on a changing table, couch, bed, chair or other high surface? ☐ Yes ☐ No ☐ N/A

b. Put in a baby walker? ☐ Yes ☐ No ☐ N/A

HOME SAFETY

HS29. How often are small objects kept out of baby's reach, including small food objects like grapes?

☐ All of the time
☐ Most of the time
☐ Some of the time
☐ None of the time

HS30. Are all household items with cords (such as drapes, blinds, wall phones, etc.) out of baby's reach? ☐ Yes ☐ No ☐ N/A

HS31. Are there plastic outlet covers in all unused electrical outlets within child's reach? ☐ Yes ☐ No ☐ N/A

HS32. Are there any matches or lighters left on tables within child's reach? ☐ Yes ☐ No ☐ N/A

HS33. Are cleaning supplies stored in locked cabinets or out of child's reach? ☐ Yes ☐ No ☐ N/A

POISON SAFETY

HS34. Are medicines & vitamins stored in locked cabinets or out of child's reach? ☐ Yes ☐ No ☐ N/A

HS35. Is the Poison Control Center number posted on or near each phone in house/apartment? ☐ Yes ☐ No ☐ N/A

GUN SAFETY

*The following questions about guns in the home are **PCG's self-report only**, unless the FSW's observations differ.*

HS36. Are there guns and/or rifles in the home? → **IF NO, SKIP TO HS40** ☐ Yes ☐ No

HS37. Are guns and/or rifles stored unloaded? ☐ Yes ☐ No

HS38. Is ammunition stored separate from guns and in locked cabinets? ☐ Yes ☐ No

HS39. Are guns stored in locked cabinets or out of child's reach? ☐ Yes ☐ No

WHEELED ACTIVITIES SAFETY

Complete items HS40-43 for children 2 years and older

*The following questions about wheeled activities are **PCG's self-report only**, unless the FSW's observations differ.*

HS40. During the past 6 months, has your child ridden a bike, scooter, skateboard, roller skates or roller blades? ☐ Yes ☐ No **(If No, Skip t o HS42)**

HS41. How often does he/she wear a helmet when riding a bike, scooter, skateboard, roller skates or roller blades? ☐Never ☐Sometimes ☐Usually ☐Always

HS42. During the past 6 months, has your child ridden an All Terrain Vehicle (ATV)? ☐ Yes ☐ No **(If No, STOP HERE)**

HS43. How often does he/she wear a helmet when ridden an All Terrain Vehicle (ATV)? ☐Never ☐Sometimes ☐Usually ☐Always

Instructions for Home Safety Form

Purpose

The purpose of the Home Safety Form is to determine whether the program has made an impact on the home environment. It provides the opportunity to gather data on how well parents have followed through on the safety teaching provided during prior home visits. It also allows the home visitor to identify some areas where more education may be needed.

General Instructions

- **Whose form:** The PCG's form. If the child's mother is no longer the caregiver, administer the form with the new caregiver.
- **When:** This form is administered initially at 2nd home visit from the child's birth or the family's enrollment and followed up every six months according to the child's age.
- **What:** This form collects information on the safety of the home environment where the child lives.
- **File:** This form is filed in the family folder at the PAT program site that is providing services.

Special Instructions for Multiple Births

There are some questions on this form that are child-specific. To keep from administering and entering this form more than once for a PCG:

- Pick the first-born of a multiple birth to complete the form and enter only that one form.
- The Home Safety form does not have to be completed for multiple births other than the first-borne of the multiple births.

Top Box Item Instructions

Note:
You must complete all fields listed in the Top box. Ensure that the information pertaining to the primary caregiver (PCG) is consistent with that submitted for the first "Participant Activity Form". Similarly the information submitted for the child should be consistent with the "Pregnancy and Indentified Child Form". Avoid alternate names, miss-spells, hyphens, parenthesis, or typos, etc. Use mm/dd/yyyy format for DOB.

Information in the Top box will be used to create a unique ID that will link all the family forms to one ID.

PCG First Name / Last Name / DOB: The PCG's first and last names and date of birth.
Child First Name / Last Name / DOB: The Child's first and last names and date of birth.
Today's Date: The date on which the Home Safety form was completed. Use mm/dd/yyyy format.
FSW Name: The first and last name of the FSW assigned to this family.

Reporting Time: Check the box indicating the appropriate time frame (Child birth/ enrollment or every 6 months calculated from the child's birth date). Many program outcomes are measured over time, and this field helps to determine time sequence.

Item Instructions

Note: Read the bold instructional message at the beginning of the form prior to administering it with the client. The option "N/A" means that there is not an applicable response, either because that situation does not apply to the program participator or that the item in question was not able to be inspected or observed by the home visitor. If there is NOT an "N/A" response to the question, it is relying on the client's self-reported response only.

Sleep Safety

Ask these questions only when the child is less than 1 year of age.

HS1. Record how often the PCG says that the baby is placed on his/her back when put to sleep.

HS2. Record how often the PCG says that the baby shares a sleeping surface with other people (either adults or children). A sleeping surface could be a crib, bed, couch, an inflatable mattress, the floor, or any other place where the baby is put to sleep.

HS3. Indicate if the baby's sleeping surface is free of items that could cover his/her face and block his/her mouth. If the FSW cannot observe the baby's sleeping surface with the mother while administering the form, check "N/A."

HS4. Indicate if the bars on the baby's crib are 2 and 3/8 inches apart or closer. If the baby doesn't have a crib, or if the FSW cannot observe the baby's sleeping surface with the PCG while administering the form, check "N/A."

HS5. Indicate if the mattress on the baby's crib fits snugly. If the baby doesn't have a crib, or if the FSW cannot observe the baby's sleeping surface with the PCG while administering the form, check "N/A."

Heat Safety

HS6. Indicate how often the client says that hot liquids and foods are kept out of the baby's reach.

HS7. Indicate how often the PCG says that she or someone else holds the baby while cooking, carrying or eating hot liquids or food.

HS8. Indicate if the hot water temperature is set within the recommended range (120 degrees F). If the FSW is not able to observe the hot water temperature setting, check "N/A."

Supervision

HS9. Using the time frame of the past month, indicate whether the PCG says that any of these events (1-5) have occurred involving the child.

HS10. Indicate whether there is a pool, hot tub, pond, or other body of water (such as a decorative pond) where the child lives.

- If "Yes," indicate whether it is protected by a self-closing, self-locking gate on all sides. If the FSW is not able to observe the body of water, check "N/A."
- If "No," go to the next question.

Fire Safety

HS11. Indicate whether all space heaters are in safe condition and are not accessible to the infant. If the FSW is not able to observe the location and accessibility of space heaters, or if the FSW does not use space heaters, check "N/A."

HS12. Indicate whether there is a fireplace, wall furnace, or floor furnace where the child lives.

- If "Yes," indicate whether (a) each has a protective covering so that the child cannot get near it and (b) whether each is at a safe distance from flammable items (such as cloth, paper, etc.). If the FSW is not able to inspect the heat source(s), mark "N/A."
- If "No," go to the next question.

HS13. Indicate whether there is a fire extinguisher in the home that has not passed its expiration date. If the FSW is not able to observe the fire extinguisher and check its expiration date, check "N/A."
HS14. Write down the number of unobstructed exits the PCGs' house or apartment has.
HS15. Verify whether the PCG has made a fire escape plan for her/his home (or wherever s/he lives). If s/he lives in a residential facility, verify that s/he knows of and understands the facility's fire escape plan. "N/A" would be checked if the PCG is homeless.
HS16. Write down how many smoke detectors are in the home where the PCG and baby live.
HS17. Write down how many of the smoke detectors work. Rely on the PCGs' response for this answer, and ensure that s/he knows how to check whether the smoke alarms are in working condition.
HS18. Write down what the PCG says about when the batteries were last changed in each identified smoke detector.

Car Safety
HS19. Indicate how often the PCG says that the infant/toddler is buckled in a car safety seat when riding in a car.
HS20. Indicate whether the infant's car seat is properly installed in the car. If the FSW is not able to observe the car seat, or if the PCG does not have a car or car seat, choose "N/A."
HS21. Indicate whether the infant/toddler's car seat is appropriate for his/her age, weight and height. If the FSW is not able to observe the car seat, or if the PCG does not have a car or car seat, choose "N/A."
HS22. Using the time frame of the past month, indicate whether the PCG says that the event occurred involving the child.
HS23. Indicate whether the PCG says that s/he and visitors to the home make sure that the child is in a safe place before moving their car.

Fall Safety
HS24. Indicate whether there is a gate at the top of the stairs in the PCG's home where the child lives. If there are not stairs, or if the PCG is homeless, mark "N/A."
HS25. Indicate whether there is a gate at the bottom of the stairs in the PCG's home where the child lives. If there are not stairs, or if the PCG is homeless, mark "N/A."
HS26. Indicate how many gates in the home are of the accordion type.

- If there are no gates in the home, or if the PCG is homeless, skip this question.

HS27. Indicate if there are any open or unguarded windows in rooms above the 1st floor of the PCG's home/apartment that are within the child's reach? Unguarded means that a child would be able to open them. If the house/apartment is not on or does not have a 2nd story, or if the PCG is homeless, or if the FSW is not able to observe the windows, mark "N/A."
HS28. Using the time frame of the past month, indicate if the participant says the events (a-b) have happened.

Home Safety
HS29. Indicate how often the PCG says that small objects (such as small toys, nails, quarters, and small food items like grapes) are kept out of baby's reach.

HS30. Indicate whether household items with cords (ex: blinds, drapes, the cord of a wall telephone, ceiling fans, etc.) are out of the infant's reach – especially close to places where the infant is often kept for longer periods of time, such as a play area or crib. If the FSW is not able to observe the house or if there are no items in the house with cords, check "N/A."
HS31. Indicate whether all unused electrical outlets within the child's reach have plastic covers over them. If the FSW is not able to observe electrical outlets to confirm that they are covered with plastic covers, mark "N/A."
HS32. Indicate whether matches or lighters have been left on tables within the child's reach. If the FSW is unable to observe, mark "N/A."
HS33. Indicate whether cleaning supplies are stored in locked cabinets out of the child's reach. If the FSW is unable to observe, mark "N/A."

Poison Safety
HS34. Indicate whether medicines and vitamins are stored in locked cabinets out of the child's reach. If the FSW is unable to observe, mark "N/A."
HS35. Indicate whether the Poison Control Center phone number is posted on or near each phone in the house/apartment where the PCG lives. If the PCG does not have a telephone, or if FSW is unable to observe, mark "N/A."

Gun Safety
Note: There is not a N/A option on the gun safety questions because these questions rely on PCG self-report and do not expect the FSW to inspect the conditions in which the PCG or the PCG's family store guns and ammunition.
HS36. Indicate whether the PCG says there are guns and/or rifles in the home where the child lives.
HS37. Indicate whether the PCG says that the guns are stored unloaded or not.
HS38. Indicate whether the PCG says that the ammunition is stored separate from the guns and stored in locked cabinets.
HS39. Indicate whether the PCG says that the ammunition is stored in locked cabinets, out of the child's reach.

Wheeled Activities Safety – ***Only complete this for children 2 years old and older.***
Note: There is not a N/A option on the wheeled activities questions because these questions rely on PCG self-report.
HS40. Using the time frame of the past six months, record whether the PCG says that the child has participated in the wheeled activities indicated.
HS41. Record the number of times the PCG says that the child uses a helmet while participating in the wheeled activities indicated.
HS42. Using the time frame of the past six months, record whether the PCG says that the child has used an All Terrain Vehicle.
HS43. Record the number of times the PCG says that the child uses a helmet while using an All Terrain Vehicle.

