

***Chapter 4***

**2020**

**ADDENDUMS TO NFP & MIECHV FORMS  
AND INSTRUCTIONS**

## MIECHV Demographics: Pregnancy-Intake

Client ID	<input type="text"/>	Client Name	<input type="text"/>	DOB	<input type="text"/>
Client SSN	<input type="text"/>				
Date	<input type="text"/>	Nurse Home Visitor ID	<input type="text"/>	Nurse Home Visitor Name	<input type="text"/>

**Section I - Personal/Family** – This section is to be entered into the Individual Profile screen in DCS.

1. ♦ Client's DOB: \_\_\_\_\_  
M1. Client's EDD: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. ♦ Ethnicity (check one):
  - Hispanic or Latina
  - Not Hispanic or Latina
  - Declined to self-identify
3. ♦ Race (check all that apply)
  - American Indian or Alaska Native
  - Asian
  - Black or African-American
  - Native Hawaiian or other Pacific Islander
  - White
  - Declined to self-identify
  - Multi-racial, (please list) \_\_\_\_\_
4. ♦ Client's Primary Language (check only one):
 

<ul style="list-style-type: none"> <li><input type="checkbox"/> English</li> <li><input type="checkbox"/> Spanish</li> <li><input type="checkbox"/> Arabic</li> <li><input type="checkbox"/> Cantonese</li> <li><input type="checkbox"/> Creole (Haitian)</li> <li><input type="checkbox"/> French</li> <li><input type="checkbox"/> Hindi</li> <li><input type="checkbox"/> Italian</li> <li><input type="checkbox"/> Japanese</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Korean</li> <li><input type="checkbox"/> Mandarin</li> <li><input type="checkbox"/> Polish</li> <li><input type="checkbox"/> Russian</li> <li><input type="checkbox"/> Tagalog</li> <li><input type="checkbox"/> Tribal Languages</li> <li><input type="checkbox"/> Vietnamese</li> <li><input type="checkbox"/> Other (please specify) _____</li> </ul>
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5. ♦ Client's Zip Code: \_\_\_\_\_
6. ♦ Are you participating in this program voluntarily?
  - Yes
  - No

## MIECHV Demographics: Pregnancy-Intake

**Section II – Other Demographics** – This section is to be entered into the Demographics Intake Assessment in DCS.

1. ♦ Marital Status:

- Married - Legal
- Married – Common Law
- Single - never married
- Widowed
- Divorced
- Separated
- Not Married – living with partner

2. ♦ 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

3. ♦ With whom do you live? (check only one from options 1 – 5)

- Live with others (check all that apply)
  - Client's mother
  - Father of Child (FoC)
  - Current husband/partner (not FoC)
  - Other family members
  - Infant/child
  - Other adults
- Live alone (or with infant/child)
- Live in a group home/shelter
- Confined to an institutional facility (residential treatment facility, incarcerated)
- Homeless
  - Homeless and sharing housing (skip to 5)
  - Homeless and living in emergency or transitional shelter (skip to 5)
  - Other (skip to 5)

4. ♦ If you are not homeless, where do you currently live?

- Owns or shares own home, condominium, or apartment
- Rents or shares own home or apartment
- Lives in public housing
- Lives with parent or family member
- Other

## MIECHV Demographics: Pregnancy-Intake

5. ♦ Which members of your family are in the Military – active or reserve? (check all that apply)

- Self (client)
- Client's spouse
- Client's parent(s)
- Father of child (FoC)
- None

M2. Which members of your family are currently serving or **formerly** served in the military – active or reserve? (Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Index Parent           | <input type="checkbox"/> Father of the Child |
| <input type="checkbox"/> Index Parent's Spouse  | <input type="checkbox"/> Mother of the Child |
| <input type="checkbox"/> Index Parent's Parents | <input type="checkbox"/> None                |

### Section III – Education and Income

6. ♦ Are you currently enrolled in middle or high school, GED, college and/or vocational/certification program (check all that apply)?

- Yes
  - Middle school (6<sup>th</sup> – 8<sup>th</sup> grades)
  - High school
  - GED program
  - Post-high school vocational/certification/technical training
    - Full Time – 12 semester hours or equivalent
    - Part Time
      - 7 – 11 semester hours or equivalent
      - 6 or less semester hours or equivalent
  - College
    - Full Time – 12 semester hours or equivalent
    - Part Time
      - 7 – 11 semester hours or equivalent
      - 6 or less semester hours or equivalent
- Not enrolled

## MIECHV Demographics: Pregnancy-Intake

7. ♦ Have you completed high school, GED, vocational/certification, and/or higher educational programs (check all that apply)?
- Yes
- High school
  - GED
  - Vocational/certification/technical training program
  - Some college (no degree)
  - Associate's degree
  - Bachelor's degree
  - Master's degree
  - Professional degree (for example: LLB, LD, MD, DDS)
  - Doctorate degree (for example: PhD, EdD)
  - Non-US based post primary education
- No. What is the last grade you have completed?  grade
8. ♦ Do you **have a** plan to enroll in any additional kind of school, vocational, certification or educational program?
- Yes
- No
9. ♦ Are you currently working?
- Yes
- Full-time: 37+ hours per week
  - Part-time
    - 20 – 36 hours per week
    - 10 – 19 hours per week
    - less than 10 hours per week
- No
- Unemployed and seeking employment
  - Not employed (student, homemaker, other)

## MIECHV Demographics: Pregnancy-Intake

10. ♦ Which of the following categories best describes your total yearly household income and types of benefits you receive? Include your income and any other income you may have received. For the purpose of this question, the household should include only you and your child. Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).

- Less than or equal to \$6,000
- \$6,001 - \$9,000
- \$9,001 - \$12,000
- \$12,001 - \$16,000
- \$16,001 - \$20,000
- \$20,001 - \$30,000
- Over \$30,000
- Client is dependent on parent/guardian

11. ♦ Does the client meet the agencies low-income criteria/threshold?

