

Healthy Start Mandatory Background Information Form | Jan 2020

OMB Control No. 0915-0338, Expiration Date XX/XX/202X

INFORMATION IN THIS BOX IS FOR GRANTEE RECORDS ONLY—DO NOT UPLOAD

Name of Primary Participant: _____ Date of Birth: _____

Name of Accompanying Adult: _____ Date of Birth: _____

Name of Interviewer: _____

NAMES AND DATES OF BIRTH ARE INCLUDED ABOVE FOR GRANTEE TRACKING PURPOSES ONLY AND SHOULD NOT BE SUBMITTED TO HRSA. EACH PERSON'S UNIQUE ID# SHOULD REMAIN THE SAME ACROSS PHASES AND YEARS, AND SHOULD INCLUDE THE GRANTEE'S ORG CODE PLUS A UNIQUE NUMBER. EVERY MANDATORY FORM SHOULD INCLUDE THE PRIMARY PARTICIPANT'S UNIQUE ID#. THE PRIMARY PARTICIPANT FOR THIS FORM IS A WOMAN (REPRODUCTIVE AGE FEMALE) WHO IS ENROLLED FOR PRECONCEPTION, PRENATAL, POSTPARTUM, OR PARENTING/INTERCONCEPTION HEALTH; OR THE PRIMARY PARTICIPANT MAY BE AN ENROLLED FATHER OR OTHER ADULT (IF APPLICABLE) WHO HAS PRIMARY RESPONSIBILITY/CUSTODY FOR AN ENROLLED CHILD. THE ACCOMPANYING ADULT PARTICIPANT IS THE PRIMARY PARTICIPANT'S SPOUSE OR PARTNER, AND/OR THE ENROLLED CHILD'S CO-PARENT. THE UNIQUE IDs OF THE ENROLLED WOMAN AND ANY ACCOMPANYING ADULT SHOULD ALL BE PROVIDED BELOW AS APPLICABLE, SO THAT THESE CAN BE LINKED IN THE ELECTRONIC DATABASE.

Public Burden Statement: The purpose of this data collection is to obtain consistent information across all grantees about Healthy Start and its outcomes. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0338 and it is valid until XX/XX/202X. This information collection is voluntary. Public reporting burden for this collection of information is estimated to average 0.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

EVERY PRIMARY PARTICIPANT AND ACCOMPANYING ADULT SHOULD COMPLETE THIS FORM, REGARDLESS OF WHICH REPRODUCTIVE PHASE THEY ARE IN.

- PRIMARY PARTICIPANTS AND ACCOMPANYING ADULTS COMPLETE SEPARATE BACKGROUND INFORMATION FORMS AND RESPOND ACCORDING TO THEIR OWN EXPERIENCES.
- PREGNANCY/CHILDBIRTH HISTORY AND PREVIOUS BIRTHS SECTIONS AT THE END OF THIS FORM SHOULD BE LEFT BLANK FOR CUSTODIAL FATHERS AND ACCOMPANYING ADULTS.
- UPON PHASE CHANGE, ONLY THE PRIMARY PARTICIPANT'S FORM IS UPDATED.
- UPON EXIT FROM THE PROGRAM, BOTH PRIMARY PARTICIPANTS AND ACCOMPANYING ADULTS HAVE THEIR BACKGROUND INFORMATION FORMS UPDATED.
- UNIQUE ID#s OF BOTH PRIMARY PARTICIPANT AND ACCOMPANYING ADULT MUST APPEAR TOGETHER ON THIS FORM SO THAT THE TWO ID#s CAN BE LINKED IN THE DATABASE.

GENERAL INFORMATION to be completed by staff before uploading data for this participant:

1. PRIMARY PARTICIPANT UNIQUE ID#: _____

- [Enter as One Number: Grantee Org Code + PP + Unique ID]

2. ACCOMPANYING ADULT (IF APPLICABLE) UNIQUE ID#: _____

- [Enter as One Number: Grantee Org Code + AA + Unique ID
- Or indicate no AA

3. DATES OF ENROLLMENT IN HEALTHY START:

- Primary Participant _____
- Accompanying Adult _____

4. WHAT PHASE OF THE REPRODUCTIVE CYCLE WAS THE PRIMARY PARTICIPANT IN WHEN HE/SHE FIRST ENROLLED IN HS?

- Preconception (no prior pregnancies)
- Prenatal (currently pregnant)
- Postpartum
 - Has a live infant less than 6 months old or
 - Had a pregnancy loss less than 6 months ago)
- Parenting/Interconception
 - Has child[ren] 6-18 months enrolled in HS
 - Has children, but they are not enrolled in or are not eligible for HS services
 - A woman with no live children but who had a pregnancy loss 6 or more months ago

