# Office of Child Development and Early Learning

# Family Supports

# Family Support Program Data System

# Data Collection Forms

Table of Contents

[Office of Child Development and Early Learning 1](#_Toc152756122)

[Family Supports 1](#_Toc152756123)

[Family Support Program Data System 1](#_Toc152756124)

[Data Collection Forms 1](#_Toc152756125)

[Demographics: Family Intake 2](#_Toc152756126)

[Demographics: Family Update 3](#_Toc152756127)

[Enrollment: Caregiver Intake 4](#_Toc152756128)

[Demographics: Caregiver Intake 6](#_Toc152756129)

[Demographics: Caregiver Update 8](#_Toc152756130)

[Demographics: Caregiver Exit 10](#_Toc152756131)

[Enrollment and Demographics: Child Intake 12](#_Toc152756132)

[Enrollment and Demographics: Child Update 14](#_Toc152756133)

[Demographics: Child Exit 15](#_Toc152756134)

## **Demographics: Family Intake**

**\*Indicates Required**

**\*Time periods for completion**

o At Enrollment

**\*Family (Case) Identifier:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must match Caregiver(s) / child(ren))

**\*Total number of people in the household:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Number 1,2,3, 4, etc.)

**\*Annual Household Income**

o Less than or equal to $6,000

o $20,001 to $30,000

o $6,001 to $12,000

o $30,001 to $40,000

o $12,001 to $20,000

o Over $40,000

o Refused to Respond

**Household Receives Disability Benefits (any Caregiver in home) (optional)**

o Yes

o No

**\*Users of tobacco products**

o Yes, Primary Caregiver

o Yes, Other Caregiver

o Yes, both

o No

**\*Tobacco use location (only if Yes above)**

o In Home

o Outside Home

o Both

**\*Have, or have child with, low student achievement (any Caregiver and/or child in the home)**

o Yes, Caregiver

o Yes, Child

o Yes, Both

o No

**\*Have a child with developmental delays or disabilities (any child in home)**

o Yes

o No

**\*Family member is serving, or formerly served, in the US armed forces (any family member living in the home)**

o Yes

o No

**\*Household has a history of child abuse or neglect or has had interactions with child welfare services (any Caregiver and/or child in the home)**

o Yes

o No

o Refused to Respond

**\*Please indicate the primary referral source for this family? (This question is required starting on October 1, 2020)**

o Court System (Judge)

o Children and Youth

o Doctor Office

o Department of Corrections

o Early Intervention (EI)

o Early Learning Resource Center (ELRC)

o Hospital

o Managed Care Organization

\***Which Care Organization?**

o AmeriHealth Caritas Pennsylvania

o Geisinger Health Plan

o Health Partners Plans

o Highmark Wholecare (formerly Gateway)

o Keystone First

o United Healthcare Community Plan

o UPMC for You, Inc.

o Other Home Visiting or Family Support Program

o Self-Referral

o Word of Mouth **If Word of Mouth, was the referral from any of the following? (If applicable)**

o Current Participant in Services

o Prior Participant in Services

o Other

\***Please Specify**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Demographics: Family Update**

**\*Indicates Required**

**\*Time periods for completion**

o Between June 1st and June 30th each calendar year

o Between September 1st and September 30th each calendar year

**\*Family (Case) Identifier:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must match Caregiver(s) / child(ren))

**\*Total number of people in the household at Update:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Number 1,2,3, 4, etc.)