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name	Date of Birth	
Address	City	
Area Code & Telephone Number	State	Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow _____ to share my protected health information as set forth below, for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Persons/Organizations Authorized to Receive My Information (Name, Address, Phone & Fax)	Relationship	Purpose

B. Information to be shared

1. Check one or more boxes below.

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
☐ Entire Medical Record (includes all records except Psychotherapy Notes)
☐ Mental Health Records
☐ Alcohol or Drug Abuse Records
☐ HIV Records
☐ STD Records
☐ Progress Notes
☐ Medical Images
☐ Radiology Report(s)
☐ Cardiology Report(s)
☐ History and Physical
☐ Operation Reports
☐ Consultation Report(s)
☐ Pathology Reports
☐ Discharge Summary
☐ Physician's Orders
☐ Laboratory Report(s)

☐ Other _____

2. Covering Services Between _____ and _____ (Insert either date(s) or "all.")

III. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

☐ 12 months from the date signed in Part IV.B. ☐ Other (insert date or event): _____

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

IV. ACKNOLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. ☐ If checked and initialed, _____is authorized to share my protected health information for the purpose of marketing. I understand _____ may receive either direct or indirect compensation for sharing my information in this case. Individual initials _____

3. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

Address of entity authorized to release information:_____

The following information is for administrative purposes and may only be completed by an entity that is a "Program" under 42 C.F.R. Part 2 with respect to alcohol and drug abuse records.

☐ If checked — disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C.F.R. Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTORIZACIÓN ESTANDARIZADA DE OKLAHOMA PARA USAR Y COMPARTIR INFORMACIÓN MÉDICA PROTEGIDA (PHI, por sus siglas en inglés)

I. INFORMACIÓN INDIVIDUAL (DE LA PERSONA QUE SE VA A COMPARTIR LA INFORMACIÓN)

Nombre _____ Fecha de Nacimiento _____

Dirección _____ Ciudad _____

Código de área & Número de teléfono _____ Estado _____ Código Postal _____

II. ALCANCE Y PROPÓSITO PARA COMPARTIR LA INFORMACIÓN

Yo entiendo que la información de la salud protegida es información que me identifica. El propósito de ésta información es permitir a _____ el compartir mi información médica protegida como se expone abajo, por razones adicionales a las que permite la ley.

A. Persona/Organización Recibiendo la Información y el Propósito para la Divulgación

Personas/Organizaciones Autorizadas a Recibir mi Información (Nombre, Dirección, Teléfono y Fax)	Relación	Propósito

B. Información ha ser compartida

1. Marque una ó más de las casillas abajo.

☐ Notas de Psicoterapia (si marca esta casilla,no debe marcar otras casillas)
☐ Archivo Médico Completo (incluye todos los archivos excepto las Notas de Psicoterapia)
☐ Archivo de Salud Mental
☐ Archivos de Abuso de Alcohol y Drogas
☐ Archivos de VIH
☐ Archivos de ETS
☐
☐ Notas del Progreso
Imágenes Médicas
Reporte(s) de Radiología
Reporte(s) de Cardiología
Historial y Físico
Reportes de Operaciones
Reporte(s) de Consulta
Reporte(s) de Patología
Informe del Proceso de dado de Alta
Órdenes del Doctor
Reporte(s) del Laboratorio

☐ Otro _____

2. Servicios realizados entre _____ y _____(Incluya fecha(s) específicas o "todos.")

III. CADUCIDAD Y REVOCACIÓN

A. Esta Autorización Caducará (debe elegir una):

☐ 12 meses desde la fecha firmada en Parte IV.B ☐ Otra (incluya fecha o evento): _____

B. Derecho a Revocar
Yo entiendo que yo puedo cambiar ésta autorización en cualquier momento escribiendo a la dirección mencionada al final de ésta forma. Yo entiendo que yo no puedo restringir la información que pudiera haber sido compartida basada en ésta autorización.

IV. Reconocimientos y Firmas

A. Reconocimientos

1. Yo entiendo que ésta autorización es voluntaria y no afectará mi eligibilidad para recibir beneficios, tratamiento, inscripción o pago de cuentas.

2. ☐ Si está marcada y con iniciales, _____está autorizado a compartir mi información médica protegida con el propósito de publicidad. Yo entiendo _____ puede recibir indemnización directa o indirecta por compartir mi información en éste caso. Iniciales del individuo _____

3. Yo entiendo que si la persona/organización autorizada para recibir mi información médica protegida no es un plan de salud o un proveedor de atención médica, las regulaciones de privacidad ya no protegerán la información.

4. Yo entiendo que yo puedo inspeccionar u obtener una copia de la información médica protegida compartida bajo ésta autorización, enviando una petición por escrito a la dirección señalada al final de ésta forma.

B. Firma

Éste documento debe ser firmado por el individuo o el representante legal del individuo.

Firma (Paciente o Representante Legal) Fecha

Nombre Impreso del Paciente o Representante Legal Capacidad Legal del Representante (si aplica)

Dirección de la entidad autorizada a compartir la información:_____

La siguiente información es para propósitos administrativos y puede ser completada solamente por una entidad que sea el "Programa" bajo 42 C.F.R. Parte 2 en relación a los archivos de abuso de alcohol y drogas.

☐ Si está marcada— la revelación de Archivos de Abuso de Alcohol y Drogas está sujeta a las siguientes restricciones bajo 42 C.F.R. Parte 2:

Esta información ha sido revelada a usted de archivos protegidos por las normas Federales de confidencialidad (42 CFR parte 2). Las normas Federales le prohiben hacer cualquier revelación posterior de esta información a menos que se permitan revelaciones posteriores por escrito de la persona a quien le pertenecen, o que se permita de otro modo de acuerdo a 42 CFR parte 2. Una autorización general de la revelación de información médica u otra información médica u otro tipo NO es suficiente para este propósito. Las normas Federales restringen cualquier uso de la información para investigación o persecución de pacientes con abuso de alcohol o drogas.

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

PATIENT INSTRUCTIONS

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Write your name, date of birth, complete address, area code and telephone number in the spaces provided.

II. SCOPE & PURPOSE FOR SHARING INFORMATION

This section explains what protected health information is and lets you know that you are allowing your protected health information to be shared with the person (s) you name in Section II A.

A. Person/Organization Receiving Information and Purpose for Sharing

Write the person/organization's name you wish to share information with, their address, phone number and fax number, their relationship to you (example: lawyer, family member, etc.), and the purpose for which you wish to share the information. **If you write more than one person/organization in this section, the information you check in Section B will be shared with everyone listed.**

B. (1) This section lists what information you want to share. You can check one or more boxes, **unless** you are sharing psychotherapy notes. If you are sharing psychotherapy notes, you can only check that box and no others.

(2) List the dates of service for the information you want to share (if you don't know the exact dates, try to at least give the month and year), or you can choose to share all your records by writing the word "all".

III. EXPIRATION & REVOCATION

A. Expiration

By law, your permission to share information can only last for a certain amount of time. You must check one box.

B. Right to Revoke

You can change your mind about sharing this information at any time. If you change your mind, you must write to the address listed under your signature in Section IV.B and ask that your information no longer be shared. Information may already have been shared before your written request is received.

IV. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. This section explains that you voluntarily signed the form and that you can't be denied eligibility for benefits, treatment, enrollment, or payment of claims if you don't sign the form.

2. If you check the box and write your initials in this section, you are agreeing to share your protected health information for marketing purposes. The person/company asking you to sign the form may receive some sort of payment for your information.

3. If you give permission to share your protected health information with someone who is not a health plan or health care provider, (family member, etc) privacy regulations may no longer protect the information.

4. You may look at or get a copy of the protected health information shared under this form by writing to the address listed under your signature in Section IV.

B. Signature - Sign and date the form in the spaces provided.

If you are agreeing to share alcohol or drug abuse records, law protects that information in certain instances. If the box under your signature is checked, the person or organization receiving your alcohol or drug abuse records under this authorization may not be able to share this information without your written permission.

The last paragraph under the gray-shaded box is for the physician/provider use only.

AUTORIZACIÓN ESTANDARIZADA DE OKLAHOMA PARA USAR O COMPARTIR INFORMACIÓN MÉDICA PROTEGIDA (PHI - por sus siglas en inglés)

INSTRUCCIONES DEL PACIENTE

I. INFORMACIÓN INDIVIDUAL (DE LA PERSONA DE QUIEN SE COMPARTIRÁ LA INFORMACIÓN)

Escriba su nombre, fecha de nacimiento, dirección completa, código de larga distancia y número telefónico en los espacios indicados.

II. ALCANCE Y PROPÓSITO DE COMPARTIR INFORMACIÓN

Esta sección explica el significado de la información médica protegida y le informa que usted está permitiendo que su información médica protegida sea compartida con la(s) persona(s) que usted nombre en la Sección III A.

III. AUTORIZACIÓN E INFORMACIÓN A COMPARTIR

En la mayoría de los casos, su información médica protegida puede ser compartida para tratamiento, pago y actividades de atención médica, bajo la Ley de Responsabilidad y Portabilidad del Seguro Médico (HIPAA). Por razones adicionales al tratamiento permitido, pago y actividades de atención médica, usted debe llenar las secciones III A y B como se indica:

A. Persona/Organización que recibe la información y el propósito por el que desea compartirla

Escriba el nombre de la persona/organización con quien usted desea compartir la información, su dirección, número telefónico y de fax, la relación con usted (ejemplo: abogado, familiar, etc.), y el propósito por el cual usted desea compartir esta información. **Si usted escribe más de un nombre/organización en esta sección, la información que usted marcó en la sección B, será compartida con cada uno en la lista.**

B. (1) Esta sección lista la información que usted quiere compartir. Usted puede marcar una o más casillas, **a menos** que usted esté compartiendo archivos de psicoterapia. Si usted está compartiendo archivos de psicoterapia, usted puede marcar solo esa casilla y no las otras.

(2) Liste las fechas de servicio de la información que quiere compartir (si no sabe las fechas exactas, trate al menos de poner el mes y el año), o puede elegir compartir todos los archivos, escribiendo la palabra “todo” (“all”).

IV. CADUCIDAD Y REVOCACIÓN

A. Caducidad

Por ley, su permiso para compartir información solo puede ser válido por cierto periodo de tiempo. Usted debe marcar una casilla.

B. Derecho de Revocar

Usted puede cambiar de parecer en cuanto a compartir esta información. Si usted cambia de parecer, usted debe escribir a la dirección que aparece en la parte inferior de esta forma y pedir que su información ya no sea compartida. La información puede ya haberse compartido antes de recibir su petición por escrito.

V. RECONOCIMIENTOS Y FIRMAS

A. Reconocimientos

1. Esta sección explica que usted firmó voluntariamente esta forma y que a usted no se le puede negar la elegibilidad para recibir beneficios, tratamiento, inscripción o pago de cuentas si usted no firma esta forma.

2. Si usted marca esta casilla y escribe sus iniciales en esta sección, usted está de acuerdo en compartir su información médica protegida para propósitos de promoción. La persona/compañía que le está solicitando firmar la forma puede recibir algún tipo de pago por su información.

3. Puede ser que si usted da permiso de compartir su información de salud protegida a alguien que no es un proveedor de atención médica o un plan de salud, (familiar, etc.) las normas de privacidad ya no puedan proteger más la información.