- Yes
- No

- M3. Last **month**, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? *All information will be kept private and will not affect any services you are now getting.*

- |  |  |
|--|--|
| <input type="checkbox"/> \$250 or less     | <input type="checkbox"/> \$1,751 - \$2,000 |
| <input type="checkbox"/> \$251 - \$500     | <input type="checkbox"/> \$2,001 - \$2,250 |
| <input type="checkbox"/> \$501 - \$750     | <input type="checkbox"/> \$2,251 - \$2,500 |
| <input type="checkbox"/> \$751 - \$1,000   | <input type="checkbox"/> \$2,501 - \$2,750 |
| <input type="checkbox"/> \$1,001 - \$1,250 | <input type="checkbox"/> \$2,751 - \$3,000 |
| <input type="checkbox"/> \$1,251 - \$1,500 | <input type="checkbox"/> \$3,001 or more   |
| <input type="checkbox"/> \$1,501 - \$1,750 | <input type="checkbox"/> Don't Know        |

M4. Number of Adults in Household: \_\_\_\_\_ M5. Number of Children in Household: \_\_\_\_\_

## MIECHV Demographics: Pregnancy-Intake

12. ♦ Do you (client) have health insurance coverage?

Yes

No

If yes, which type of health insurance do you use when you go for medical care? (please check all that apply)?

Medicaid

CHIP

Tri-Care

Private

Other (please specify) \_\_\_\_\_

M6. Does anyone living in the household have a history of substance abuse or need substance abuse treatment?

Yes

No

Unknown

M7. Do you use tobacco products?

Yes

If Yes, are you currently receiving tobacco cessation services?

Yes

No

No

M8. Does anyone else living in the household use tobacco products?

Yes

No

Unknown

M9. Has anyone living in the household had a history of child abuse or neglect and/or interactions with child welfare services?

Yes

No

Unknown

M10. Is there anyone in your household (including adults and children) who had/has a low student achievement level?

Yes

No

## Instructions for the MIECHV DEMOGRAPHICS: PREGNANCY INTAKE Form

**When to complete this form:** At the time of Enrolling the Client into the MIECHV program (1<sup>st</sup> Visit).

*The following MIECHV Reporting Data Points have been incorporated into the ETO Demographics: Pregnancy Intake form:*

### Item Instructions

Item	Guidelines
<b>M1. Expected delivery date</b>	The date that the mother's current pregnancy's baby is estimated to be delivered on. <i>MM/DD/20YY</i>
<b>M2. Which members of your family are currently serving or formerly served in the military – active or reserve? (Check all that apply)</b>	<i>Based on self-report</i> , families that include individuals who are serving or <b>formerly</b> served in the Armed Forces.
<b>M3. Last month, what was your (parent's) gross TOTAL HOUSEHOLD income from employment and any benefits you receive? All information will be kept private and will not affect any services you (parent) are now getting.</b>	Reassure parent that income information will not be used to determine eligibility in any programs or affect any services they are now getting. <i>Based on self-report</i> , what was the total household income, before taxes, last month? <u>For 2-parent households, include both parents' income and benefits. If household income/benefit source includes someone other than parents, include that also.</u> Include all of these Income Sources: Paycheck or money from a job Benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) Money from a business, fees, dividends, or rental income  Child support or alimony Social security, workers' compensation, disability, veteran benefits or pensions Unemployment benefits
<b>M4. Number of adults in household</b>	Total number of adults living in household. Include any adults who stay in the household at least 4 nights a week.
<b>M5. Number of children in household</b>	Total number of children living in household. Includes Index child and any other children, ages Birth – 18 yrs old, who stay in the household at least 4 nights a week.
<b>M6. Does anyone living in the household have a history of substance abuse or need substance abuse treatment?</b>	<i>Based on self-report</i> , a household with members who have a history of substance abuse or who have been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.
<b>M7. Do you use tobacco products?</b>	<i>Based on self-report</i> , if the mother uses tobacco products or has been identified as using tobacco through a substance abuse screening administered

	<p>during intake. Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and electronic nicotine delivery systems (ENDS).</p> <p>If Yes, mother does use tobacco products, check <b>Yes</b>, if she is receiving tobacco cessation services, or check <b>No</b>, if she is not.</p>
<p><b>M8. Does anyone else living in the household use tobacco products?</b></p>	<p><i>Based on self-report</i>, a household with members who use tobacco products in the home or have been identified as using tobacco through a substance abuse screening administered during intake. Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and electronic nicotine delivery systems (ENDS).</p>
<p><b>M9. Has anyone living in the household had a history of child abuse or neglect and/or interactions with child welfare services?</b></p>	<p><i>Based on self-report</i>, a household with members who have a history of abuse or neglect and have had involvement with child welfare services either as a child or as an adult.</p>
<p><b>M10. Is there anyone in your household (including adults and children) who had/has a low student achievement level?</b></p>	<p><i>Based on self-report</i>, a household with members who have perceived themselves or their child(ren) as having low student achievement.</p>

**N1**  
**Addendum to Clinical IPV Assessment Form**  
**5<sup>th</sup> – 7<sup>th</sup> VISIT**  
*To be completed within 6 months of parent's enrollment*

*\*\*Reminder: Only return this Addendum to state. Do not return Clinical IPV Assessment to state.*

Name of Home Visitor: \_\_\_\_\_

NFP ID # of Mother: \_\_\_\_\_

Name of Mother: \_\_\_\_\_

**1. Clinical IPV Assessment completed (with *mother*)?**

Yes, completed → **Date Assessment completed:** \_\_\_\_ / \_\_\_\_ / 20 \_\_\_\_ → *Go to Question 1a.*

**1a. If Yes, result of Clinical IPV:**

Score indicates risk of IPV → *Go to Question 1b.*

Score does not indicate risk of IPV

**1b. If Score indicates risk of IPV, did you give referral information?**

Yes

No, client declined or is not ready for a referral and/or services

No, an earlier referral is still in process or the client is currently receiving services

No, other reason → *Please specify:* \_\_\_\_\_

No, not completed → *Go to Question 1c.*

**1c. If No, reason why Clinical IPV not completed:**

Concern previously identified

Other

# Instructions for the MIECHV

## N1

### Addendum to: CLINICAL IPV ASSESSMENT Form 5<sup>th</sup> – 7<sup>th</sup> VISIT

**When to complete this form:** Within 6 months of Enrolling the Client into the MIECHV program, at the 5<sup>th</sup> – 7<sup>th</sup> visit.

#### Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this family.
NFP ID # of Mother	The Mother's NFP ID #.
Name of Mother	The Mother who signed up to participate in the MIECHV Program.
Clinical IPV Assessment Completed (with mother)?	Was the Clinical IPV Assessment completed to screen for Intimate Partner Violence? If it was, enter the date that the assessment was completed and continue to Question 1a. If it was not completed, go to Question 1c. <b>DO NOT send the Clinical IPV Assessment to the state.</b>
If Yes, Result of Clinical IPV	If the Clinical IPV Assessment was completed, indicate if the score indicates risk of IPV or does not indicate risk of IPV. If the score does indicate risk of IPV, go to Question 1b.
If Score indicates risk of IPV, did you give referral information?	Was referral information provided? If not, indicate the reason why. Write in Other reason, if applicable.
If No, reason why Clinical IPV not completed	If the Clinical IPV Assessment was not completed, indicate if the reason was either because Concern previously identified or Other reason.