**\*Annual Household Income at Update**

o Less than or equal to $6,000

o $20,001 to $30,000

o $6,001 to $12,000

o $30,001 to $40,000

o $12,001 to $20,000

o Over $40,000

o Refused to Respond

**Household Receives Disability Benefits (any Caregiver in home) (optional) at Update**

o Yes

o No

**\*Users of tobacco products at Update**

o Yes, Primary Caregiver

o Yes, Other Caregiver

o Yes, both

o No

**\*Tobacco use location at Update (only if yes above) at Update**

o In Home

o Outside Home

o Both

**\*Have, or have child with, low student achievement (any Caregiver and/or child in the home) at Update**

o Yes, Caregiver

o Yes, Child

o Yes, Both

o No

**\*Have a child with developmental delays or disabilities (any child in home) at Update**

o Yes

o No

**\*Family member is serving, or formerly served, in the US armed forces (any family member living in the home) at Update**

o Yes

o No

**\*Household has a history of child abuse or neglect or has had interactions with child welfare services (any Caregiver and/or child in the home) at Update**

o Yes

o No

o Refused to Respond

**\*Please indicate the primary referral source for this family? (This question is required starting on October 1, 2020)**

o Court System (Judge)

o Children and Youth

o Department of Corrections

o Doctor Office

o Early Intervention (EI)

o Early Learning Resource Center (ELRC)

o Hospital

o Managed Care Organization

\***Which Care Organization?**

o AmeriHealth Caritas Pennsylvania

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o Keystone First

o United Healthcare Community Plan

o UPMC for You, Inc.

o Other Home Visiting or Family Support Program

o Self-Referral

o Word of Mouth **If Word of Mouth, was the referral from any of the following? (If applicable)**

o Current Participant in Services

o Prior Participant in Services

o Other \***Please Specify**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Enrollment: Caregiver Intake**

**\*Indicates Required**

**\*Time periods for completion**

o At Enrollment

**\*Client Identifier** *(Caregiver)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Unique number to identify Caregiver)

**\*Family Identifier** *(Case)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must Match Family/Child(s))

**\*First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suffix:** o None | o Jr. | o Sr. | o I | o II | o III | o IV | o V | o VI | o VII|

**\* Under the program type (i.e. MIECHV, FC, etc.) selected for this family is the Primary Caregiver enrolled in an evidence-based home visiting program and/or other family support program(s) (e.g. a parenting class, non-evidence-based home visiting, etc.)?**

o Evidence-Based Home Visiting (EBHV)

o Family Support Program (FSP)

o Both

**\*Evidence-based Home Visiting Program (Select One) (Based on the HOMVEE List)**

o Attachment and Biobehavioral Catch-Up Intervention (ABC)  
o Child First (CF)  
o Early Head Start - Home Based Option (EHS)  
o Early Start (New Zealand) (ESNZ)  
o Family Check-up (FCU)  
o Family Connects (FCS)  
o Family Spirit (FS)  
o Health Access Nurturing Development Services Program (HANDS)  
o Healthy Beginnings (HB)  
o Healthy Families America (HFA)  
o Home Instruction for Parents of Preschool Youngsters (HIPPY)  
o Maternal Early Childhood Sustained Home-Visiting Program (MECSH)

o Maternal Infant Health Program (MIHP)  
o Minding the Baby (MIB)  
o Nurse-Family Partnership (NFP)  
o Parents as Teachers (PAT)  
o Play and Learning Strategies Infant Only (PALS)

o Promoting First Relationships – Home Visiting Intervention Model   
o Safe Care Augmented (SCA)

**\*If enrolled in EBHV, which program type is supporting the evidence-based home visiting model selected? (Select One)**

***OCDEL FUNDING (These Changes will be implemented August 15th, 2022)***

o CHILDREN’S TRUST FUND (CTF)

o COMMUNITY BASED CHILD ABUSE PREVENTION - AMERICAN RESCUE PLAN (CBCAP ARP)

o COMMUNITY BASED CHILD ABUSE PREVENTION (CBCAP)

o FAMILY CENTER (FC)

o FAMILY SUPPORT (FS)

o HEALTH ENTERPRISE ZONE (HEZ)

o MIECHV (MIECHV)

o OCDEL NFP (OCDEL NFP)

o PROMOTING SAFE AND STABLE FAMILIES (PSSF)