4. Usted puede ver u obtener una copia de la información de salud protegida que se comparte de acuerdo a esta forma, escribiendo a la dirección que aparece en la parte inferior de esta forma.

5. La información compartida pudiera contener archivos que pueden indicar la presencia de alguna enfermedad transmisible o no transmisible.

B. Firma – Firme y feche la forma en los espacios proporcionados.

Si usted acepta compartir archivos de abuso de alcohol o drogas, la ley protege esa información en ciertos casos. Si la casilla que está bajo su firma está marcada, entonces puede ser que la persona u organización que recibe sus archivos de abuso de drogas y alcohol bajo esta autorización no pueda compartir esta información sin su permiso por escrito.

El último párrafo bajo la casilla sombreada con gris, es para el uso del doctor/proveedor solamente.

Critical Incident Intake Form

Date:_____ **County:**_____ **Critical Incident Reported By:**_____

Client Name:_____ **Client DOB:**_____ **Identified Child Initials:** _____

Child's DOB: _____ **Home Visitor's Name:**_____

Home Visiting Program: _____ **Date of First Home Visit:**_____ **Date of Last Home Visit:**_____

1. Is the incident related to: ☐ **Client** ☐ **Child** ☐ **Both** ☐ **Home Visitor** ☐ **Other**

2. Postpartum Depression Screening:

		Y	N	NA
Postpartum Depression Screen score _____	weeks postpartum _____If elevated was a referral made			
Postpartum Depression Screen score _____	weeks postpartum _____If elevated was a referral made			
Postpartum Depression Screen score _____	weeks postpartum _____If elevated was a referral made			

3. Describe the incident *(please use supplemental sheets if necessary)***:**_____

4. Check all that apply to this incident:

Physical Abuse (child)		Sexual Abuse (child)		Drowning	
Child Death		Near death of a child		Sudden Infant Death Syndrome **(SIDS)**	
Client Death		Near death Client		Mental Illness	
Suffocation		Neglect		Left in car	
Abusive Head Trauma **(Shaken Baby Syndrome - SBS)**		Fracture(s) (child)		**Other (*please explain in narrative)*:**	
DHS custody		Failure to Thrive/slow to gain weight			
Emergency Room Visit - Identified Child		Emergency Room Visit – Client			

5. Where is the infant/child now? (check all that apply)

With Client		DHS custody		Other family member:	
Hospital		Unknown		Other:	

6. Did the Home Visitor (HV) make a report to Child Protective Services (CPS) regarding this incident? Yes No

If yes, enter the date of the report_____; enter the name of the HV: _____

7. Was a 333F completed? Yes No **Enter the case/referral number if available:**_____

8. Has this family had a previous CPS report in your program? Yes No

If yes, enter the date of the report/s:_____ Name of the HV: _____

Give a brief description of the results: _____

Critical Incident Intake Form

9. Is the HV aware of any reports to CPS by any other party? Yes No

If yes, enter the date of the report_____, enter the name of the person/party_____
Give a brief description of the results:_____

10. List any significant risk factors for child maltreatment: RISK FACTORS (Check all that apply)

Weapons in the home		Alcohol abuse by caretaker/s		Substance abuse by caretaker/s	
Domestic violence child present		Domestic violence child not present		Client incarceration	
Incarceration of family member		Family member unemployment		Client unemployment	
Family member mental illness		Client developmentally delayed		Child developmentally delayed	
Family developmentally delayed		Client mental illness		Neglect	
Other:					

11. Has this case been discussed in individual Supervision? Yes No
If yes, describe any significant information that has been discussed:_____

12. Have you contacted your consultant by telephone? (This should occur w/in 24 clock hours) Yes No
If yes, describe any significant information that has been discussed:_____

13. Any other significant information you would like to share?

Critical Incident Intake Form

Supplemental

Critical Incident

When a critical incident occurs, the Family Support Worker (FSW) should immediately notify the Parents as Teachers (PAT) Supervisor and in turn, the Office of Child Abuse Prevention (OCAP) and the PAT Program Staff. A critical incident may be defined as but is not limited to:

- Severe injury to a PAT client or the child of a PAT client;
- Severe illness of a PAT client or the child of a PAT client;
- Death of a PAT client or the child of a PAT client;
- Any harm that has come to a FSW by a client or someone connected to the client.
- Legal issues such as a subpoena
- Department of Human Services (DHS) Custody
- Issues or concerns related to Child Protective Services (CPS)
- Any other significant event that may occur

When contacting the program the following information is needed:

- PAT Program and county in which this incident occurred
- PCG Initials and DOB
- Infant/Child Initial (if applicable) and DOB
- Date of incident
- Initials of the FSW and which PAT Program and county he/she is based in
- Name of the FSW
- Has a report to CPS been made by the FSW regarding this incident
- If a report was made, when and by whom
- Was a 333F completed (case # if available and priority assigned)
- Has the FSW made any other reports to CPS regarding this family
- If a report was made was a 333F completed (case # if available and priority assigned)
- Has a previous report been made by someone other than PAT (this could include family member, neighbors etc.)

REMINDERS:

- Report must given by telephone to the PAT Program Consultant within 24 hours of the incident
- The PAT Program Supervisor must be notified prior to a phone call to the Office of Child Abuse Prevention (OCAP)/PAT Staff.

CONTACT INFORMATION:

Suzy Gibson, M.S.
Phone: 405.271.7611
Direct extension: 56925
Blackberry: 405.802.9309

Persephone Starks, M.S.
Phone: 405.271.7611
Direct extension: 56717
Blackberry: 405.246.6538

Submit by Email | Print Form

OKLAHOMA STATE DEPARTMENT OF HEALTH
SUSPECTED CHILD ABUSE/NEGLECT REPORT FORM

I understand that the Oklahoma State Department of Health policy requires me, as a mandated reporter, to promptly contact the Oklahoma Department of Human Services or call the statewide 24-hour hotline number (1-800-522-3511) to make a report of suspected child abuse and/or neglect in good faith and in accordance with the law of the state of Oklahoma. I understand that this form (333-F) does not replace a call to OKDHS, but is to be used to document adherence to policy, to be sent to OKDHS for hardcopy documentation, and to provide quality assurance.

This written report documents an oral report made to OKDHS on (Date)____/____/_____, (Time)____:____ ☐am ☐pm to (Person accepting the report)_____ Referral #_____.

IF THIS SITUATION POSES IMMINENT DANGER, WAS LAW ENFORCEMENT CALLED? ☐ Yes ☐ No
WAS THIS REPORT MADE ANONYMOUSLY? ☐ Yes ☐ No

Reporter Information

Reporter's Name:_____ Position/Title:_____

Phone number: _____-_____-_____ Fax number: _____-_____-_____ County: _____

E-mail address? _____

At which health department or contract agency do you work (also specify city)? _____

At the time of this incident, for which program or clinic were you working?

☐ Children First ☐ Early Intervention ☐ Immunization clinic ☐ Start Right/OCAP ☐ Well-child clinic

☐ Child Guidance ☐ Family Planning ☐ Maternity Clinic ☐ STD clinic ☐ WIC

☐ Administrative staff, multiple programs/clinics ☐ Other: _____

Child Information

Name: _____ DOB/Age: _____ Race/Ethnicity: _____ Gender: ____

Is this child physically or developmentally disabled? ☐ Yes ☐ No IF YES → Please describe: _____

_____

Address or location of child at the time of the report? _____

Family/Caretaker Information

List each person's name and relationship to child (if known):	Age	Race/Ethnicity	Gender	Disabled? Explain:
1. Parent/Caretaker:			☐	
2. Parent/Caretaker:			☐	
3. Sibling/Other:			☐	
4. Sibling/Other:			☐	
5. Sibling/Other:			☐	

What is the primary language spoken in the home? ☐ English ☐ Spanish ☐ Other (specify):_____

Home Address: _____ Telephone: _____-_____-_____

_____ Alternative phone: _____-_____-_____

Finding Directions: _____

Out of Home Care

Is the child in out-of-home care? Check type:

☐ Unknown/Not Applicable ☐ OKDHS custody ☐ Foster family home ☐ Relative's home

☐ Childcare center or school ☐ Family friend ☐ Group home or institution ☐ Other:_____

Address: _____ Telephone: _____-_____-_____

_____ Alternative phone: _____-_____-_____

Who are the person(s) responsible for the child at this location? _____

Name of school or childcare/daycare center: _____

Incident Information

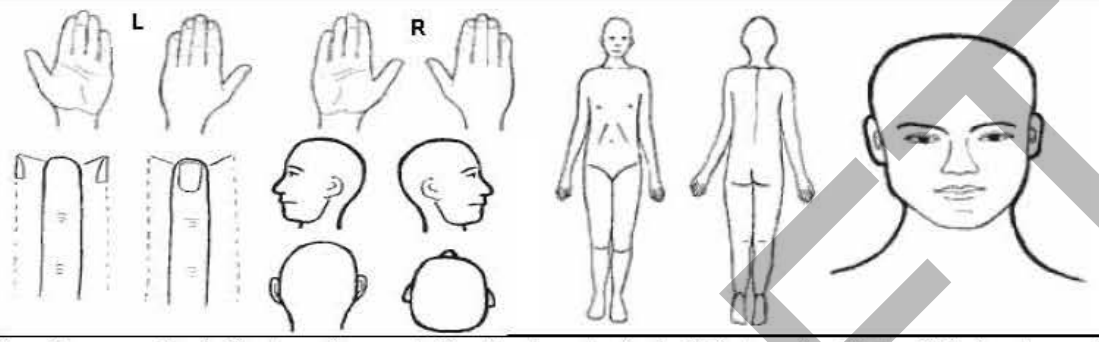
Please classify the type(s) of suspected maltreatment you are reporting (check all that apply):

☐ Physical abuse ☐ Sexual abuse ☐ Emotional or psychological abuse ☐ Neglect

Is domestic or intimate partner violence in the home? ☐ Yes:_____ ☐ No ☐ Unknown
Is alcohol or a controlled dangerous substance involved? ☐ Yes:_____ ☐ No ☐ Unknown
Are there dangers in the home (i.e. dogs, weapons, meth lab, etc.)? ☐ Yes: ☐ No ☐ Unknown

Incident Information, continued

Please describe the nature and extent of the child's injuries, neglect or endangered condition (indicate sites on body map):



Alleged types and/or indicators of suspected maltreatment; check all that apply. (Note: This is not an exhaustive list)

☐ Abrasions/laceration	☐ Exposure to domestic violence	☐ Inadequate clothing	☐ Substance abuse by caretaker
☐ Age-inappropriate sexual behavior	☐ Failure to obtain medical attention	☐ Inadequate or dangerous shelter	☐ Threat of harm
☐ Bite marks	☐ Failure to protect	☐ Inadequate physical care	☐ Vaginal penetration/intercourse
☐ Bone fracture (not skull)	☐ Failure to provide adequate nutrition	☐ Lack of supervision	☐ Wounds/cuts/punctures
☐ Bruises/welts	☐ Failure to thrive	☐ Mental trauma	☐ Other:_____
☐ Burns/scalds	☐ Fondling	☐ Pornography	☐ Other:_____
☐ Exposure to adult sexuality	☐ Head trauma	☐ Skull fracture	☐ Other:_____

Identify any child or adult who gave an explanation of the child's injury/condition and the date; What did the child or adult say happened?

How do you know this child? How long have you known him/her? When did you last see the child, and what was his/her condition? Does the child have any injuries now?

When did the incident occur (time, date, location)? Did you witness the incident?