**M2B**

**MIECHV REFERRALS TRACKING & FOLLOW-UP – INDEX PARENT**

Please send this form to the State **MONTHLY** with updates  
(due by the 15<sup>th</sup> of the following month)

Name of Home Visitor: \_\_\_\_\_

Home Visiting Program:  Early Head Start     Healthy Families Oregon     Nurse-Family Partnership

Parent ID #: \_\_\_\_\_

Name of Index Parent: \_\_\_\_\_

	<b>INITIAL REFERRAL</b>	<b>FOLLOW-UP</b>
<b>Type of Service</b>	<b>Date Referred to Service</b>	<b>Date Service Started/Received</b>
<b>1) Depression</b>	<b>/ / 20</b>	<b>/ / 20</b>
<b>1A) Depression</b>	<b>/ / 20</b>	<b>/ / 20</b>
<b>1B) Depression</b>	<b>/ / 20</b>	<b>/ / 20</b>
<b>1C) Depression</b>	<b>/ / 20</b>	<b>/ / 20</b>
<b>2) Tobacco Cessation</b>	<b>/ / 20</b>	<b>/ / 20</b>
<b>2A) Tobacco Cessation</b>	<b>/ / 20</b>	<b>/ / 20</b>
<b>2B) Tobacco Cessation</b>	<b>/ / 20</b>	<b>/ / 20</b>
<b>2C) Tobacco Cessation</b>	<b>/ / 20</b>	<b>/ / 20</b>

**Instructions for the MIECHV**  
**M2B-REFERRAL TRACKING & FOLLOW-UP Form - INDEX PARENT**

**When to complete this form:**

***Initial Referral Section:*** Identification of needed services should be completed at the time of enrolling the Index Parent into the MIECHV program using your standard Home Visiting Model Process. The date referrals are made to needed services should be recorded ***any time they are made for the parent.*** This form should be sent to the state when any initial referral is made for the parent.

*Note: For MIECHV, tracking is required for the limited number of referrals on this form. For your home visiting model, you will likely make and track additional referrals, however these are not required to be reported to MIECHV.*

***Follow-up Section:*** Following the initial referral for service, when the parent receives the service, record the date service is started or received. If the parent has not received the service, continue to follow up as appropriate encouraging the parent to access services for themselves when ready. During this time of follow up with the parent, send the referral tracking form monthly to the state when updates are made. A reminder email will be sent monthly to your program from the state requesting the updated form.

**Referral Guidelines:** A referral to services can be made directly by calling a community service agency and requesting services for the parent or by giving the parent a list of resources to call for assistance.

**Referral Definitions:**

***1) Depression:***

Referrals include those made for maternal depression. These referrals may include but are not limited to: mental health treatment, therapy, counseling, or primary care or other provider for prescription management. Please use your nursing judgment and talk with your supervisor if you are unsure if a referral you are making should be counted as a referral for depression treatment or services.

***1A, 1B, 1C) Additional Referrals to Depression:***

If there is more than one referral for Depression services, the second, third or fourth referrals can be recorded here.

***2) Tobacco Cessation:***

Referrals include those made for tobacco cessation counseling or services. These referrals may include: tobacco quit line, primary care provider, or other tobacco cessation programs.

**2A, 2B, 2C) Additional Referrals to Tobacco Cessation:**

If there is more than one referral for Tobacco Cessation services, the second, third or fourth referrals can be recorded here.

**Item Instructions**

<b>Item</b>	<b>Guidelines</b>
<b>Name of Home Visitor</b>	The Home Visitor assigned to this index parent.
<b>Parent ID#</b>	The Mother's NFP ID #.
<b>Name of Index Parent</b>	The Mother who signed up to participate in the MIECHV Program.
<b>Initial Referral Section:</b>	
<b>Date Referred to Service</b>	When a referral is made, date the referral to the service was made to the parent. <i>MM/DD/20YY</i>
<b>Follow-up Section:</b>	
<b>Date Service Started/Received</b>	Date service started or was received. <i>MM/DD/20YY</i>

# MIECHV Infant Birth



Infant ID  Client ID   
Client Name  DOB   
Date  Nurse Home Visitor ID  Nurse Home Visitor Name

**Section I** – This section is to be entered into the Individual Profile screen in DCS.

1. ♦ Infant's First Name \_\_\_\_\_
2. ♦ Infant's Last Name \_\_\_\_\_
3. ♦ Infant's DOB: \_\_\_\_\_
4. ♦ Child's Ethnicity (check one):  
 Hispanic or Latina/Latino  
 Not Hispanic or Latina/Latino
5. ♦ Child's Race (check one):  
 American Indian or Alaska Native  
 Asian  
 Black or African-American  
 Native Hawaiian or other Pacific Islander  
 White  
 Declined to self-identify  
 Multi-racial, (please list) \_\_\_\_\_
6. ♦ Gender: \_\_\_\_\_  
 Male  
 Female

**Section II** – This section is to be entered into the Infant Birth Assessment in DCS.

1. Birth weight:  grams or  lbs.  oz.
2. ♦ Gestational age at birth:  weeks
3. ♦ Did (child's name) have to spend any time in the NICU or a special care nursery because of problems?  
 Yes – NICU  
 Yes – Special Care Nursery  
If yes, is the child still in NICU/Special Care Nursery?  
 Yes  
 No, for how many days prior to being discharged?  days  
What was the purpose of the stay (please check all that apply)?  
 Low birth weight  
 Very low birth weight  
 Respiratory distress  
 Prematurity  
 Congenital defect  
 Other (please specify) \_\_\_\_\_  
 No

# MIECHV Infant Birth

4. ♦ What was your overall weight gain during pregnancy?  lbs.

5. ♦ Did your baby receive breast milk?

- Yes  
 No

6. ♦ Type of labor

- Induced  
 Not induced

7. ♦ Type of delivery

- Vaginal  
 Caesarean

**Safe Sleep: For questions 8, 9, and 10, select 'N/A' if the infant is in the hospital when the form is completed**

8. ♦ How often do you place your infant to sleep on their back?

- Always  
 Sometimes  
 Never  
 N/A

9. ♦ How often do you bed-share with your infant?