5. INITIAL COMPLETION OF THIS FORM (PRIMARY PARTICIPANT OR ACCOMPANYING ADULT):

- Date of initial completion of this Background Information form: _____

6. THIS FORM HAS BEEN UPDATED WITH THE PRIMARY PARTICIPANT FOLLOWING ITS INITIAL COMPLETION BASED ON [select below as applicable]:

- Enrolled woman enters prenatal phase
 - Date updated: _____
- Enrolled woman ends prenatal phase
 - Date updated: _____
- Already enrolled child turns 6 months
 - Date updated: _____
- Other update (eg, primary participant continues enrollment after enrolled child exits program, annual reporting occurs with no phase change on primary participant's part, major life event such as death of spouse/partner or divorce, significant change in health status, etc)
 - Date updated: _____
 - Specify reason for update: _____

7. UPDATE THIS FORM WHEN THE PARTICIPANT (PRIMARY PARTICIPANT OR ACCOMPANYING ADULT) EXITS HS:

- Date of exit from HS services: _____
- Reason for exit: _____

8. PARTICIPANT TYPE:

Primary Participant

- Enrolled woman (primary person receiving support is/identifies as a female)
- Enrolled father (primary parent receiving support is/identifies as a male)
- Other adult with primary custody of child, Specify_____

Accompanying Adult (Primary Participant’s Spouse or Partner)

- None
- Yes

[STAFF: COMPLETE BELOW AS APPROPRIATE REGARDING THE SITE SERVED]:

GRANTEE SITE IS LOCATED IN STATE: _____

WHAT TYPE OF AREA DOES THIS GRANTEE SITE SERVE:

- Urban
- Rural
- Tribal
- Border

WHAT REGION IS THIS GRANTEE SITE LOCATED IN:

- I
- III
- V
- VII
- IX
- II
- IV
- VI
- VIII
- X

ADDITIONAL INSTRUCTIONS

- This form must be administered by a trained case worker or other Healthy Start grantee staff member, to ensure consistency in responding across participants and grantees when questions or misunderstandings arise. It should not be self-administered or administered by untrained staff.
- If the accompanying adult changes across the primary participant’s phases, then each accompanying adult participant should complete a separate Background Information Form and be given a separate Unique ID.
- Completing this form allows us to count the number of participants (both primary participants and accompanying adults) served by HS. INFORMATION REGARDING EACH ENROLLED CHILD IS PROVIDED IN THE CHILD SECTION OF THE PARENT/CHILD FORM.
- Items in *italics* are questions for or statements to the participant. Instructions to staff may be [bracketed].

Please read the following statement to the participant:

- *Thank you for participating in the Healthy Start program. The purpose of these forms is to examine how well the Healthy Start program is meeting its goals of helping families improve their health and the health of their babies. This questionnaire should take about 25 minutes to complete. Any*

information you provide will be kept confidential. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits.

Participant General Information

Please read the following:

First, I'd like to ask you a few general background questions. Asking these questions gives us a better idea of who our Healthy Start participants are, so we can serve you better.

1. What is your sex?

Select one.

- Female
- Male
- Declined to answer

1a. [Staff: Indicate here if participant expresses discomfort with or reluctance to use the male/female binary classification.]

- Participant prefers not to use the male/female binary categorization (including 'I'm not sure/don't know/don't want to answer' responses)
- No, the participant seemed comfortable with the binary male/female designation
- Unable to determine

2. Now I'd like to ask some questions about your education. What is the highest grade or level of school that you have completed?

- No formal schooling
- 8th grade or less
- Some high school (Grades 9, 10, 11, & 12)
- High school diploma (Completed 12th grade)
- G.E.D.
- Some college or 2 year degree
- Technical or trade school
- Bachelor's degree
- Graduate or professional school

3. Are you of Hispanic or Latino/a origin?

Select one.

- Yes, Hispanic or Latino
- No, Not Hispanic or Latino
- Don't know
- Declined to answer

4. What is your race?

Select all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American

- Native Hawaiian or Other Pacific Islander
- White
- Don't know
- Declined to answer

5. Which ONE racial classification below do you identify with the most?

Select ONE only.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- More than one race/biracial/multiracial
- Other: _____
- Don't know
- Declined to answer

Participant Health Care

Next, I'd like to ask you some questions about your current health care. Collecting this information gives us a better idea of our participants' experiences and needs, so we can improve the services we offer.

6. Is there a place that you USUALLY go for care when you are sick or need advice about your health?

- Yes
- No
- Don't know
- Declined to answer

7. Where do you USUALLY go first?

Select one only.