Other pertinent information, including the name and address of others who may be willing to provide information about this case:

One Week Follow-Up

DHS Caseworker:_____ Phone number: _____-_____-_____ County:_____

Was this report: ☐ Accepted ☐ Screened out ☐ Don't know

Was this report assigned for: ☐ Investigation ☐ Assessment ☐ No ☐ Don't know

What priority was assigned by DHS (if known)? ☐ Priority 1 (urgent) ☐ Priority 2

Notes: _____

_____

Have you had any problems or concerns interfacing with the local OKDHS / child welfare agency in making this report?

☐ Yes ☐ No → If YES please describe: _____

Reporter's Signature: _____ **Today's date:** _____/_____/_____

Instructions
ODH Form 333F
Suspected Child Abuse/Neglect Report Form

Purpose:
To comply with OSDH Policy and Procedure regarding mandated reported of suspected child abuse and/or neglect (child maltreatment)

NOT ALL INFORMATION MAY BE KNOWN. PLEASE INCLUDE AS MUCH INFORMATION AS POSSIBLE.

REFERRAL INFORMATION:

Date: Enter the date the oral report was made in (mm/dd/yyyy) format
Time: Enter the time the call was made to the DHS office.
TO: Enter the name of the person at DHS who accepted the report.
Referral Number: Ask for a referral number for this report and enter the number in the space provided **(this is a critical piece of information for follow-up).**
Imminent Danger: Indicate by checking yes or no if the child is in imminent danger based on your assessment.
Anonymous Report: Indicate by checking yes or no if the reporter made this report to OKDHS anonymously (did not give his/her name). **If the report was made anonymously, the reporter will not be able to obtain the follow-up information.**

REPORTER INFORMATION:

Reporter's Name: Enter the name of the person making the report.
Position/Title: Enter the name of title of the person making the report.
Phone/Fax Number: Enter the phone number and fax number of the person making the report.
County: Enter the name of the County in which the person making the report resides.
E-mail address: Enter the e-mail address of the person making the report if applicable.
County Health Department: Enter the name of the County Health Department or contract agency where the person who made the report is employed and the name of the city in which he/she works.
Program: Indicate which clinic the person making the report was working at the time of the incident.

CHILD VICTIM INFORMATION:

Name: Enter the name of the child to whom the suspected maltreatment
DOB/Age: Enter the DOB of the child if known, or if the DOB is not known, enter the age (or approximate age if not known) of the child. If approximating, please write an "A" after the age.
Race/Ethnicity: Enter the race of the child if known
Gender: Enter the gender of the child
Developmental Disability: Check the box to indicate if the child is disabled. If the child has a disability, specify the type of disability if known or describe the disability.

FAMILY/CARETAKER INFORMATION:

Parent/Caretaker: Enter the name of the parent or caretaker for this child and their relationship to the child. Enter the age, race and gender for each caretaker. If the caretaker is disabled in any way, explain the disability in the space provided.

Sibling; Enter the name (this includes step brother/s and step sister/s), age, race, and gender of each sibling. If the sibling is disabled in any way, explain the disability in the space provided.
Primary Language: Indicate the primary language spoken in the home, if the primary language is not English or Spanish, check other and enter the primary language in the space provided.
Home Address: Enter the mailing address where the child resides.
Telephone: Enter the phone number including area code where the caretaker can be reached.
Finding Directions: Enter the specific finding directions to the caretaker's residence. Be specific.
Alternative Phone Number: Enter another phone number where the caretaker can be reached.

OUT OF HOME CARE

Out of Home Care Type: Indicate the type of "out of home care" by checking the appropriate box. If the type of care is not listed, check other and specify the type of care in the space provided.
Home Address: Enter the "out of home care" facility mailing address.
Telephone: Enter the "out of home care" facility phone number including area code.
Finding Directions: Enter the "out of home care" facility finding directions.
Alternative Phone Number: Enter an alternate number for the "out of home care" facility if available.
Name of school or childcare/daycare center: Enter the name of the daycare center or childcare center the child/ren attend.

INCIDENT INFORMATION

NOTE: If Additional space is needed, document on plain paper or on a progress note and attach to 333F.

Types of maltreatment: Indicate the type of maltreatment by checking the appropriate box for each type of maltreatment that applies.
Domestic or Intimate Partner Violence: If domestic violence or intimate partner violence is occurring in the home check yes and specify the type of violence (ex. throwing items, threatened with weapon, use of weapon in domestic dispute)
Alcohol or controlled substance: If alcohol or controlled substances were present regarding this incident, check yes. In the space provided specify any significant information regarding the use of these items.
Danger to a worker: If there are circumstances that may put a caseworker at risk for harm when providing a home visit check yes. In the space provided specify the type of potential danger (i.e. dogs, weapons, potential meth lab)
Describe the nature of incident: In the space provided give detailed information to explain what you saw, heard, and smelled, etc. and indicate on the body map any injuries noted.
Alleged types of abuse: Check the appropriate box/es to indicate the type/s of suspected maltreatment. If there are any types of maltreatment not listed check other and specify in the space provided the specific type of maltreatment.
Explanation by any child or adult: In the space provided, document the child or adult's explanation of the incident and specify who gave the information. If the child has any injuries now, explain this also.

Incident time: In the space provided document the time (use military time or be sure to indicate am or pm), if the specific time is not known indicate if the incident occurred in the am or pm. Document the date (mm/dd/yyyy) the incident occurred if known. Document the location in which the incident took place (ex. child's home, _____ Park, maternal grandmother's home).
Other Information: Document any other pertinent information not yet specified.

ONE-WEEK FOLLOW-UP

DHS Caseworker: Enter the name of the caseworker assigned to this case:
Phone Number: Enter the phone number where the caseworker can be reached.
County: Enter the name of the county where the caseworker is headquartered.
Report: Indicate the status of the report as accepted, screened out, or don't know
Assigned: If the report was accepted, indicate what occurred by checking the appropriate box.
Priority: Check the appropriate box to indicate if a priority was assigned to this report.
Notes: document any significant information obtained in the space provided.
Difficulties with OKDHS: Check yes if there were any problems interfacing with DHS regarding this case. In the space provided specify the type of problem.
Reporter's Signature: Sign your name and title in the space provided.
Today's date: Enter the date (mm/dd/yyyy) the report was made to OKDHS.

PRIMARY CAREGIVER RENEWAL FORM

First Name: _____ Last Name: _____ DOB (mm/dd/yyyy): _____/_____/_____

Today's Date (mm/dd/yyyy): ____/____/_____ FSW Name: _____

Reporting Time: (Months from enrollment date)
☐6 ☐12 ☐18 ☐24 ☐30 ☐36
☐42 ☐48 ☐54 ☐60 ☐66 ☐72

1. Gender: ☐ Male ☐ Female

2. Which of the following is your race?
(Please check all that apply)
☐ American Indian/ Alaskan Native Tribe_____
☐ Asian
☐ Black/African American
☐ Caucasian
☐ Native Hawaiian/Pacific Islander
☐ Other, specify _____

3. Are you Hispanic or Latino? ☐ Yes ☐ No

4. Marital Status:
☐ Married ☐ Widowed ☐ Separated
☐ Single, never married ☐ Divorced

5. What is the highest level of school you have completed?
(Please choose one)
☐ 8th grade or less
☐ 9th-12th grade, no diploma
☐ High school graduate or GED completed
☐ Completed GRE
☐ Some college, no degree
☐ Vo-tech certification
☐ Associate Degree
☐ Bachelor's Degree
☐ Post Graduate

6. Are you currently enrolled in any kind of school, vocational or educational program? ☐ Yes ☐ No

7. Annual Household income:
(Please choose one)
☐ Under $5,000
☐ $5,000 - $14,999
☐ $15,000 - $24,999
☐ $25,000 - $34,999
☐ $35,000 - $44,999
☐ $45,000 and above
☐ Unknown

8. How many *adults* live in the home? _____ Adults

9. How many *children* live in the home? _____ Children

10. Who are the *other adults* who live in the home:
(Other than yourself, check all that apply)
☐ None
☐ Father of child
☐ Stepfather of child
☐ Boyfriend/ Not father of child
☐ Grandmother of the child
☐ Grandfather of the child
☐ Your Aunt
☐ Your Uncle
☐ Your Sister
☐ Your Brother
☐ Your Friend
☐ Others specify_____

11. Information about *all* children living in the home:

Name of child (First Name and Last Name)	Date of Birth (mm/dd/yyyy)	Gender (Female/Male)	Relationship to You (Biological Child, Adopted Child, Step-Child, Grandchild, Niece/Nephew, Unrelated, Other)

12. Do you have health care insurance that covers your health expenses? ☐ Yes ☐ No (If no, skip to 14)

13. What kind of health care insurance?

☐ Private Insurance ☐ Medicaid /SoonerCare ☐ Military Facility
☐ Indian (I.H.S./Tribal Health Service) ☐ Other, specify: _____

14. Type of housing:

(Please choose one) ☐ Apartment ☐ Mobile Home
☐ House ☐ Other, specify: _____

15. Do you rent or own your residence?

☐ Rent ☐ Own ☐ Live with someone else

16. Have you moved in the last 6 months?

☐ Yes ☐ No (if no, skip to 18)

17. How many times? _____

18. Employment:

(Please choose one)
☐ Full time employed (35+ hours/week)
☐ Unemployed, but looking
☐ Part time employed (less than 35 hours/week)
☐ Unemployed, not looking
☐ Odd jobs/irregular employment
☐ Medical leave/disability
☐ Other, specify _____

19. Have you received education on preconception/inter-conception care topics, such as the importance of folic acid; the harmful effects of alcohol, smoking, and illegal drugs; medical check-ups?

☐ Importance of folic acid,
☐ harmful effects of alcohol,
☐ harmful effects of smoking,
☐ harmful effects of illegal drugs,
☐ importance of medical check-ups.
☐ No

20. How many live births have *you* had up until now? _____ Live births

21. Where are these children living and how many?

☐ With you, # of children: _____ ☐ With someone else, # of children: _____

22. Have you been pregnant since you had (identified child)?
☐ Yes ☐ No if no, skip to 23

22a. When did the pregnancy begin? Month_____ Year _____

22b. What was the outcome?
☐ Live Birth (Skip to 22c)
☐ Still Birth (Skip to 23)
☐ Miscarriage (Skip to 23)
☐ Abortion (Skip to 23)
☐ Still pregnant ((Skip to 22d)

22c. If live birth, what was the date of birth for the child? (mm/dd/yyyy) _____/_____/_____

22d. Are you getting prenatal care? ☐Yes ☐No

23. Thinking back to *just before* you got pregnant with your *new* baby, how did you feel about becoming pregnant? **(Choose one answer)**
☐ I wanted to be pregnant sooner (Skip to #25)
☐ I wanted to be pregnant later
☐ I wanted to be pregnant then (Skip to #25)
☐ I didn't want to be pregnant then or at any time in the future (Skip to #25)

24. How much later did you want to become pregnant?
☐ Less than 1 year
☐ 1 year to less than 2 years
☐ 2 years to less than 3 years
☐ 3 years to less than 4 years
☐ 4 years or more

25. Are you or your partner doing anything now to keep from getting pregnant? (Some things people do to keep from getting pregnant include not having sex at certain times [rhythm], or withdrawal, and using birth control methods such as pill, condoms, cervical ring, IUD, having their tubes tied or their partner having a vasectomy.)
☐ Yes ☐ No (Skip to 27)

26. Which type of birth control method have you used in the last 6 months?
☐ Male condom
☐ Natural family planning, rhythm method
☐ Spermicides, jelly, foam, cream suppositories, vaginal cream
☐ Diaphragm
☐ Cervical cap
☐ Sponge
☐ Withdrawal method
☐ Birth control pills
☐ Patch
☐ Cervical ring
☐ Quarterly birth control shot (Depo-Provera)
☐ Monthly birth control shot (Lunelle)
☐ Progestrone IUD
☐ Non-progestrone IUD
☐ Emergency contraception
☐ Female condom
☐ Other: _____

27. What are your or your partner's reasons for not doing anything to keep from getting pregnant now? Choose 'Yes' if it is a reason, and choose 'No' if it is not.