***Other Non OCDEL Funding***

o DOH – Title V

o OCYF & CCY

o CCYA – Needs Based Budget

o CCYA – Family First

o CCYA – Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o OCYF – Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o Medical Assistance (MA)

o Managed Care Organization – Home Visiting

o Other Local Funding – County

o Other Local Funding – Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o United Way

**\*Date of EBHV enrollment:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*If the Primary Caregiver is enrolled in Family Support Program, please enter the program, the Supporting Program and the date of enrollment for each one.**

|  |  |
| --- | --- |
| o 24/7 Dad  o 27/7 Dad AM & PM  o ACT / ACT Raising Safe Kids  o Active Parenting 4th Edition  o Active Parenting for Teens  o Circle of Programs  o Circles  o Doctor Dad  o Exchange Parent Aide  o Families in Recovery  o Father in 15  o Foundations of Fatherhood  o Growing Great Kids  o Incredible Years  o Inside Out Dad  o Logic Model  o Make Parenting a Pleasure  o Moving Beyond Depression  o Nurse Legal Partnership | o Nurturing Dads  o Nurturing Parenting  o ParentChild+  o Parent Café  o Parent Child Home Program (PCHP)  o Parenting Inside Out  o Positive Solutions for Families  o SAFE  o Safe Care (Non-Augmented)  o Smart Parent Safe and Healthy Kids (SPHK)  o Strengthening Families Program  o Systematic Training for Effective Parenting (STEP)  o The Father Project  o The Refugee Family Strengthening Program  o Triple P  o Video Interaction Project |

**Family Support Program Type 1\*:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Choose from List Above)

**Which FS program type is supporting the Family Support Program 1? (Select one) \***

***OCDEL FUNDING (These Changes will be implemented August 15th, 2022)***

o CHILDREN’S TRUST FUND (CTF)

o COMMUNITY BASED CHILD ABUSE PREVENTION - AMERICAN RESCUE PLAN (CBCAP ARP)

o COMMUNITY BASED CHILD ABUSE PREVENTION (CBCAP)

o FAMILY CENTER (FC)

o FAMILY SUPPORT (FS)

o HEALTH ENTERPRISE ZONE (HEZ)

o MIECHV (MIECHV)

o OCDEL NFP (OCDEL NFP)

o PROMOTING SAFE AND STABLE FAMILIES (PSSF)

***Other Non OCDEL Funding***

o DOH – Title V

o OCYF & CCY

o CCYA – Needs Based Budget

o CCYA – Family First

o CCYA – Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o OCYF – Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o Medical Assistance (MA)

o Managed Care Organization – Home Visiting

o Other Local Funding – County

o Other Local Funding – Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o United Way

**\*Date of FSP 1 enrollment:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Can add up to 4 Family Support Programs if Necessary**

**FSP 2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Funding Type: \_\_\_\_\_\_\_\_\_\_\_\_ Enrollment Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

**FSP 3:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Funding Type: \_\_\_\_\_\_\_\_\_\_\_\_ Enrollment Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

**FSP 4:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Funding Type: \_\_\_\_\_\_\_\_\_\_\_\_ Enrollment Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

## **Demographics: Caregiver Intake**

**\*Indicates Required**

**\*Time periods for completion**

o At Enrollment

o Within 15 Days of Enrollment

**\*Client Identifier** *(Caregiver)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Unique number to identify Caregiver)

**\*Family Identifier** *(Case)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must Match Family/Child(s))

**\*Caregiver Address**

\* Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Date of Birth** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Gender**

o Male

o Female

o Gender Non-Binary (includes enrolled participants who do not identify as either male or female, which may include participants who identify as gender non-binary and/or genderqueer)

**\*Enrolled Prenatally?**

o Yes

o No

**\*Pregnancy Status at Enrollment**

o Currently pregnant

o Not currently pregnant

**\* If Currently Pregnant Number of weeks pregnant**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Number: 6, 10, 18, etc.)