- Always  
 Sometimes  
 Never  
 N/A

10. ♦ How often does your infant sleep with soft bedding?

- Always  
 Sometimes  
 Never  
 N/A

11. ♦ During a typical week, how many days do you (and/or a family member) read, tell stories, and/or sing songs to your child?

- 0  1  2  3  4  5  6  7

12. ♦ Does your child have health insurance coverage?

Yes

No

If yes, which type of health insurance do you use when you take your child for medical care

(please check all that apply)?

Medicaid

CHIP

Tri-Care

Private

Other (please specify) \_\_\_\_\_

M1. Where do you usually take your child for medical care?

Doctor's/Nurse Practitioner's Office

Hospital Emergency Room

Hospital Outpatient

Federally Qualified Health Center (FQHC)

Retail Store or Minute Clinic

Other: \_\_\_\_\_

**Instructions for the**  
**MIECHV INFANT BIRTH Form**

**When to complete this form:** At the time of Enrolling the Index Child into the MIECHV program.

*The following MIECHV Reporting Data Point has been incorporated into the ETO Infant Birth form:*

**Item Instructions**

<b>Item</b>	<b>Guidelines</b>
<b>M1. Where do you usually take your child for medical care?</b>	The particular medical professional, doctor's office, clinic, health center, or other place where the parent would take the child if he/she were sick or in need of advice about their health.

**N2**  
**Addendum to NFP PHQ-9 Form**

*To be completed within 3 months of infant's birth*

**Name of Home Visitor:** \_\_\_\_\_

**NFP ID # of Mother:** \_\_\_\_\_

**Name of Mother:** \_\_\_\_\_

**1. PHQ-9 completed (with *mother*)?**

Yes, completed → **Date tool completed:** \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_ → *Go to Question 1a.*

**1a. If Yes, result of PHQ-9:**

Score of 10 or higher → *Go to Question 1b.*

Score of 9 or lower

**1b. If a Score of 10 or higher, did you give referral information?**

Yes → *Complete M2B-MIECHV Referral Tracking & Follow-up Form*

No, client declined or is not ready for a referral and/or services

No, an earlier referral is still in process

No, the client is currently receiving services

No, other reason → *Please specify:* \_\_\_\_\_

No, not completed → *Go to Question 1c.*

**1c. If No, reason why PHQ-9 not completed:**

Concern previously identified

Other

**Instructions for the**  
**N2**  
**Addendum to: NFP PHQ-9 Form**

**When to complete this form:** Within 3 months of infant's birth.

**Item Instructions**

<b>Item</b>	<b>Guidelines</b>
<b>Name of Home Visitor</b>	The Home Visitor assigned to this family.
<b>NFP ID # of Mother</b>	The Mother's NFP ID #.
<b>Name of Mother</b>	Mother's name.
<b>PHQ-9 completed (with mother)?</b>	Was the PHQ-9 completed to screen for depression? If it was, enter the date that the PHQ-9 was completed and continue to Question 1a. <b>DO NOT send the PHQ-9 to the state.</b> <b>See Appendix A for PHQ-9 Tool and Scoring Guidelines</b>
<b>If Yes, result of PHQ-9</b>	If the PHQ-9 was completed, indicate if the score on the PHQ-9 was either 10 or higher or 9 or lower. If the score was 10 or higher, go to Question 1b.
<b>If a Score of 10 or higher, did you give referral information?</b>	Was a referral made? If not, indicate the reason why. Write in Other reason, if applicable. <b><i>If Referral was made, use M2B-MIECHV Referral Tracking &amp; Follow-up Form</i></b>
<b>If No, reason why PHQ-9 not completed</b>	If the PHQ-9 was not completed, indicate if the reason was either because Concern previously identified or any Other reason.

**N3**  
**NFP Baby's Age 3 Months**  
*Index Child*

Name of Home Visitor: \_\_\_\_\_

NFP ID # of Mother: \_\_\_\_\_

Name of Mother: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Date data gathered: \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

1. How often do you place your infant to sleep on their back?

- Always
- Sometimes
- Never

2. How often do you bed-share with your infant?

- Always
- Sometimes
- Never

3. How often does your infant sleep with soft bedding?

- Always
- Sometimes
- Never

4. During a typical week, how many days do you (and/or a family member) read, tell stories and/or sing songs to your child?

- 0 – Not at all     1     2     3     4     5     6     7 – Every day

**Instructions for the**  
**N3**  
**NFP BABY'S AGE 3 MONTHS Form – Index Child**

**When to complete this form:** When Child is between 2 - 4 months old.

**Item Instructions**

<b>Item</b>	<b>Guidelines</b>
<b>Name of Home Visitor</b>	The Home Visitor assigned to this family.
<b>NFP ID # of Mother</b>	The Mother's NFP ID #.
<b>Name of Mother</b>	The Mother who signed up to participate in the MIECHV Program.
<b>Name of Child</b>	The child who was born to the mother who is participating in the MIECHV program.
<b>Date Data Gathered</b>	Date that the questions on the form were asked of the Index Parent or date the data needed to answer the questions was gathered.
<b>How often do you place your infant to sleep on their back?</b>	Indicate if the Parent places their infant to sleep on their back: Always, Sometimes or Never?
<b>How often do you bed-share with your infant?</b>	Indicate if the Parent shares a bed with their infant: Always, Sometimes or Never?
<b>How often does your infant sleep with soft bedding?</b>	Indicate if the infant sleeps with soft bedding: Always, Sometimes or Never?
<b>During a typical week, how many days do you (and/or a family member) read, tell stories and/or sing songs to your child?</b>	Indicate how many days in a typical week does the parent or other family member read, tell stories and/or sing songs to the child.