- Doctor's Office
- Hospital Emergency Room
- Hospital Outpatient Department
- Clinic or Health Center
- Retail Store Clinic or "Minute Clinic"
- School (Nurse's Office, Athletic Trainer's Office)
- Some other place* _____
- Don't Know
- Declined to answer

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[*Staff: If participant says 'urgent care,' mark this as 'some other place' and write in 'urgent care.' If participant does not know what a 'Minute Clinic' is, explain that it is a walk-in clinic at a local pharmacy or store.]

8. DURING THE PAST 12 MONTHS, were you EVER covered by ANY kind of health insurance or health coverage plan?

- Yes, I was covered all 12 months
- Yes, but I had a gap in coverage
- No
- Don't know
- Declined to answer

9. What kind of health insurance do you have now?

Please select all that apply.

Insurance Type	Check if Currently have
Private health insurance from my job or the job of my spouse or partner	<input type="checkbox"/>
Private health insurance from my parents	<input type="checkbox"/>
Private health insurance from the <State> Health Insurance Marketplace or <state website> or HealthCare.gov	<input type="checkbox"/>
Medicaid (Title XIX) (required: state Medicaid name_____)	<input type="checkbox"/>
CHIP (Title XXI)	<input type="checkbox"/>
Subsidized ACA plan (also called 'subsidized premium or subsidized coverage through the Affordable Care Act')	<input type="checkbox"/>
TRICARE or other military health care	<input type="checkbox"/>
* Indian Health Service or tribal [also check 'no health insurance' below]	<input type="checkbox"/>
Other health insurance, Please tell us:_____	<input type="checkbox"/>
I do not have health insurance now	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

Declined to answer	€

[*Staff note: If the participant uses Indian Health Service, please indicate above. We understand that Indian Health Service does not constitute insurance, and so if a participant uses IHS, please check both the IHS and the 'no health insurance coverage' boxes, so that IHS can be tracked as a separate item in addition to being counted as 'no health insurance coverage'.]

10. During the past 12 months, did you see a doctor, nurse, or other health care professional for PREVENTIVE medical care, such as a physical or well-visit checkup? A preventive check-up is when you are not sick or injured, such as an annual or sports physical, or well-visit.

Select one only.

- € Yes
- € No
- € Don't know
- € Declined to Answer

[Staff: a visit for PREVENTIVE medical care DOES NOT include prenatal care]

Personal Well-Being

Next, I'm going to ask you some questions about how you're doing in day to day life, that is, your own sense of personal well-being. I'll start with a couple of questions about income because the financial resources available to us can have a big impact on stress in our daily lives.

11. First, can you tell me, during the past 12 months, what was your yearly total household income before taxes? Please include all sources of income, including your income, your spouse's or partner's income, and any other income you may have received. All information will be kept private and will not affect any services you are now getting.

Select one only.

- € \$0 to \$16,000
- € \$16,001 to \$20,000
- € \$20,001 to \$24,000
- € \$24,001 to \$28,000
- € \$28,001 to \$32,000
- € \$32,001 to \$40,000
- € \$40,001 to \$48,000
- € \$48,001 to \$57,000
- € \$57,001 to \$60,000
- € \$60,001 to \$73,000
- € \$73,001 to \$85,000
- € \$85,001 or more

12. During the past 12 months, how many people, including yourself, depended on this income?

STAFF: Enter number of people.

€ _____ People

13. Of the people who depended on this income during the past 12 months, how many are:

- € Adults age 18 or older: _____ [Note: A pregnant woman counts as one person]
- € Children age 17 or younger: _____
- € Don't know
- € Declined to answer

14. [If participant currently has children, ask:] Do you have any children less than 18 months old who are enrolled or you would like to enroll in Healthy Start?

Select one only.

- € Yes [Participant will need to complete the mandatory Parent/Child Form if the child is or will be enrolled in HS], How many? _____
- € No
- € Don't know
- € Declined to answer

Next I'm going to ask you a couple of questions about how your mood has been lately.

15. Over the last 2 weeks, how often have you been bothered by the following problems?

[STAFF: Read each item to participant, and check one response for each item. A Total Score of 3 or more indicates additional screening and possible referral is needed.]

	Mood	Not at all	Several Days	More than half the days	Nearly every day	TOTAL
a.	Little interest or pleasure in doing things	€ 0	€ 1	€ 2	€ 3	
b.	Feeling down, depressed, or hopeless	€ 0	€ 1	€ 2	€ 3	
TOTAL SCORE						

16. [Staff: has this participant responded to the items of the depression screening in the previous question?]