1. I am not having sex	☐ Yes	☐ No
2. I want to get pregnant	☐ Yes	☐ No
3. I don't want to use birth control	☐ Yes	☐ No
4. My husband or partner doesn't want to use anything	☐ Yes	☐ No
5. I don't think I can get pregnant (sterile)	☐ Yes	☐ No
6. I can't pay for birth control	☐ Yes	☐ No
7. I am pregnant now	☐ Yes	☐ No
8. Other, Please tell us: _____	☐ Yes	☐ No

Instructions for Primary Caregiver Renewal Form

Purpose
Primary Caregiver Renewal form gathers demographic and initial pregnancy related information on the person who accepts program services. The form is to be completed every six months to measure the changes that have occurred since enrollment into the program.

General Instructions

Whose form: The primary caregiver (PCG) form.
When: The form is completed six months from the date of intake and at six-month intervals.
What: The form gathers updated information on the demographics and initial pregnancy related information. Outcome measures are determined by comparing intake status to update status over time.
File: This form is filed in the family folder at the program site that is providing services.

Top Box Item Instructions
NOTE: You must complete all fields listed in the box at the top of the form. Ensure that the information pertaining to the PCG is consistent with that submitted for the first "Participant Activity Form". Avoid alternate names, miss-spells, hyphens, parenthesis or typos etc. Use mm/dd/yyyy format for DOB.

Information in the box will be used to create a unique ID that will link all the family forms to one ID.

First Name / Last Name / DOB: The PCG's first and last names and date of birth.

Today's Date: The date on which the screening was conducted. Use mm/dd/yyyy format.

FSW Name: The first and last name of the FSW assigned to this family.

Reporting Time: Check the box indicating the appropriate time frame (PCG intake or every 6 months calculated from the enrollment date). Many program outcomes are measured over time, and this field helps to determine time sequence.

Item Instructions

1: Check the appropriate box indicating the gender of the primary caregiver.

2: Check the appropriate box indicating the race of the primary caregiver. Please check all boxes that apply. If the "Other" box has been checked, please specify the specific race of the primary caregiver.

3: Check the appropriate box indicating whether the primary caregiver is Hispanic or Latino.

4: Check the appropriate box indicating the marital status of the primary caregiver.

5: Check the appropriate box indicating the highest level of education the primary caregiver has completed. Only choose one box.

6: Check the appropriate box indicating whether the primary caregiver is currently enrolled in school, a vocational program or an educational program.

7: Check the appropriate box indicating the primary caregiver's annual household income. Only choose one box.

8: Record the number of adults living in the home in which the primary caregiver resides.

9: Record the number of children living in the home in which the primary caregiver resides.

10: Check the appropriate boxes indicating all adults other than the primary caregiver that live in the home in which the primary caregiver resides. Check all boxes that apply. If the "Others" box is checked, please specify the relationship to the primary caregiver of the other person/people.

11: For all children living in the home in which the primary caregiver resides, record the first and last names, the date of birth in mm/dd/yyyy format, the gender, and the relationship of the child to the primary caregiver. Relationships include biological child, adopted child, step-child, grandchild, niece/nephew, unrelated, and other.

12: Check the appropriate box indicating the type of health insurance the primary caregiver has. If the "Other" box is checked, indicate the specific type of health insurance.

13: Check the appropriate box indicating the type of housing in which the primary caregiver resides. Choose only one box. If the "Other" box is checked, indicate the specific type of housing.

14: Check the appropriate box indicating whether the primary caregiver rents or owns the home in which he/she resides.

15: Check the appropriate box indicating whether the primary caregiver has moved within the previous 6 months. If the primary caregiver has not moved in the last 6 months, skip to 20.

16: Record the number of times the primary caregiver has moved within the previous 6 months.

17: Check the appropriate box indicating the primary caregiver's type of employment. Choose only one box. If the "Other" box is checked, indicate the specific type of employment.

18: Check the appropriate box indicating if the primary caregiver is currently enrolled in any type of educational, vocational or work program.

19: Check the appropriate box indicate if the mother reports ever receiving education about preconception/interconception care topics, such as the importance of folic acid, effects of alcohol, tobacco and drugs, and importance of medical check-ups.

20: Record the number of live births the primary caregiver has had up to this point in time.

21: Check the appropriate box indicating the adult with which the primary caregiver's children currently live. Additionally, record the number of the primary caregiver's children that live with the primary caregiver and that live with someone else.

22: Check the appropriate box indicating whether the primary caregiver has been pregnant since the birth of the index child. If the "No" box is checked, skip to 31.

22a: Record the month and year in which the primary caregiver's most recent pregnancy began.

22b: Check the appropriate box indicating the outcome of the primary caregiver's most recent pregnancy. If any box other than "Still pregnant" is checked, skip to 27.

22c: Check the appropriate box indicating whether the primary caregiver is currently getting prenatal care.

23: Check the appropriate box describing the primary caregiver's feelings toward becoming pregnant at the time just before becoming pregnant with the current baby. If the box for "I wanted to be pregnant later" is checked, continue to 28; otherwise, skip to 29.

24: Check the appropriate box indicating how much later the primary caregiver would have liked to wait before becoming pregnant.

25: Check the appropriate box indicating whether the primary caregiver or his/her partner is using a method to prevent pregnancy. If "No" is checked, skip to 31.

26: Check the appropriate box indicating the type of birth control method the primary caregiver used within the previous 6 months. If the "Other" box is checked, indicate the specific type of birth control method used.

27: Check the appropriate "Yes" or "No" box indicating for each reason whether it was an issue for the primary caregiver and his/her partner to not use the birth control method. If the "Yes" box is checked for "Other", indicate the specific reason.

STAFF/VOLUNTEER INFORMATION FORM

Staff/Volunteer Information

SV1 **First name:** _____ SV2 **Maiden name:**_____

SV3 **Last name:** _____

SV4 **Program name:** _____ SV5 **Agency county**: _____

SV6 **Beginning date of employment/volunteer effort:** (mm/dd/yyyy) ____/____/_____

SV7 **Date of resignation from position:** (mm/dd/yyyy) ____/____/_____

SV8 **Other languages spoken in home:** (language other than English)
- ❑ None
- ❑ Spanish
- ❑ American Sign Language
- ❑ Other, specify _____

SV9 **Employment:** (check one)
- ❑ Full time employed (35+ hours/week)
- ❑ Full time volunteer (35+ hours/week)
- ❑ Contract employee
- ❑ Part time employed (<35 hours/week)
- ❑ Part time volunteer (<35 hours/week)

SV10 **Education level:** (check highest level completed)
- ❑ GED
- ❑ High school graduate
- ❑ Some college/post high school training
- ❑ Associates degree
- ❑ Bachelors degree
- ❑ Graduate degree

SV11 **Job title(s):** (check all that apply)
- ❑ Program Director/Manager
- ❑ Program Coordinator
- ❑ Administrative Supervisor
- ❑ Clinical Supervisor
- ❑ Support Staff
- ❑ Child Development Specialist
- ❑ Public Speaker
- ❑ Family Assessment Worker
- ❑ Family Support Worker
- ❑ Parent Educator
- ❑ Child Care Worker
- ❑ Transportation Provider
- ❑ Community Outreach Worker
- ❑ Other specify_____

Federal Background Check

- must be completed prior to staff serving families or having access to information about families
- Note: No person having a felony conviction shall work (paid or volunteer) in the Program.

SV12 **Date criminal history "no record" report was received by Program:** (mm/dd/yyyy) ____/____/_____

Prior Experience *– at the time of initial employment/volunteering*

SV13 **Months of educational experience in child abuse and neglect/prevention issues:** ____

SV14 **Months of experience in presenting parenting classes:** ____

SV15 **Months of experience in home visiting:** ____

SV16 **Months of experience in early childhood education programs:** ___

STAFF/VOLUNTEER INFORMATION FORM

SV17 **Is the person filling out the form a:** (check one)
- ❑ Home Visitor
- ❑ Assessment Worker
- ❑ Supervisor
- ❑ None of the above

The following information is required only for assessment workers, home visitors, and supervisors. **A completed copy of this form for each assessment worker, home visitor, and program supervisor should be submitted with the Bi-Annual and Annual Narrative Reports.**

Staff Training

- ❖ Document the date training was completed.
- ❖ If circumstances prevent staff from completing a specific training during the required time frame, the Program Supervisor should document those circumstances.
- ❖ Ongoing training should be documented by the Program Supervisor.

SV18 ***Orientation Training*** (3 hours) (mm/dd/yyyy): _____/_____/_____

PAT Core Training (required within 6 months of hire)

- □ SV19 **Assessment** (FAW) (mm/dd/yyyy): _____/_____/_____
- □ SV 20 **Support Worker or Integrated Strategies** (FSW) (mm/dd/yyyy): _____/_____/_____
- □ SV 21 **Supervisor** (mm/dd/yyyy): _____/_____/_____

PAT Required Training

- □ SV 22 **Foundational Training** (mm/dd/yyyy): _____/_____/_____
- □ SV 23 **3 Years to Kindergarten Entry** (mm/dd/yyyy): _____/_____/_____
- □ SV 24 **Issues in Working with Teen Parents** (mm/dd/yyyy): _____/_____/_____

Required Training

Training Topics to Be Covered Within 6 Months of Hire

- SV25 **Infant Care** (mm/dd/yyyy): _____/_____/_____
  - □ a Sleeping (mm/dd/yyyy): _____/_____/_____
  - □ b Feeding/breastfeeding (mm/dd/yyyy): _____/_____/_____
  - □ c Physical care of the baby (mm/dd/yyyy): _____/_____/_____
  - □ d Crying and comforting the baby (mm/dd/yyyy): _____/_____/_____
- SV26 **Child Health and Safety** (mm/dd/yyyy): _____/_____/_____
  - □ a Home safety (mm/dd/yyyy): _____/_____/_____
  - □ b Shaken baby syndrome (mm/dd/yyyy): _____/_____/_____
  - □ c SIDS (mm/dd/yyyy): _____/_____/_____
  - □ d Seeking medical care (mm/dd/yyyy): _____/_____/_____
  - □ e Well-child visits/immunizations (mm/dd/yyyy): _____/_____/_____
  - □ f Seeking appropriate child care (mm/dd/yyyy): _____/_____/_____
  - □ g Care seat safety (mm/dd/yyyy): _____/_____/_____
  - □ h Failure to thrive (mm/dd/yyyy): _____/_____/_____
- SV27 **Maternal and Family Health** (mm/dd/yyyy): _____/_____/_____
  - □ a Family planning (mm/dd/yyyy): _____/_____/_____
  - □ b Nutrition (mm/dd/yyyy): _____/_____/_____
  - □ c Pre-natal/post-natal healthcare (mm/dd/yyyy): _____/_____/_____
  - □ d Pre-natal/post-partum depression (mm/dd/yyyy): _____/_____/_____
- SV28 **Infant and Child Development** (mm/dd/yyyy): _____/_____/_____