**N4**  
**Addendum to Clinical IPV Assessment Form**  
**12 WEEKS**

*\*\*Reminder: Only return this Addendum to state. Do not return Clinical IPV Assessment to state.*

**Name of Home Visitor:** \_\_\_\_\_

**NFP ID # of Mother:** \_\_\_\_\_

**Name of Mother:** \_\_\_\_\_

**1. Clinical IPV Assessment completed (with *mother*)?**

Yes, completed → **Date Assessment completed:**    /    / 20    → *Go to Question 1a.*

**1a. If Yes, result of Clinical IPV:**

Score indicates risk of IPV → *Go to Question 1b.*

Score does not indicate risk of IPV

**1b. If Score indicates risk of IPV, did you give referral information?**

Yes

No, client declined or is not ready for a referral and/or services

No, an earlier referral is still in process or the client is currently receiving services

No, other reason → *Please specify:* \_\_\_\_\_

No, not completed → *Go to Question 1c.*

**1c. If No, reason why Clinical IPV not completed:**

Concern previously identified

Other

## Instructions for the MIECHV

### N4

### Addendum to: CLINICAL IPV ASSESSMENT Form – 12 WEEKS

**When to complete this form:** When the Index Child is between 2 - 4 months old.

#### Item Instructions

Item	Guidelines
Name of Home Visitor	The Home Visitor assigned to this family.
NFP ID # of Mother	The Mother's NFP ID #.
Name of Mother	The Mother who signed up to participate in the MIECHV Program.
Clinical IPV Assessment Completed (with <i>mother</i> )?	Was the Clinical IPV Assessment completed to screen for Intimate Partner Violence? If it was, enter the date that the assessment was completed and continue to Question 1a. If it was not completed, go to Question 1c. <b>DO NOT send the Clinical IPV Assessment to the state.</b>
If Yes, result of Clinical IPV	If the Clinical IPV Assessment was completed, indicate if the score indicates risk of IPV or does not indicate risk of IPV. If the score does indicate risk of IPV, go to Question 1b.
If Score indicates risk of IPV, did you give referral information?	Was referral information provided? If not, indicate the reason why. Write in Other reason, if applicable.
If No, reason why Clinical IPV not completed	If the Clinical IPV Assessment was not completed, indicate if the reason was either because Concern previously identified or Other reason.

# ASQ (ASQ-3) Questionnaire



Infant ID  Infant Name  ♦ Infant DOB

Client ID  Client Name  DOB

Date  Nurse Home  Nurse Home Visitor Name

## No contact with client at this time

Check one:  Infancy 4 Months  Infancy 10 Months  Toddler 18 Months  Toddler 24 Months (optional)

(if applicable) Age-Adjusted Level of ASQ Questionnaire Used: \_\_\_\_\_ Months

### 1. Please provide Ages and Stages scores for the child:

- Communication .....  .....  
 Child not eligible for screening in this subscale at this time because child is receiving services  
 Parent declined further screening
- Gross Motor .....  .....  
 Child not eligible for screening in this subscale at this time because child is receiving services  
 Parent declined further screening
- Fine Motor .....  .....  
 Child not eligible for screening in this subscale at this time because child is receiving services  
 Parent declined further screening
- Problem Solving .....  .....  
 Child not eligible for screening in this subscale at this time because child is receiving services  
 Parent declined further screening
- Personal-social .....  .....  
 Child not eligible for screening in this subscale at this time because child is receiving services  
 Parent declined further screening

### 2. Was a referral to services made?

- Yes  
No (If no, please indicate the reason)  
Referral not needed at this time  
Monitoring prior to referral

**If Child scores in gray or black areas of concern in any sub-area, complete backside of this form. Also record referrals to EI on Use of Government and Community Services form.**

Squires, J., Twombly, E., Bricker, D. & Potter, L. (2009). ASQ-3 User's Guide 3<sup>rd</sup> Ed. Baltimore, MD: Paul H. Brookes Publishing Co, Inc.

**Instructions for the MIECHV  
ASQ (ASQ-3) QUESTIONNAIRE**

**When to complete this form:** When Index Child is between 9 months 0 days – 10 months 30 days and between 17 months 0 days and 18 months 30 days of age.

*The following MIECHV Reporting Data Points have been incorporated into the ETO ASQ (ASQ-3) Questionnaire Form:*

**Item Instructions**

<b>Item</b>	<b>Guidelines</b>
<b>No contact with client at this time</b>	Check this box if the ASQ questionnaire was not completed due to the fact that there was no contact with the client.
<b>(if applicable) Age-Adjusted Level of ASQ Questionnaire Used:</b> _____ Months	If an age-adjusted ASQ questionnaire is being used due to a premature birth, indicate the age level of the questionnaire being used in Months.

**ASQ REFERRAL TRACKING & FOLLOW-UP – INDEX CHILD**  
**\*For Children who Screened at Risk for Developmental Delay\***

Please send this form to the State **MONTHLY** with updates  
 (due by the 15<sup>th</sup> of the following month)

Name of Home Visitor: \_\_\_\_\_

NFP Child ID #: \_\_\_\_\_

Name of Index Child: \_\_\_\_\_

Name of Index Parent: \_\_\_\_\_

Type of Service	INITIAL REFERRAL CONTACT	FOLLOW-UP	
	Date Service Referral Contacted	Date Service Started/Received	If Service NOT received within 30 days of initial referral contact -- REASON:
1) Individualized developmental support from a home visitor	N/A	/ / 20	N/A
1a) Individualized developmental support from a home visitor	N/A	/ / 20	N/A
2) Another Community Service: Type: _____	/ / 20	/ / 20	<input type="checkbox"/> Parent declined the referral or did not take action <input type="checkbox"/> Child is waiting for service <input type="checkbox"/> Parent was unable to access service due to barriers (such as transportation, cost, time, child care, etc.) <input type="checkbox"/> Other: _____
2a) Another Community Service: Type: _____	/ / 20	/ / 20	<input type="checkbox"/> Parent declined the referral or did not take action <input type="checkbox"/> Child is waiting for service <input type="checkbox"/> Parent was unable to access service due to barriers (such as transportation, cost, time, child care, etc.) <input type="checkbox"/> Other: _____

Type of Service	INITIAL REFERRAL CONTACT	FOLLOW-UP		Enrolled in EI?
	Date EI Referral Contacted	Date of EI Evaluation	If EI Evaluation NOT completed within 45 days of initial referral contact -- REASON:	
3) Early Intervention Services	/ / 20	/ / 20	<input type="checkbox"/> Parent declined the EI referral or did not take action <input type="checkbox"/> Child is waiting for EI evaluation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3a) Early Intervention Services	/ / 20	/ / 20	<input type="checkbox"/> Parent declined the EI referral or did not take action <input type="checkbox"/> Child is waiting for EI Evaluation <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Instructions for the MIECHV**  
**ASQ REFERRAL TRACKING & FOLLOW-UP - INDEX CHILD**  
**\*FOR CHILDREN WHO SCREENED AT RISK FOR DEVELOPMENTAL DELAY\***

**When to complete this form:** As a result of an MIECHV-required ASQ-3 Developmental Screening: when Index Child is between 9 months 0 days – 10 months 30 days and between 17 months 0 days and 18 months 30 days of age; this form should be completed whenever the screening results show **1 or more ASQ domains in the Black** (at-risk) OR **2 or more domains in the Gray** (monitoring) OR a **combination of Black and Gray**.