**\* If Currently Pregnant Estimated Date of Delivery**

\_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\* If currently Pregnant Number of Children Expected from Current Pregnancy** (Used to Calculate Enrollment)

o 1 o 3

o 2 o 4

**\*History of substance abuse**

o Yes, Opioids

o Yes, Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o No

o Refused to Respond

**\*Current Substance Use / Needs Substance Abuse Treatment**

o Yes, Opioids

o Yes, Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o No

o Refused to Respond

**\*If the Caregiver is pregnant and is currently using substances has a Plan of Safe Care been developed for the family?**

o Yes

o No

o Unknown

**\*Has the Caregiver self-identified that they have a disability? (\*Required beginning on April 1, 2021)**

o Yes

o No

o Refused to respond

**\* Race**

**(Select all that apply)**

o American Indian or Alaska Native

o Native Hawaiian or Other Pacific Islander

o Asian

o White

o Black or African-American

o Refused to Respond

**\* Ethnicity**

o Not Hispanic or Latino

o Hispanic or Latino

o Refused to Respond

**\* Legal Marital Status at Enrollment (Current official legal status, meaning if Currently Divorced but living with a partner this would be entered as Divorced, as this is the current identified legal status)**

o Never Married

o Not Married but Living Together with Partner

o Married

o Separated/Divorced/Widowed

**\* Educational Attainment at Enrollment (highest level)**

o Less than HS diploma (Not currently enrolled in school, did not receive GED or a High School diploma)

o Currently enrolled in middle school

o Currently enrolled in high school

o Currently enrolled in GED program

o HS Diploma / GED

o Some college/training

o Technical training or certification

o Associate’s degree

o Bachelor’s degree or Higher

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

**\* Educational Status at Enrollment**

o Student/trainee

o Not a student/trainee

**\* Employment Status at Enrollment**

o Full-time (30+ hours per week)

o Part-time (Less than 30 hours per week)

o Not employed

**\* Housing Status at Enrollment**

o Not Homeless o Homeless

o Owns or shares own home, condominium, or apartment o Homeless and sharing housing

o Rents or shares own home or apartment o Homeless and living in an emergency or transitional shelter

o Lives in public housing o Some other arrangement

o Lives with parent or family member

o Some other arrangement

**\* Health Insurance Status at Enrollment**

o No Insurance Coverage

o Not eligible

o Caregiver applied for coverage, application is pending

o Private Pay (Pay out of Pocket)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o Medicaid or CHIP

**Optional Question: Managed Care Organization**

o AmeriHealth Caritas Pennsylvania

o CHIP

o Geisinger Health Plan

o Health Partners Plans

o Highmark Wholecare (formerly Gateway)

o Keystone First

o United Healthcare Community Plan

o UPMC for You, Inc.

o Medicare

o Tri-Care

o Private (Such as employer sponsored healthcare plans, i.e. Aetna, BlueCross)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

## **Demographics: Caregiver Update**

**\*Indicates Required**

**\*Time periods for completion**

o Between June 1st and June 30th each calendar year

o Between September 1st and September 30th each calendar year

o As needed if a change occurs (10th of the following month after being notified of the change)

**\*Are there any changes to the demographics for the Caregiver (6/30 and 9/30)?**

o Yes (Continue updating the information below)

o No (End)

**\* Pregnancy Status at Update (Do not update Pregnancy Status for NFP Clients if Second Child is not going to be receiving services)**

o Currently pregnant

o Not currently pregnant

**\* If Currently Pregnant Number of weeks pregnant at Update**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Number: 6, 10, 18, etc.)

**\* If Currently Pregnant Estimated Date of Delivery at Update**

\_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\* If currently Pregnant Number of Children Expected from Current Pregnancy at Update** (Used to Calculate Enrollment)

o 1 o 3

o 2 o 4

**\*History of substance abuse**

o Yes, Opioids

o Yes, Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o No

o Refused to Respond

**\*Current Substance Use / Needs Substance Abuse Treatment**

o Yes, Opioids

o Yes, Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o No

o Refused to Respond

**\*If the Caregiver is pregnant and is currently using substances has a Plan of Safe Care been developed for the family?**