- □ a Language and literacy development (mm/dd/yyyy): _____/_____/_____
- □ b Physical and emotional development (mm/dd/yyyy): _____/_____/_____

Required Training

Training Topics to Be Covered Within 6 Months of Hire *(continued)*

- □ c Identifying developmental delays (mm/dd/yyyy): _____/_____/_____
- □ d Brain development (mm/dd/yyyy): _____/_____/_____

- SV29 **Role of Culture in Parenting** (mm/dd/yyyy): _____/_____/_____
  - □ a Working with diverse cultures/populations (mm/dd/yyyy): _____/_____/_____
  - □ b Culture of poverty (mm/dd/yyyy): _____/_____/_____
  - □ c Values clarification (mm/dd/yyyy): _____/_____/_____

- SV30 **Supporting the Parent-Child Interaction** (mm/dd/yyyy): _____/_____/_____
  - □ a Supporting attachment (mm/dd/yyyy): _____/_____/_____
  - □ b Positive parenting strategies (mm/dd/yyyy): _____/_____/_____
  - □ c Discipline (mm/dd/yyyy): _____/_____/_____
  - □ d Parent-child interactions (mm/dd/yyyy): _____/_____/_____
  - □ e Observing parent-child interactions (mm/dd/yyyy): _____/_____/_____
  - □ f Strategies for working with difficult relationships (mm/dd/yyyy): _____/_____/_____

Training Topics to Be Covered Within 12 Months of Hire

- SV31 **Child Abuse and Neglect** (mm/dd/yyyy): _____/_____/_____
  - □ a Etiology of child abuse and neglect (mm/dd/yyyy): _____/____/_____
  - □ b Working with survivors of abuse (mm/dd/yyyy): _____/_____/_____

- SV32 **Family Violence** (mm/dd/yyyy): _____/_____/_____
  - □ a Indicators of family violence (mm/dd/yyyy): _____/_____/_____
  - □ b Dynamics of domestic violence (mm/dd/yyyy): _____/_____/_____
  - □ c Intervention protocols (mm/dd/yyyy): _____/_____/_____
  - □ d Strategies for working with families with family violence issues (mm/dd/yyyy): _____/_____/_____
  - □ e Referral resource for domestic violence (mm/dd/yyyy): _____/_____/_____
  - □ f Effects on children (mm/dd/yyyy): _____/_____/_____
  - □ g Gangs (mm/dd/yyyy): _____/_____/_____

- SV33 **Substance Abuse** (mm/dd/yyyy): _____/_____/_____
  - □ a Etiology of substance abuse (mm/dd/yyyy): _____/_____/_____
  - □ b Culture of drug use (mm/dd/yyyy): _____/_____/_____
  - □ c Strategies for working with families with substance abuse issues (mm/dd/yyyy): _____/_____/_____
  - □ d Smoking cessation (mm/dd/yyyy): _____/_____/_____
  - □ e Alcohol use/abuse (mm/dd/yyyy): _____/_____/_____
  - □ f Fetal alcohol syndrome (mm/dd/yyyy): _____/_____/_____
  - □ g Street drugs (mm/dd/yyyy): _____/_____/_____
  - □ h Referral resources for substance abuse (mm/dd/yyyy): _____/_____/_____

- SV34 **Staff Related Issues** (mm/dd/yyyy): _____/_____/_____
  - □ a Stress and time management (mm/dd/yyyy): _____/_____/_____
  - □ b Burnout prevention (mm/dd/yyyy): _____/_____/_____
  - □ c Personal safety or staff (mm/dd/yyyy): _____/_____/_____
  - □ d Ethics (mm/dd/yyyy): _____/_____/_____
  - □ e Crisis intervention (mm/dd/yyyy): _____/_____/_____
  - □ f Emergency protocols (mm/dd/yyyy): _____/_____/_____

Required Training

Training Topics to Be Covered Within 12 Months of Hire *(continued)*

- SV35 **Family Issues** (mm/dd/yyyy): _____/_____/_____
  - □ a Life skills management (mm/dd/yyyy): _____/_____/_____
  - □ b Engaging fathers' (mm/dd/yyyy):_____/_____/_____
  - □ c multi-generational families (mm/dd/yyyy): _____/_____/_____
  - □ d Teen parents (mm/dd/yyyy): _____/_____/_____
  - □ e Relationship (mm/dd/yyyy): _____/_____/_____
  - □ f HIV and AIDS (mm/dd/yyyy): _____/_____/_____

- SV36 **Mental Health** (mm/dd/yyyy): _____/_____/_____
  - □ a Promotion of positive mental health (mm/dd/yyyy): _____/_____/_____
  - □ b Behavioral signs of mental health issues (mm/dd/yyyy): _____/_____/_____
  - □ c Depression (mm/dd/yyyy): _____/_____/_____
  - □ d Strategies for working with families with mental health issues (mm/dd/yyyy): _____/_____/_____
  - □ e Referral resources for mental health (mm/dd/yyyy): _____/_____/_____

Ongoing Training

1. SV37 **Approved by:**_____ **Date:** _____ **Hours:** _____

2. SV38 **Approved by:**_____ **Date:** _____ **Hours:** _____

3. SV39 **Approved by:**_____ **Date:** _____ **Hours:** _____

4. SV40 **Approved by:**_____ **Date:** _____ **Hours:** _____

5. SV41 **Approved by:**_____ **Date:** _____ **Hours:** _____

6. SV42 **Approved by:**_____ **Date:** _____ **Hours:** _____

7. SV43 **Approved by:**_____ **Date:** _____ **Hours:** _____

8. SV44 **Approved by:**_____ **Date:** _____ **Hours:** _____

9. SV45 **Approved by:**_____ **Date:** _____ **Hours:** _____

10. SV46 **Approved by:**_____ **Date:** _____ **Hours:** _____

11. SV47 **Approved by:**_____ **Date:** _____ **Hours:** _____

12. SV48 **Approved by:**_____ **Date:** _____ **Hours:** _____

13. SV49 **Approved by:**_____ **Date:** _____ **Hours:** _____

14. SV50 **Approved by:**_____ **Date:** _____ **Hours:** _____

15. SV51 **Approved by:**_____ **Date:** _____ **Hours:** _____

Ongoing Training *(continued)*

16. SV52 **Approved by:**_____ **Date:** _____ **Hours:** _____

17. SV53 **Approved by:**_____ **Date:** _____ **Hours:** _____

18. SV54 **Approved by:**_____ **Date:** _____ **Hours:** _____

19. SV55 **Approved by:**_____ **Date:** _____ **Hours:** _____

20. SV56 **Approved by:**_____ **Date:** _____ **Hours:** _____

21. SV57 **Approved by:**_____ **Date:** _____ **Hours:** _____

22. SV58 **Approved by:**_____ **Date:** _____ **Hours:** _____

23. SV59 **Approved by:**_____ **Date:** _____ **Hours:** _____

24. SV60 **Approved by:**_____ **Date:** _____ **Hours:** _____

25. SV61 **Approved by:**_____ **Date:** _____ **Hours:** _____

26. SV62 **Approved by:**_____ **Date:** _____ **Hours:** _____

27. SV63 **Approved by:**_____ **Date:** _____ **Hours:** _____

28. SV64 **Approved by:**_____ **Date:** _____ **Hours:** _____

29. SV65 **Approved by:**_____ **Date:** _____ **Hours:** _____

30. SV66 **Approved by:**_____ **Date:** _____ **Hours:** _____

31. SV67 **Approved by:**_____ **Date:** _____ **Hours:** _____

32. SV68 **Approved by:**_____ **Date:** _____ **Hours:** _____

33. SV69 **Approved by:**_____ **Date:** _____ **Hours:** _____

34. SV70 **Approved by:**_____ **Date:** _____ **Hours:** _____

35. SV71 **Approved by:**_____ **Date:** _____ **Hours:** _____

36. SV72 **Approved by:**_____ **Date:** _____ **Hours:** _____

37. SV73 **Approved by:**_____ **Date:** _____ **Hours:** _____

38. SV74 **Approved by:**_____ **Date:** _____ **Hours:** _____

39. SV75 **Approved by:**_____ **Date:** _____ **Hours:** _____

40. SV76 **Approved by:**_____ **Date:** _____ **Hours:** _____

41. SV77 **Approved by:**_____ **Date:** _____ **Hours:** _____

Instructions for Staff/Volunteer Information Form

Purpose

Used to collect information regarding the program staff such as experience with child abuse and neglect prevention and model specific training. Only volunteer staff who serve in a professional capacity need to complete the form.

A completed copy of this form for each assessment worker, home visitor, and program supervisor should be submitted with the Bi-Annual and Annual Narrative Reports.

Staff/Volunteer Information

SV1 *First Name* – Record the legal first name of the staff member or program volunteer.

SV2 *Maiden Name* – Record the legal maiden name of the staff member or program volunteer. If the staff member or program volunteer is male, record only the last name.

SV3 *Last Name* – Record the legal last name of the program staff or program volunteer.

SV4 *Program Name* – Record the name of the program for which the staff member is employed.

SV5 *Agency County* - Record the name of the county in which the agency is located.

SV6 *Date of Employment* – Record the first day (mm/dd/yyyy) of employment for the staff member or the first day of service for the program volunteer.

SV7 *Date of Resignation* – Record the last day (mm/dd/yyyy) of service for the staff member or program volunteer.

SV8 *Languages* – Record languages other than English that the staff member or program volunteer speaks in their home.

SV9 *Employment* – Record the level of employment for the staff member or the level of volunteerism for the program volunteer.

SV10 *Education* – Record the highest level of education that the staff member or program volunteer has achieved.

SV11 *Job Titles* - Record all of the job titles that describe the staff member's or program volunteer's position:
Program Director/Manager – Code Agency Administrator in this category
Program Coordinator – Code Program Supervisor in this category
Administrative Supervisor
Clinical Supervisor
Family Assessment Worker
Family Support Worker
Community Outreach Worker

Child Development Specialist
Parent Educator .
Support Staff
Child Care Worke
Transportation Provider
Public Speaker.
Other –Record other job title

SV12 *Federal Background Check* - Record the date the federal background report stating "no record" was received by the program. It should be noted that no person having a felony conviction shall work (paid or volunteer) in the program.

SV13 *Months Educational Experience* – Record the number of months educational experience the staff member or program volunteer has in child abuse and neglect and prevention issues.

SV14 *Months Class Experience* – Record the number of months experience the staff member or program volunteer has in parenting classes.

SV15 *Months Home Visiting Experience* – Record the number of months experience the staff member or program volunteer has in elivering home visitation services.

SV16 *Months Childhood Education Experience* – Record the number of months experience the staff member or program volunteer has in delivering childhood education programs.

SV17 *Completion of the remaining question is only required for assessment workers, home visitors, and supervisors* - Record the position of the employee.