**Initial Referral Contact Column:** The date referral contacts are made to needed services should be recorded **any time they are made for the child**. This form should be sent to the state when any initial referral contact is made for the child.

**Follow-up Columns:** Following the initial contact with a referral service, when the child receives the Early Intervention (EI) Evaluation or other service, record the date that service is started or received. If the child has not received the service, continue to follow up as appropriate by encouraging the parent to access services for the child when ready or by checking on the referral. During this time of follow up with the parent, send the referral tracking form monthly to the state when updates are made. A reminder email will be sent monthly to your program from the state requesting the updated form.

**Referral Guidelines:** A referral to services can be made directly by calling Early Intervention or a community service agency and requesting services for the parent or by giving the parent a list of resources to call for assistance related to enhancing the child's development.

**Referral Definitions:**

**1) Individualized developmental support from a home visitor:**

For when the home visitor provides individualized developmental support directly to the parent and/or child. This would include follow up activities to work on developmental skills identified in the monitoring zones, including additional screening. This should be done for any child who screens in the monitoring or at-risk zone for an ASQ domain.

**1a) Additional Individualized developmental support from a home visitor:**

If the child receives this service more than once, the second occurrence can be recorded here.

**2) Another Community Service:**

Referrals include those made to a different community service, other than Early Intervention, that provide support to enhance a child's development. Examples may include referrals to health or mental health services, speech, occupational or physical therapy services,

parent-child groups, parent classes or early literacy supports. Benchmark will measure the percent of children who receive services within 30 calendar days of the referral. The 30 days begins when contact is made with the community service.

**2a) Additional Referrals to Another Community Service:**

If there are more than one referral for other community services, the second referral can be recorded here.

**3) Early Intervention Services:**

Referrals made to Early Intervention (EI) Services for further evaluation and services. Benchmark will measure the percent of children who receive an EI evaluation within 45 calendar days of the referral. The 45 days begins when contact is made with EI services.

**3a) Additional Referrals to Early Intervention Services:**

If there is more than one referral for EI services over time, the second referral can be recorded here.

**Item Instructions**

Item	Guidelines
<b>Name of Home Visitor</b>	The Home Visitor assigned to this index parent.
<b>NFP Child ID#</b>	The Child’s NFP ID #.
<b>Follow-up Column: Individualized developmental support from a home visitor</b>	
<b>Date Service Started/Received</b>	Date that the home visitor provided support to parent and/or child. <i>MM/DD/20YY</i>
<b>Initial Referral Contact Column: Another Community Service</b>	
<b>Another Community Service</b>	If referral was made to another community service, other than EI, list type of Community Service.
<b>Date Service Referral Contacted</b>	When a referral to another community service is made, date the referral contact was made. <i>MM/DD/20YY</i>
<b>Follow-up Columns:</b>	
<b>Date Service Started/Received</b>	Date service started or was received. <i>MM/DD/20YY</i>
<b>If service NOT received within 30 days of initial referral contact —REASON:</b>	If the child did not receive the other community service within 30 calendar days of referral contact, the reason they did not. Write in Other reason, if applicable.
<b>Initial Referral Contact Column: Early Intervention Services</b>	
<b>Date EI Referral Contacted</b>	When a referral to EI is made, date the referral contact was made. <i>MM/DD/20YY</i>
<b>Follow-up Columns:</b>	
<b>Date of EI Evaluation</b>	Date of Early Intervention Evaluation. <i>MM/DD/20YY</i>
<b>If EI Evaluation not completed within 45 days of initial referral contact —REASON:</b>	If the child did not receive the EI Evaluation within 45 calendar days of referral contact, the reason they did not. Write in Other reason, if applicable.
<b>Enrolled in EI?</b>	Was child enrolled in EI as a result of the evaluation? Check Yes or No.

## MIECHV Demographics Update

Client ID  Client Name  DOB

Date  Nurse Home Visitor ID  Nurse Home Visitor Name

Check one:  Infancy 6 Months  Infancy 12 Months  Toddler 18 Months  Toddler 24 Months

### Personal/Family

1. ♦ Marital Status:
  - Married – Legal
  - Married – Common Law
  - Single - never married
  - Widowed
  - Divorced
  - Separated
  - Not Married – living with partner
  
2. ♦ 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
  
3. ♦ During the past three months, how often did the baby's biological father spend time taking care of and/or playing with the baby?
  - Not at all
  - Less than once a week
  - At least once a week but not daily
  - Daily
  
4. ♦ With whom do you live? (check only one from options 1 – 5)
  - Live with others (check all that apply)
    - Client's mother
    - Father of Child (FoC)
    - Current husband/partner (not FoC)
    - Other family members
    - Infant/child
    - Other adults
  - Live alone (or with infant/child)
  - Live in a group home/shelter
  - Confined to an institutional facility (residential treatment facility, incarcerated)
  - Homeless
    - Homeless and sharing housing (skip to 6)
    - Homeless and living in emergency or transitional shelter (skip to 6)
    - Other (skip to 6)

## MIECHV Demographics Update

5. ♦ If you are not homeless, where do you currently live?
- Owns or shares own home, condominium, or apartment
  - Rents or shares own home or apartment
  - Lives in public housing
  - Lives with parent or family member
  - Other
6. ♦ Which members of your family are in the Military – active or reserve? (check all that apply)
- Self (client)
  - Client's spouse
  - Client's parent(s)
  - Father of child (FoC)
  - None
- M1. *At 12 and 24 months only.* Which members of your family are currently serving or **formerly** served in the military – active or reserve? (*Check all that apply.*)
- |   |  |
|---|--|
| <input type="checkbox"/> Index Parent           | <input type="checkbox"/> Father of the Child |
| <input type="checkbox"/> Index Parent's Spouse  | <input type="checkbox"/> Mother of the Child |
| <input type="checkbox"/> Index Parent's Parents | <input type="checkbox"/> None                |

### Education and Income

7. ♦ Are you currently enrolled in middle or high school, GED, college and/or vocational/certification program (check all that apply)?
- Yes
    - Middle school (6<sup>th</sup> – 8<sup>th</sup> grades)
      - High school
      - GED program
      - Post-high school vocational/certification/technical training
        - Full Time – 12 semester hours or equivalent
        - Part Time
          - 7 – 11 semester hours or equivalent
          - 6 or less semester hours or equivalent
    - College
      - Full Time – 12 semester hours or equivalent
      - Part Time
        - 7 – 11 semester hours or equivalent
        - 6 or less semester hours or equivalent
  - Not enrolled

## MIECHV Demographics Update

8. ♦ Have you completed high school, GED, vocational/certification, and/or higher educational programs (check all that apply)?