o Yes

o No

o Unknown

**\*Has the Caregiver self-identified that they have a disability? (\*Required beginning on April 1, 2021)**

o Yes

o No

o Refused to respond

**\* Legal Marital Status at Update (Current official legal status, meaning if Currently Divorced but living with a partner this would be entered as Divorced, as this is the current identified legal status)**

o Never Married

o Not Married but Living Together with Partner

o Married

o Separated/Divorced/Widowed

**\* Educational Attainment at Update (highest level)**

o Less than HS diploma (Not currently enrolled in school, did not receive GED or a High School diploma)

o Currently enrolled in middle school

o Currently enrolled in high school

o Currently enrolled in GED program

o HS Diploma / GED

o Some college/training

o Technical training or certification

o Associate’s degree

o Bachelor’s degree or Higher

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

**\* Educational Status at Update**

o Student/trainee

o Not a student/trainee

**\* Employment Status at Update**

o Full-time (30+ hours per week)

o Part-time (Less than 30 hours per week)

o Not employed

**\* Housing Status at Update**

o Not Homeless

o Owns or shares own home, condominium, or apartment

o Rents or shares own home or apartment

o Lives in public housing

o Lives with parent or family member

o Some other arrangement

o Homeless

o Homeless and sharing housing

o Homeless and living in an emergency or transitional shelter

o Some other arrangement

**\* Health Insurance Status at Update**

o No Insurance Coverage

o Not eligible

o Caregiver applied for coverage, application is pending

o Private Pay (Pay out of Pocket)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o Medicaid or CHIP

**Optional Question: Managed Care Organization**

o AmeriHealth Caritas Pennsylvania

o CHIP

o Geisinger Health Plan

o Health Partners Plans

o Highmark Wholecare (formerly Gateway)

o Keystone First

o United Healthcare Community Plan

o UPMC for You, Inc.

o Medicare

o Tri-Care

o Private (Such as employer sponsored healthcare plans, i.e. Aetna, BlueCross)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**\*Caregiver Education (if enrolled without High School Diploma or Equivalent) at Update (Measure 15)**

**Have you (Caregiver) enrolled in, maintained continuous enrollment in, or completed a high school degree or equivalent?**

o Currently enrolled in high school and/or a GED Program

o Yes, they have obtained a high school diploma or equivalent prior to the update

o No, they have not obtained a high school diploma or equivalent

## **Demographics: Caregiver Exit**

**\*Indicates Required**

**\*Time periods for completion**

o Upon exit from a program

**\*Client Identifier** *(Caregiver)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Unique number to identify Caregiver)

**\*Family Identifier** *(Case)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must Match Family/Child(s))

**\*First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suffix:** o None | o Jr. | o Sr. | o I | o II | o III | o IV | o V | o VI |

**\*Please select all programs you are exiting the Caregiver from?**

o Evidence-Based Home Visiting (EBHV)

o \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Family Support Program (FSP)

o FSP 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o FSP 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o FSP 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o FSP 4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Date of Exit**

o EBHV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\* Reason for Exit**

o Completed Program EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Currently Enrolled but not actively participating in program (On hold (1)) EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Stopped before completion **(Select the most appropriate option below)**  EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Child no longer in family’s custody (parental rights terminated) EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Caregiver returned to work or school EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Dissatisfied with program EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Enrolled in another program EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Excessive missed appointment/attempted visits EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Home visitor resigned; refused new home visitor EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Miscarried/fetal death/child death EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Moved out of service area EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Pressure from family EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Safety of the home visitor EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Unable to contact/Unable to locate EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Unable to meet model requirements due to other obligations EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

(1) If Caregiver is placed on hold they will automatically be exited 6 months after the date of exit.