SV18*Orientation Training* (3 hours) –Record the date orientation was completed. Orientation training, as required by Healthy Families America, includes the following:

- All staff members (assessment workers, home visitors, and supervisors) are oriented to their roles as they relate to the program's goals, services, policies, operating procedures, (including forms, evaluation tools, and data collection) and philosophy of home visiting/family support. Staff is familiarized to the program's relationship with other community resources (e.g., organizations in the community with which the program has working relationships). Staff is oriented to child abuse and neglect indicators and reporting requirements. All staff members are oriented to issues of confidentiality and boundaries. **Staff orientation is completed prior to direct work with families.**
- All staff members (assessment workers, home visitors, and supervisors) are oriented with site-specific operating policies and procedures. This includes information on the services provided, work hours, supervision requirements, emergency procedures, confidentiality issues, etc. **Staff orientation is completed prior to direct work with families.**

SV19-21 *Core Training (required within 6 months of hire)* – Record the date core training was completed. Core training, as required by Healthy Families America, is training for all direct service staff and their supervisors/program managers that must be completed

within six months of hire. Core training instructs staff in their specific roles as described below:

- *Assessment Core Training* -The Assessment Core Training is an in-depth, formalized training designed for staff whose primary role is to conduct initial assessments.
- *Integrated Strategies for Home Visiting Programs Training* (formerly known as Family Support Worker Core Training) - Home Visitors Core Training is an in-depth, formalized training intended for home visitors of a PAT program.
- *Supervisor Training* - A day of training for supervisors and program managers of PAT direct service staff positions (Family Assessment Specialists and Home Visitors).

SV22-24 *Parents as Teachers (PAT) required training* - Record the date PAT training was completed. PAT training that is required includes Foundational Training; 3 Years to Kindergarten Entry*;* and Issues in Working with Teen Parents.

Required training for all direct service staff and their supervisors/program managers within six months of hire, core training instructs staff in their specific roles.

SV25-30 *Training required within 6 months of hire* – Record the date training was completed**.** Training topics to be covered within 6 months of hire include the following:
SV25a-d Infant Care

- Sleeping;
- Feeding/breastfeeding;
- Physical care of the baby; and
- Crying and comforting the baby

SV26a-h Child Healthy an Safety

- Home safety;
- Shaken baby syndrome;
- SIDS;
- Seeking medical care;
- Well-child visits/immunizations;
- Seeking appropriate child care;
- Care seat safety; and
- Failure to thrive

SV27a-d Maternal and Family Health

- Family planning;
- Nutrition;
- Pre-natal/post-natal healthcare; and
- Pre-natal/post-partum depression

SV28a-d Infant and Child Development

- Language and literacy development;
- Physical and emotional development;
- Identifying developmental delays; and
- Brain development

SV29a-c Role of Culture in Parenting

- Working with diverse cultures/populations
- Culture of poverty; and
- Values clarification

SV30a-f Parent-Child Interaction

- Supporting attachment;
- Positive parenting strategies;
- Discipline;
- Parent-child interactions;
- Observing parent-child interactions; and

SV31-36 *Training required within 12 months of hire* – Record the date training was completed. Training topics to be covered within 12 months of hire include the following:

SV31a-b Child Abuse and Neglect

- Etiology of child abuse and neglect; and
- Working with survivors of abuse

SV32a-g Family Violence

- Indicators of family violence;
- Dynamics of domestic violence;
- Intervention protocols;
- Strategies for working with families with family violence issues;
- Referral resource for domestic violence;
- Effects on children; and
- Gangs

SV33a-h Substance Abuse

- Etiology of substance abuse;
- Culture of drug use;
- Strategies for working with families with substance abuse issues;
- Smoking cessation;
- Alcohol use/abuse;
- Fetal alcohol syndrome;
- Street drugs; and
- Referral resources for substance abuse

SV34a-f Staff Related Issues

- Stress and time management;
- Burnout prevention;
- Personal safety or staff;
- Ethics;
- Crisis intervention; and
- Emergency protocols

SV35a-f Family Issues

- Life skills management;
- Engaging fathers' multi-generational families;
- Teen parents;
- Relationship; and
- HIV and AIDS

SV36a-e Mental Health

- Promotion of positive mental health;
- Behavioral signs of mental health issues;

- Depression;
- Strategies for working with families with mental health issues; and
- Referral resources for mental health

SV37-77 *Ongoing training as required* – Record who approved the training, the date training was completed, and the length of the training in clock hours**.** Ongoing training, as required by PAT, is training based upon the specific staff needs and issues of families within the community served.

PROGRAM INFORMATION FORM

Program Information

PI1 Name of Program: _____

Contract period: From PI2____/____/_____ to PI3 ____/____/_____

PI4 Total budget: (YEAR 1) $_____

PI5 CAP Fund award: (YEAR 1) $_____

CAP Fund award: (YEAR 2) $_____

CAP Fund award: (YEAR 3) $_____

CAP Fund award: (YEAR 4) $_____

CAP Fund award: (YEAR 5) $_____

PI6 Year program began: _____

PI7 Number of times program has received OCAP contract: _____

PI8 Number of Staff _____

PI9 Provided MIEHCV Funds: ❑ Yes ❑ No

PI10 Geographic area served:
- ❑ Multiple counties
- ❑ Single county
- ❑ Multiple cities/towns
- ❑ Single city/town
- ❑ Neighborhoods

PI11 Geographic location: ❑ Urban ❑ Rural ❑ Urban and Rural Areas

Target Population Information

Who does the program primarily serve: (check all that apply) [Parents meaning parents who are expecting (beyond 29 weeks of pregnancy) or parents of newborns]

- ❑ PI12 First time parents
- ❑ PI13 Second time parents
- ❑ PI14 Third time or more parents
- ❑ PI15 Teen parents
- ❑ PI16 Hispanic parents
- ❑ PI17 Native American parents
- ❑ PI18 African American parents
- ❑ PI19 Those not being served by Children First or SoonerStart

Community Services Information
Check the appropriate boxes:

Type of Service	Services Available in Program Area
County Health Department	
Women, Infant, and Children (WIC) –nutrition education and supplemental food program for pregnant women and children under 5 years.	PI20
Maternity Clinic – prenatal care for uninsured or underinsured women	PI21

Family Planning Clinic – exams and birth control for men and women	PI22
Well-Baby Clinic- check-up for well babies 2 weeks to 2 years	PI23
Well-Child Clinic- check-up for well children 2 years to 21 years	PI24
Well-Woman Clinic – breast exams and PAP smears	PI25
Guidance Services – child psychological, developmental, speech, language, and hearing screenings and assessments with short term early intervention services	PI26
SoonerStart – early intervention program for children with developmental disabilities	PI27
Immunizations – infant, child care, school-aged, and adult immunizations	PI28
Medical Clinics - health care for sick or injured children	PI29

Type of Service	**Services Available in Program Area**
Dental Clinic – services for pregnant women and children	PI30
Chronic Disease – screenings and education for hypertension, diabetes, and cancer	PI31
STD/HIV – testing and counseling for sexually transmitted diseases including HIV	PI32
Children First –home visitation for first time mothers who are < 28 weeks pregnant	PI33
Indian Health Services or Tribal Health Care	
Family medicine – *prenatal care, well-baby, illnesses, and injuries*	PI34
Nutrition – outpatient planning and education	PI35
Dentistry - dental health needs	PI36
Counseling – outpatient services for counseling or health education	PI37
Department of Human Services	
Temporary Assistance for Needy Families (TANF) - cash assistance to meet basic needs for families on a time-limited basis (Formerly AFDC)	PI38
Day Care Assistance – assist families to meet the cost of child care for children while parent(s) are at work, at school, or work-related training	PI39
Food Stamps – monthly benefits to purchase food	PI40
Energy Assistance – seasonal assistance for winter heating bills or if family has received utility cut-off notices	PI41
Disability Benefits (SSI/SSA) – *assistance for children with disabilities or special health care needs*	PI42
Family Support Assistance – help families to care for children with developmental disabilities	PI43
Health Insurance	
Medicaid - *includes SoonerCare Plus or SoonerCare Choice received through the Health Care Authority*	PI44
Housing and Urban Development	
Housing Assistance - HUD, Section 8	PI45
Other Community Services	
Childbirth or Prenatal Classes – *preparation for birth of child*	PI46
Adult Education Programs - GED, College, Literacy, Vo-Tech	PI47

Community Resources - food, toys, diapers, clothing or furnishings	PI48
Legal Aid, legal assistance	PI49
Family Violence Programs - prevention, intervention, or treatment	PI50
Crisis Intervention - assistance with management of crisis situations	PI51
Counseling (Individual/Group) - family violence, marital, etc.	PI52
Drugs/Alcohol Programs - prevention, intervention, or treatment	PI53
Emergency Child Care – crisis related, emergency child care	PI54
Job Readiness and Counseling – *services through the Oklahoma Employment Security Commission, vo-techs, colleges, or universities*	PI55
Other family support programs – *Parents as Teachers, Parents Anonymous, First Steps, Adopt-A-Caseworker*	PI56
Early Head Start – *early education and socialization of children*	PI57
Personal Safety/Violence Prevention Life Skills Training – prevention lessons	PI58
Life Management Skills Training – teach living skills such as how to access health care, shopping, budgeting and financial management, problem-solving and how to apply for employment	PI59

Type of Service	**Services Available in Program Area**
Parenting Support Telephone Line – answer questions about parenting, child development, community resources, and concerns	PI60
Program Services	
Respite Care – short term care services for children who have disabilities, chronic or terminal illness, or experienced/in danger of maltreatment	PI61
Individual Parent Education Consultation – *individual, agency-based sessions*	PI62
Transportation Assistance – *to community resources such as health care or program services*	PI63
Other Services	
Smoking Cessation	PI64
(Specify)	PI65
(Specify)	PI66

Instructions for Program Information Form

Purpose

Program Information Form is used to record information about the program, its funding, identified populations, and community services. The form is completed and returned to the Office of Child Abuse Prevention at the beginning of the contract cycle.

Program Information

PI1 *Name of Program* –Record the name of the program
PI2 *Contract Start* – Record when the current contract was initiated (mm/dd/yyyy).
PI3 *Contract End* – Record when the current contract expires (mm/dd/yyyy).
PI4 *Budget* –Record total community-based family resource and support program budget for one year.
PI5 *CAP Fund* – Record the Child Abuse Prevention Fund award amount for each year of the contract.
PI6 *Year Began* – Record the year that the OCAP program began.
PI7 *Times Funded* –Record the number of times that the program has contracted with the Office of Child Abuse Prevention ending with the current contract cycle.
PI8 Number of Staff-Record the number of staff in the program
PI9 Awarded MIECHV Funds - Record whether or not the program is receiving MIECHV funds.
PI10 *Area* – Record the one most appropriate response to what type of area is served.
PI11 *Location* - Record if the program serves an urban, rural, or urban and rural location.

Use the check boxes to indicate the primary population served by the program.