- Yes
- High school
  - GED
  - Vocational/certification/technical training program
  - Some college (no degree)
  - Associate's degree
  - Bachelor's degree
  - Master's degree
  - Professional degree (for example: LLB, LD, MD, DDS)
  - Doctorate degree (for example: PhD, EdD)
  - Non-US based post primary education
- No. What is the last grade you have completed?  grade

9. ♦ Do you **have a** plan to enroll in any **additional** kind of school, vocational, certification or educational program?

- Yes  
 No

10. ♦ Are you currently working?

- Yes
- Full-time: 37+ hours per week, how many months since the birth of your infant?  
 months
  - Part-time
    - 20 – 36 hours per week, how many months since the birth of your infant?  
 months
    - 10 - 19 hours per week, how many months since the birth of your infant?  
 months
    - less than 10 hours per week, how many months since the birth of your infant?  
 months
- No
- Unemployed and seeking employment
  - Not employed (student, homemaker, other)

## MIECHV Demographics Update

11. ♦ Which of the following categories best describes your total yearly household income and types of benefits you receive? Include your income and any other income you may have received. For the purpose of this question, the household should include only you and your child. Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).

- Less than or equal to \$6,000
- \$6,001 - \$9,000
- \$9,001 - \$12,000
- \$12,001 - \$16,000
- \$16,001 - \$20,000
- \$20,001 - \$30,000
- Over \$30,000
- Client is dependent on parent/guardian

12. ♦ Does the client meet the agencies low-income criteria/threshold?

- Yes
- No

M2. *At 12 and 24 months only.* Last **month**, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? *All information will be kept private and will not affect any services you are now getting.*

- |  |  |
|--|--|
| <input type="checkbox"/> \$250 or less     | <input type="checkbox"/> \$1,751 - \$2,000 |
| <input type="checkbox"/> \$251 - \$500     | <input type="checkbox"/> \$2,001 - \$2,250 |
| <input type="checkbox"/> \$501 - \$750     | <input type="checkbox"/> \$2,251 - \$2,500 |
| <input type="checkbox"/> \$751 - \$1,000   | <input type="checkbox"/> \$2,501 - \$2,750 |
| <input type="checkbox"/> \$1,001 - \$1,250 | <input type="checkbox"/> \$2,751 - \$3,000 |
| <input type="checkbox"/> \$1,251 - \$1,500 | <input type="checkbox"/> \$3,001 or more   |
| <input type="checkbox"/> \$1,501 - \$1,750 | <input type="checkbox"/> Don't Know        |

M3. Number of Adults in Household: \_\_\_\_\_ M4. Number of Children in Household: \_\_\_\_\_

## MIECHV Demographics Update

### Birth Control and Additional Pregnancies

13. ♦ In the last 6 months, have you been using any form of birth control?

- Yes. If yes, please indicate the reason.
- To prevent another pregnancy
  - Other reasons
- No. If no, do any of the following apply? (Check all that apply and skip to 16)
- Female partner
  - Plan to become pregnant
  - Currently pregnant
  - Not sexually active

14. Please tell me all the different types of birth control you have used in the last six months. Mark all that apply.

- Male condom (rubbers)
- Natural family planning (rhythm method)
- Spermicides/jelly/foam/cream/suppositories/vcf
- Diaphragm/Cervical cap/Sponge
- Withdrawing (pulling out before coming)
- Birth control pills
- Patch
- Cervical ring
- Quarterly birth control shot (Depo-Provera)
- Monthly birth control shot (Lunelle)
- IUD
- Emergency contraception
- Female Condom
- Birth Control Implant
- Tubal ligation or hysterectomy
- Partner has a vasectomy
- Practicing abstinence
- Other (please specify) \_\_\_\_\_

15. Thinking about all the times you've had sexual intercourse in the last six months, about how often did you use birth control?

- Some of the time
- About half the time
- Most of the time
- Every time

## MIECHV Demographics Update

16. Do you plan to use birth control in the next six months?

- Yes. If yes, please indicate the reason.
- To prevent another pregnancy
  - Other reasons

Please indicate the different types you plan to use (Please check all that apply).

- Male condom (rubbers)
  - Natural family planning (rhythm method)
  - Spermicides/jelly/foam/cream/suppositories/vcf
  - Diaphragm/Cervical cap/Sponge
  - Withdrawing (pulling out before coming)
  - Birth control pills
  - Patch
  - Cervical ring
  - Quarterly birth control shot (Depo-Provera)
  - Monthly birth control shot (Lunelle)
  - IUD
  - Emergency contraception
  - Female Condom
  - Birth Control Implant
  - Tubal ligation or hysterectomy
  - Partner has a vasectomy
  - Practicing abstinence
  - Other (please specify) \_\_\_\_\_
  - None
- No. If no, do any of the following apply? (Check all that apply)
- Female partner
  - Plan to become pregnant
  - Currently pregnant
  - Not sexually active

# MIECHV Demographics Update



17. ♦ Since you had [child's name], have you been pregnant?

- Yes (Complete table below)
- No (skip to 19)

Subsequent Pregnancy after Index Child	
a.	Which pregnancy after index child? <input type="checkbox"/> First pregnancy <input type="checkbox"/> Second pregnancy <input type="checkbox"/> Third pregnancy
b.	What have you been told is your due date (EDD)? <input type="text"/> EDD
c.	Was this pregnancy planned? <input type="checkbox"/> Yes <input type="checkbox"/> No
d.	Are you still pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No. If no, what was the outcome of the pregnancy?  <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Stillbirth <input type="checkbox"/> Live birth

18. For the live birth reported in Question 17, please complete the following information:

Client's Subsequent Child	
a.	DOB <input type="text"/>
b.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
c.	Birthweight <input type="text"/> grams or <input type="text"/> lbs. <input type="text"/> oz.
d.	Did ( <u>name</u> ) have to spend any time in the NICU or a special nursery because of problems? <input type="checkbox"/> Yes – NICU <input type="checkbox"/> Yes – Special Care Nursery If yes, for how many days prior to being discharged? <input type="text"/> days What was the purpose of the stay (please check all that apply)? <input type="checkbox"/> Low birth weight <input type="checkbox"/> Very low birth weight <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Prematurity <input type="checkbox"/> Congenital defect <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> No
e.	Gestational age at birth: <input type="text"/> weeks

