# Office of Child Development and Early Learning

# Family Supports

# Family Support Program Data System

# Data Collection Forms

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## **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

o Geisinger Health Plan

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

## **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 Dado 27/7 Dad AM & PMo ACT / ACT Raising Safe Kidso Active Parenting 4th Editiono Active Parenting for Teenso Circle of Programso Circleso Doctor Dado Exchange Parent Aideo Families in Recoveryo Father in 15o Foundations of Fatherhoodo Growing Great Kidso Incredible Yearso Inside Out Dado Logic Modelo Make Parenting a Pleasure o Moving Beyond Depressiono Nurse Legal Partnership | o Nurturing Dads o Nurturing Parentingo ParentChild+o Parent Caféo Parent Child Home Program (PCHP)o Parenting Inside Outo Positive Solutions for Familieso SAFEo Safe Care (Non-Augmented)o Smart Parent Safe and Healthy Kids (SPHK) o Strengthening Families Programo Systematic Training for Effective Parenting (STEP)o The Father Projecto The Refugee Family Strengthening Programo Triple Po 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.