PI12 *First Time Parents.*
PI13 *Second Time Parents.*
PI14 *Third Time or More Parents.*
PI15 *Teen Parents.*
PI16 *Hispanic Parents.*
PI17 *Native American Parents.*
PI18 *African American Parents.*
PI19 *Those not being served by Children First or SoonerStart.*

Community Services Information

Check the appropriate boxes that describe the services available in the community:

County Health Department

PI20 *Women, Infant, and Children (WIC)* –nutrition education and supplemental food program for pregnant women and children under 5 years.
PI21 *Maternity Clinic* – prenatal care for uninsured or underinsured women
PI22 *Family Planning Clinic* – exams and birth control for men and women
PI23 *Well-Baby Clinic*- check-up for well babies 2 weeks to 2 years

PI24 *Well-Child Clinic*- check-up for well children 2 years to 21 years
PI25 *Well-Woman Clinic* – breast exams and pap smears
PI26 *Guidance Services* – child psychological, developmental, speech, language, and hearing screenings and assessments with short term early intervention services
PI27 *SoonerStart* – early intervention program for children with developmental disabilities
PI28 *Immunizations* – infant, child care, school-aged, and adult immunizations
PI29 *Medical Clinics* - health care for sick or injured children
PI30 *Dental Clinics* – services for pregnant women and children
PI31 *Chronic Disease* – screenings and education for hypertension, diabetes, and cancer
PI32 *STD/HIV* – testing and counseling for sexually transmitted diseases including HIV
PI33 *Children First* – health case-based home visitation for first time mothers who are < 28 wks pregnant

Indian Health Services or Tribal Health Care

PI34 *Family medicine* – prenatal care, well-baby, illnesses, and injuries
PI35 *Nutrition* – outpatient planning and education
PI36 *Dentistry* - dental health needs
PI37 *Counseling* – outpatient services for counseling or health education

Department of Human Services

PI38 *Temporary Assistance for Needy Families (TANF)* - cash assistance to meet basic needs for families on a time-limited basis (Formerly AFDC)
PI39 *Day Care Assistance* – assist families to meet the cost of day care while parent(s) are at work, at school, or work-related training
PI40 *Food Stamps* – monthly benefits to purchase food
PI41 Energy Assistance – seasonal assistance for winter heating bills or if family has received utility cut-off notices
PI42 Disability Benefits (SSI/SSA) – assistance for children with disabilities or special health care needs
PI43 Family Support Assistance – help families to care for children with developmental disabilities

Health Insurance

PI44 *Medicaid* - includes Sooner Care or Sooner Choice if received through the Health Care Authority.

Housing and Urban Development

PI45 *Housing Assistance* - HUD, Section 8

Other Community Services

PI46 *Childbirth or Prenatal Classes* – preparation for birth of child
PI47 *Adult Education Programs* - GED, College, Literacy, Vo-Tech
PI48 *Community Resources* - food, toys, diapers, clothing or furnishings
PI49 *Legal Aid*, legal assistance
PI50 *Family Violence Programs* - prevention, intervention, or treatment
PI51 *Crisis Intervention* - assistance with management of crisis situations

PI52 *Counseling (Individual/Group*) - family violence counseling
PI53 *Drugs/Alcohol Programs* - prevention, intervention, or treatment
PI54 *Emergency Child Care* – crisis related, emergency child care
PI55 *Job Readiness and Counseling* – services through the Oklahoma Employment Security Commission, vo-techs, colleges, or universities
PI56 *Other family support programs* – Parents as Teachers, Parents Anonymous, First Steps, Adopt-A-Caseworker
PI57 *Early Head Start* – early education and socialization of children
PI58 *Personal Safety/Violence Prevention Life Skills Training* – prevention lessons
PI59 *Life Management Skills Training* – teach living skills such as how to access health care, shopping, budgeting and financial management, problem-solving and how to apply for employment
PI60 *Parenting Support Telephone Line* – answer questions about parenting, child development, community resources, and concerns

Program Services

PI61 *Respite Care* – short term care services for children who are in danger of maltreatment
PI62 *Individual Parent Education Consultation* – individual, agency-based sessions
PI63 *Transportation Assistance* – to community resources such as health care or program services

Other Services

PI64 Smoking Cessation
PI65 (specify)
PI66 (specify)

SUPPLEMENTAL INTERACTION FORM		
PCG Last Name	PCG First Name	PCG DOB / /
Today's Date (mm/dd/yyyy) / /	Home Visitor Name	
Start Time: am / pm	End Time: am / pm	

SI1. Level of visit: ☐ 1-PN ☐ 1-SS ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ X

SI2. Was the visit? ☐ Completed ☐ No Show ☐ Cancelled by Family ☐ Cancelled by FSW

SI3. Next visit scheduled: Date_____/_____/_____ Time _____am/pm

SI4. Nature of Interaction: ☐ Phone Call ☐Text Message ☐ Face to Face ☐Other_____

SI5. Person making contact:
☐PCG ☐Husband/partner ☐Supervisor ☐Interpreter
☐PCG's mother ☐Friend ☐Medical Provider ☐ HD/ Agency Employee
☐ Father of Child ☐Other family ☐Employer ☐ Unknown
☐ School ☐Other person at visit (specify)_____

SI6. Was an Intimate Partner Violence safety plan discussed, completed or reviewed today? ☐Yes ☐No

SI7. Was the client referred to appropriate services? ☐Yes ☐No

SI8. If yes, did you complete the Service Utilization form? ☐Yes ☐No

SI9: **Since the last meeting/interaction was there an ER visit for the PCG**? ☐ Yes ☐ No

SI10. Since the last meeting/interaction was there an ER visit for the Child? ☐ Yes ☐ No **(If no on SI9 & SI10; skip to SI12)**

SI11: If yes, what was the reason? Child:
☐ Non-Critical – ER visit due to non-critical incidences like ear/nose/throat infections, respiratory distress, fever, gastro-intestinal issues.
☐ Critical – ER visits due to critical incidences like injury from accident, physical trauma, poisoning, ingestion, bruising, wounds, severe bleeding.

SI11a: If yes, what was the reason? PCG:
☐ Non-Critical – ER visit due to non-critical incidences like ear/nose/throat infections, respiratory distress, fever, gastro-intestinal issues.
☐ Critical – ER visits due to critical incidences like injury from accident, physical trauma, poisoning, ingestion, bruising, wounds, severe bleeding.

SI12: Since the last meeting was there a non-ER related event that would be considered a critical incident? ☐Yes ☐No

SI13. Was a Critical Incident Report completed? ☐Yes ☐No **SI13a**. Was a DHS report completed? ☐Yes ☐No

SI14. Was a 333F completed? ☐Yes ☐No

SI15:Content of interaction:

SI16: Was a superior contacted? ☐Yes ☐No S116a: Name of supervisor: _____

SI17: Plan for follow up:

Instructions for Supplemental Interaction Form 2012

Purpose
The Supplemental Interaction Form records any contact with a family other than an attempted visit, cancellation, and completed home visit.

General Instructions

- Whose form: Primary Caregiver (PCG) form or any other contact regarding the PCG or Indentified Child.
- When: This form should be used any other time than a scheduled home visit has been completed or attempted.
- What: The form provides information the PCG receives about the interactions that are not home visits.
- Complete and enter into the OCCAP (or equivalent) data base.
- File physical copy into PCG's file folder.

Item Instructions
SI1: Check the box that describes the level of the visit:

☑	LEVEL	HOME VISITATION SERVICE CRITERIA
	LEVEL 1P	During the Prenatal Service Level, the Family Support Worker will make 2 to 4 visits monthly according to the family's needs. The Home Visitor and Supervisor will determine the frequency of home visits during the prenatal period.
	LEVEL 1	Transition the family to Level 1 when parent(s) give birth to a baby. On Level 1, the Family Support Worker will make at least 1 home visit a week. Transition to Level 2 will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL 2	The Family Support Worker will make at least 1 home visit every other week. Transition to Level 3 will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL 3	The Family Support Worker will make at least 1 home visit per month. Transition to Level 4 will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL 4	The Family Support Worker will make at least 1 home visit every 3 months. Transition out of the Program will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL X	Level X or Creative Outreach is the level assigned to parents who have not engaged in services for 4 weeks; or have received visits but currently decline or are not available for visits; or for parents who have notified the Staff that they are temporarily out of the service area (for over 1 month) but plan to return and resume service. Transition to Level X will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service.
	LEVEL SS	Special Services is the level assigned to parents who are experiencing stress due to environmental circumstances; due to the physical health of the child; or

		have had a substantiated report of abuse or neglect. Transition to Level SS will be determined by the Family, Family Support Worker and Supervisor based on the Criteria of Service. If additional assistance is needed, contact the Program Consultant.

SI2: Enter the date and time of the most recent visit.

SI3: Enter the date and time of the next scheduled home visit.

SI4: Indicate the nature of interaction. Indicate if the non-home visit interaction was a phone call, text message, face to face or other. If the interaction was "other" note what type of interaction it was.

SI5: Indicate who made the contact. If "other" is indicated, specify who it was.

SI6: Record whether or not an Intimate Partner Violence safety plan was discussed, completed or reviewed. An Intimate Partner Violence safety plan should only be completed by those who have had the appropriate training. Please provide a referral if you have not completed the Intimate Partner Violence Safety Plan Training.

SI7: Record whether or not the PCG was referred to appropriate services. Complete this process by noting the referral on the Service Utilization From.

SI8: Note whether or not a Service Utilization form was completed for the referral of appropriate services.

SI9: Record whether or not there was an emergency room visit for the Primary Caregiver since the last home visit or interaction. An Emergency Room (ER) visit can be at an urgent care center if it is accessed like an ER where no ER's are available.

SI10: Record whether or not there was an emergency room visit for the Indentified Child since the last home visit or interaction. Emergency Room (ER) visit can be an urgent care center if it is accessed like an ER where no ER's are available.

SI11. Indicate the reason for the Primary Caregiver's ER visit. The purpose of this question is to discern if the ER visit was due to a Non-critical or Critical event.

> **Non-critical events** – This question references events that are not associated with abuse and neglect. Non-critical events might become critical under extreme circumstance, especially if there is any harmful intent or a suspicious grouping of several events. Examples of non-critical ER visits include events like ear/nose/throat infections, respiratory distress, fever, and gastro-intestinal issues. Completing a critical incident is not required but could be completed if there is a concern that the non-critical event might become critical.
>
> **Critical Events** – This question references events that are associated with abuse and neglect. ER visits due to critical incidents might include injury from

accident, physical trauma, poisoning, ingestion, bruising, wounds, and severe bleeding. Critical events can become non-critical under certain circumstances. A critical incident report is required, but not limited to, the following circumstances:

- Severe injury to a PAT family member or the child of a PAT PCG;
- Severe illness of a PAT family member or the child of a PAT PCG;
- Death of a PAT family member or the child of a PAT PCG;
- Any harm that has come to a FSW by a PCG or someone connected to the PCG;
- Legal issues such as a subpoena;
- The child of a PAT PCG is placed in Department of Human Services (DHS) Custody;
- Issues or concerns related to Child Protective Services (CPS); and
- Any other significant event that may occur.

SI11a. HV13a is consistent with HV13, but the emergency room visit was for the Indentified Child.

SI12: Record whether or not there was a non-emergency room related critical incident. Examples of circumstances that are identified as critical incidents include the following:

- Severe injury to a PAT family member or the child of a PAT PCG;
- Severe illness of a PAT family member or the child of a PAT PCG;
- Death of a PAT family member or the child of a PAT PCG;
- Any harm that has come to a FSW by a PCG or someone connected to the PCG;
- Legal issues such as a subpoena;
- The child of a PAT PCG is placed in Department of Human Services (DHS) Custody;
- Issues or concerns related to Child Protective Services (CPS); and
- Any other significant event that may occur.

SI13: If HV13, HV13a, or HV14 involved a critical incident, was a critical incident report completed?

SI13a. Was a Department of Human Services Report completed?

SI14: If warranted, was a 333F completed?

SI15: During the interaction, what was discussed? Please note all details of the conversations as important factors are not always apparent during the initial conversation. If a family thinks it's important enough to make contact, it's important to

consider all of that communication significant. Describe the tone and feeling of the interaction along with the content.

SI16: Was a supervisor contacted? A supervisor should be contacted regarding any event out of the normal scope of the home visitor's work.

SI16a: Record the name of the supervisor that was contacted.

SI17: Record the plan to follow up. Record what was discussed, as well as any steps that need to be completed.