## **Enrollment and Demographics: Child Intake**

**\*Indicates Required**

**\*Time periods for completion**

o Enrollment

o Within 15 Days of Enrollment

o First visit after birth

**\*Child Identifier** *(Child)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Unique number to identify Caregiver)

**\*Family Identifier** *(Case)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must Match Family/Child(s))

**\*Child’s First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Child’s Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Suffix:** o None | o Jr. | o Sr. | o I | o II | o III | o IV | o V | o VI | o VII |

**\* Child’s Date of Birth** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Child’s Gender (For Child Gender you may use the gender assigned at birth for the Child unless the caregiver requests to use the non-binary option, then select that as the response)**

o Male

o Female

o Gender Non-Binary (includes enrolled participants who do not identify as either male or female, which may include participants who identify as gender non-binary and/or genderqueer)

**\*EBHV Program** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Date of EBHV enrollment \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Family Support Program 1** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Family Support Enrollment Date 1 \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Family Support Program 2** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Family Support Enrollment Date 2 \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Family Support Program 3** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Family Support Enrollment Date 3 \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Family Support Program 4** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Family Support Enrollment Date 4 \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\*Primary Caregiver’s Relationship to Child**

o Biological Mother

o Other Female Caregiver

o Biological Grandmother

o Adoptive Female Caregiver

o Other Female Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required)

o Biological Father

o Other Male Caregiver

o Biological Grandfather

o Adoptive Male Caregiver

o Other Male Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required)

If Gender nonbinary is selected for the Caregiver, the following options are available

o Biological Parent

o Biological Grandparent

o Adoptive Caregiver

o Other Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required)

**\*If Caregiver was enrolled during the Pregnancy with this child.**

**\*Is this child a result of the pregnancy status?**

o Yes (Continue)

o No (End)

**\*What was the child's birth weight?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Pounds - Number) and

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Ounces - Number)

**\*What was the child's gestational age at birth?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Weeks – Number 36, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Days – Number 0 through 6)

**\*Was the child born affected by prenatal substance exposure? (Includes alcohol)?**

o Yes (Continue)

o No (End)

o Unknown (End)

**\* Child’s Race**

**(Select all that apply)**

o American Indian or Alaska Native

o Native Hawaiian or Other Pacific Islander

o Asian

o White

o Black or African-American

o Refused to Respond

**\* Child’s Ethnicity**

o Not Hispanic or Latino

o Hispanic or Latino

o Refused to Respond

**\* Primary Language Spoken at Home**

o Arabic

o Chinese (Including: Mandarin and Cantonese)

o Dutch (Including: Dutch, Afrikaans, Yiddish, Pennsylvania Dutch)

o English

o French (Including: Cajun)

o Gujarati

o Haitian

o Hindi

o Italian

o Korean

o Polish

o Russian

o Spanish

o Vietnamese

o Other (Please enter the Language Identified in the Data System **Do Not** enter the word other)

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Has the Caregiver identified that the Child has a disability? (\*Required beginning on April 1, 2021)**

o Yes

o No

o Refused to respond

**\* Health Insurance Status at Enrollment**

o No Insurance Coverage

o Not eligible

o Caregiver applied for coverage, application is pending

o Private Pay (Pay out of Pocket)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o Medicaid or CHIP

**Optional Question: Managed Care Organization**

o AmeriHealth Caritas Pennsylvania

o CHIP

o Geisinger Health Plan

o Health Partners Plans

o Highmark Wholecare (formerly Gateway)

o Keystone First

o United Healthcare Community Plan

o UPMC for You, Inc.

o Medicare

o Tri-Care

o Private (Such as employer sponsored healthcare plans, i.e. Aetna, BlueCross)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**\*Usual Source of Medical Care**

o Doctor's/Nurse Practitioner's Office

o Hospital Emergency Room

o Hospital Outpatient

o Federally Qualified Health Center

o Retail Store or Minute Clinic

o None

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

**\* Usual Source of Dental Care**

o Have a Usual Source of Dental Care

o Do not have a Usual Source of Dental Care

## **Enrollment and Demographics: Child Update**

**\*Indicates Required**

**\*Time periods for completion**

o Between June 1st and June 30th each calendar year

o Between September 1st and September 30th each calendar year

o As needed if a change occurs (10th of the following month after being notified of the change)