## MIECHV Demographics Update



19. ♦ Do you (client) have health insurance coverage?
- Yes (If yes, which type of health insurance do you use when you go for medical care; please check all that apply)
- Medicaid
  - CHIP
  - Tri-Care
  - Private
  - Other (please specify) \_\_\_\_\_
- No
- 
- M5. *At 12 and 24 months only.* Does anyone living in the household have a history of substance abuse or need substance abuse treatment?
- Yes
- No
- Unknown
- 
- M6. *At 12 and 24 months only.* Does anyone living in the household use tobacco products?
- Yes
- No
- 
- M7. *At 12 and 24 months only.* Has anyone living in the household had a history of child abuse or neglect and/or interactions with child welfare services?
- Yes
- No
- Unknown
- 
- M8. *At 12 and 24 months only:* Has a doctor or health professional ever told you that your child/any of your children has any developmental delay or developmental disability?
- Yes
- No
- Unknown
- 
- M9. *At 12 and 24 months only.* Is there anyone in your household (including adults and children) who had/has a low student achievement level?
- Yes
- No

## Instructions for the **MIECHV DEMOGRAPHICS UPDATE – 12 MONTHS Form**

**When to complete this form:** When the Child is between 11 - 13 months old.

*The following MIECHV Reporting Data Points have been incorporated into the ETO Demographics Update form and **are the MIECHV questions that needs to be answered at 12 months:***

### Item Instructions

Item	Guidelines
<b>M1. Which members of your family are currently serving or formerly served in the Military – active or reserve? (Check all that apply)</b>	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , families that include individuals who are serving or <b>formerly</b> served in the Armed Forces.
<b>M2. Last month, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? All information will be kept private and will not affect any services you are now getting.</b>	Reassure parent that income information will not be used to determine eligibility in any programs or affect any services they are now getting. <i>Based on self-report</i> , what was the total household income, before taxes, last month? <u>For 2-parent households, include both parents' income and benefits. If household income/benefit source includes someone other than parents, include that also.</u> Include all of these Income Sources: Paycheck or money from a job Benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) Money from a business, fees, dividends, or rental income Child support or alimony Social security, workers' compensation, disability, veteran benefits or pensions Unemployment benefits
<b>M3. Number of adults in household</b>	Total number of adults living in household. Include any adults who stay in the household at least 4 nights a week.
<b>M4. Number of children in household</b>	Total number of children living in household. Includes Index child and any other children, ages Birth – 18 yrs old, who stay in the household at least 4 nights a week.
<b>M5. Does anyone living in the household have a history of substance abuse or need substance abuse treatment?</b>	<i>Based on self-report</i> , a household with members who have a history of substance abuse or who have been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.
<b>M6. Does anyone living in the household use tobacco products?</b>	<i>Based on self-report</i> , a household with members who use tobacco products in the home or have been identified as using tobacco through a substance abuse screening administered during intake. Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and electronic nicotine delivery systems (ENDS).

<p><b>M7. Has anyone living in the household had a history of child abuse or neglect and/or interactions with child welfare services?</b></p>	<p><i>Based on self-report</i>, a household with members who have a history of abuse or neglect and have had involvement with child welfare services either as a child or as an adult.</p>
<p><b>M8. Has a doctor or health professional ever told you that your child/any of your children has any developmental delay or developmental disability?</b></p>	<p><i>Based on self-report or home visitor/staff observation</i>, a household with members who have a child or children suspected of having a developmental delay or disability.</p>
<p><b>M9. Is there anyone in your household (including adults and children) who had/has a low student achievement level?</b></p>	<p><i>Based on self-report</i>, a household with members who have perceived themselves or their child(ren) as having low student achievement.</p>

## Instructions for the **MIECHV DEMOGRAPHICS UPDATE – 24 MONTHS Form**

**When to complete this form:** When the Child is between 23 - 25 months old.

The following MIECHV Reporting Data Points have been incorporated into the ETO Demographics Update form and **are the MIECHV questions that needs to be answered at 24 months:**

### Item Instructions

Item	Guidelines
<b>M1. Which Members of your family are currently serving or formerly served in the Military – active or reserve? (Check all that apply)</b>	(HRSA now requires annual reporting of updates to this data point. Select current status; if same as previously recorded, check same answer) <i>Based on self-report</i> , families that include individuals who are serving or <b>formerly</b> served in the Armed Forces.
<b>M2. Last month, what was your gross TOTAL HOUSEHOLD income from employment and any benefits you receive? All information will be kept private and will not affect any services you are now getting.</b>	Reassure parent that income information will not be used to determine eligibility in any programs or affect any services they are now getting. <i>Based on self-report</i> , what was the total household income, before taxes, last month? <u>For 2-parent households, include both parents' income and benefits. If household income/benefit source includes someone other than parents, include that also.</u> Include all of these Income Sources: Paycheck or money from a job Benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) Money from a business, fees, dividends, or rental income Child support or alimony Social security, workers' compensation, disability, veteran benefits or pensions Unemployment benefits
<b>M3. Number of adults in household</b>	Total number of adults living in household. Include any adults who stay in the household at least 4 nights a week.
<b>M4. Number of children in household</b>	Total number of children living in household. Includes Index child and any other children, ages Birth – 18 yrs old, who stay in the household at least 4 nights a week.
<b>M5. Does anyone living in the household have a history of substance abuse or need substance abuse treatment?</b>	<i>Based on self-report</i> , a household with members who have a history of substance abuse or who have been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.
<b>M6. Does anyone living in the household use tobacco products?</b>	<i>Based on self-report</i> , a household with members who use tobacco products in the home or have been identified as using tobacco through a substance abuse screening administered during intake. Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and electronic nicotine delivery systems (ENDS).

<p><b>M7. Has anyone living in the household had a history of child abuse or neglect and/or interactions with child welfare services?</b></p>	<p><i>Based on self-report</i>, a household with members who have a history of abuse or neglect and have had involvement with child welfare services either as a child or as an adult.</p>
<p><b>M8. Has a doctor or health professional ever told you that your child/any of your children has any developmental delay or developmental disability?</b></p>	<p><i>Based on self-report or home visitor/staff observation</i>, a household with members who have a child or children suspected of having a developmental delay or disability.</p>
<p><b>M9. Is there anyone in your household (including adults and children) who had/has a low student achievement level?</b></p>	<p><i>Based on self-report</i>, a household with members who have perceived themselves or their child(ren) as having low student achievement.</p>