**\*Child Identifier** *(Child)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Unique number to identify Caregiver)

**\*Family Identifier** *(Case)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must Match Family/Child(s))

**\*Child’s First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Child’s Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Suffix:** o None | o Jr. | o Sr. | o I | o II | o III | o IV | o V | o VI | o VII |

**\*Primary Caregiver’s Relationship to Child at Update**

o Biological Mother

o Other Female Caregiver

o Biological Grandmother

o Adoptive Female Caregiver

o Other Female Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required)

o Biological Father

o Other Male Caregiver

o Biological Grandfather

o Adoptive Male Caregiver

o Other Male Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required)

If Gender nonbinary is selected for the Caregiver, the following options are available

o Biological Parent

o Biological Grandparent

o Adoptive Caregiver

o Other Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required)

**\* Primary Language Spoken at Home**

o Arabic

o Chinese (Including: Mandarin and Cantonese)

o Dutch (Including: Dutch, Afrikaans, Yiddish, Pennsylvania Dutch)

o English

o French (Including: Cajun)

o Gujarati

o Haitian

o Hindi

o Italian

o Korean

o Polish

o Russian

o Spanish

o Vietnamese

o Other (Please enter the Language Identified in the Data System **Do Not** enter the word other)

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Has the Caregiver identified that the Child has a disability? (\*Required beginning on April 1, 2021)**

o Yes

o No

o Refused to respond

**\* Health Insurance Status at Update**

o No Insurance Coverage

o Not eligible

o Caregiver applied for coverage, application is pending

o Private Pay (Pay out of Pocket)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

o Medicaid or CHIP

**Optional Question: Managed Care Organization**

o AmeriHealth Caritas Pennsylvania

o CHIP

o Geisinger Health Plan

o Health Partners Plans

o Highmark Wholecare (formerly Gateway)

o Keystone First

o United Healthcare Community Plan

o UPMC for You, Inc.

o Medicare

o Tri-Care

o Private (Such as employer sponsored healthcare plans, i.e. Aetna, BlueCross)

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**\*Usual Source of Medical Care at Update**

o Doctor's/Nurse Practitioner's Office

o Hospital Emergency Room

o Hospital Outpatient

o Federally Qualified Health Center

o Retail Store or Minute Clinic

o None

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

**\* Usual Source of Dental Care at Update**

o Have a Usual Source of Dental Care

o Do not have a Usual Source of Dental Care

## **Demographics: Child Exit**

**\*Indicates Required**

**\*Time periods for completion**

o Upon exit from a program

**\*Child Identifier** *(Child)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Unique number to identify Caregiver)

**\*Family Identifier** *(Case)***:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must Match Family/Child(s))

**\*First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Middle Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suffix:** o None | o Jr. | o Sr. | o I | o II | o III | o IV | o V | o VI | o VII |

**\*Please select all programs you are exiting the Child from?**

o Evidence-Based Home Visiting (EBHV)

o \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Family Support Program (FSP)

o FSP 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o FSP 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o FSP 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o FSP 4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Date of Exit**

o EBHV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

o FSP 4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Program)

o \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)

**\* Reason for Exit**

o Completed Program EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Currently Enrolled but not actively participating in program (On hold (1)) EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Stopped before completion **(Select the most appropriate option below)**  EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Child no longer in family’s custody (parental rights terminated) EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Caregiver returned to work or school EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Dissatisfied with program EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Enrolled in another program EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Excessive missed appointment/attempted visits EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Home visitor resigned; refused new home visitor EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Miscarried/fetal death/child death EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Moved out of service area EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Pressure from family EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Safety of the home visitor EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Unable to contact/Unable to locate EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Unable to meet model requirements due to other obligations EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

o Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EBHV ☐ FSP 1: ☐ FSP 2: ☐ FSP 3: ☐ FSP 4: ☐

(1) If Caregiver is placed on hold they will automatically be exited 6 months after the date of exit.