- € Yes, both items
- € Yes, but only one item
- € No, was not able to administer this

17. [Staff: Please indicate as following regarding referral for additional screening and/or follow-up services related to possible depression]

- € Participant's total score was less than 3 and so did not indicate a need for referral
- € Participant's total score of 3 or more indicates that additional screening and referral is needed and referral WAS PROVIDED

- € Participant's total score of 3 or more indicates that additional screening and referral is needed but referral was WAS NOT PROVIDED because:
- o Client is already receiving services for possible depression
 - o Client declined referral

The next couple questions are sensitive in nature and can be uncomfortable to answer. Please know that I ask everyone the same questions. It's important to answer honestly, so we can provide the best services to you. Your answers will not change what I think of you or how we work together. Your answers will not change our relationship or how you're viewed or treated.

The first questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the types of substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

18. In the past 12 months, how often have you...? [STAFF: Read substances and answers to the participant and enter one response for each type of substance.]

Substance Type	Daily or Almost Daily	Weekly	Monthly	Less than Monthly	Never	Declined to answer
Used any tobacco product (for example, cigarettes, ecigarettes, cigars, pipes, or smokeless tobacco)?	€	€	€	€	€	€
For women: Had 4 or more drinks containing alcohol in one day? For men: Had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.	€	€	€	€	€	€
Used marijuana?	€	€	€	€	€	€
Used any illicit drugs including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?	€	€	€	€	€	€
Used any prescription medications just for the feeling, more than prescribed, or that were not prescribed for you? Prescription medications that may be used this way include: Opioid pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)	€	€	€	€	€	€

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We are concerned about the safety of all participants. Please answer the following questions so that we can help you if needed.

19. During the past 12 months, has anyone...

	During the past 12 months has anyone...	Current or Former Intimate Partner	Other Family Member	Someone Else	No-one	Declined to answer
a.	Threatened you or made you feel unsafe in some way?	€	€	€	€	€
b.	Made you feel frightened for your safety or your family's safety because of their anger or threats?	€	€	€	€	€
c.	Tried to control your daily activities, for example, control who you could talk to or where you could go?	€	€	€	€	€
d.	Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?	€	€	€	€	€
e.	Forced you to take part in touching or any sexual activity when you did not want to?	€	€	€	€	€

20. [Staff, Indicate IPV screening status below]:

- € Screening completed (all questions answered)
- € Screening not completed due to
 - o Presence of partner
 - o Presence of family member/friend
 - o Participant declined to answer one or more questions
 - o Other reason, please specify _____

[STAFF: IF ANY OF THE ABOVE SCREENINGS WAS NOT COMPLETED, PLEASE SCREEN ON NEXT VISIT.]

Reproductive Life Planning

Next, I have a few questions about your thoughts about having (more) children. This information will help me support you in making decisions about whether and when you might have (more) children.

21. Do you want any (more) children?

- Yes [Go to next question]
- No [Skip to question 24]
- Unable to get pregnant [Skip to question 25]
- Don't know [Skip to question 24]
- Declined to answer [Skip to question 24]

22. →If you WANT (more) children... How many (more) children do you want? _____

23. →If you WANT (more) children... How long do you plan to wait until you become pregnant (again)?

24. All participants... What kind of birth control are you using now to keep from getting pregnant before you are ready? Or, if you are currently pregnant, what method do you plan to use following your pregnancy to prevent becoming pregnant again before you are ready?

Select all that apply.

- Tubes tied or blocked (female sterilization or Essure®)
- Vasectomy (male sterilization)
- Birth control pills
- Condoms
- Shots or injections (Depo-Provera®)
- Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
- Contraceptive implant in the arm (Nexplanon® or Implanon®)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- Not having sex (abstinence)
- Other, Please specify _____
- None
- Don't know
- Declined to answer

25. All participants... Are you currently using a condom to prevent sexually transmitted infections?

Select one only.

- Yes
- No
- N/A—not sexually active
- Don't know
- Declined to answer

26. [Staff: has this participant responded to the questions in this section, as relevant, to create a satisfactory Reproductive Life Plan (RLP)? [that is, if she does not want (more) children, she has identified a method of birth control to use to prevent pregnancy (q 24); or if she does want (more) children, she has thought about how many (q 22), and their spacing (q 23) and how to prevent pregnancy until she is ready (q 24).]

- Yes, participant has completed all relevant items to create a satisfactory RLP
- Participant responded to at least some of the questions but the RLP leaves her/him vulnerable to unplanned pregnancies
- No, was not able to administer this

STAFF: IF THE PARTICIPANT HAS NOT YET CREATED A SATISFACTORY RLP, FLAG THIS ITEM AND WORK WITH HER AT A LATER TIME (EG THE NEXT VISIT) UNTIL SHE HAS, AND THEN UPDATE THESE QUESTIONS ACCORDINGLY.

ENROLLED FATHERS AND ACCOMPANYING ADULTS: THIS FORM IS NOW COMPLETE. ENROLLED WOMEN CONTINUE WITH THE FINAL SECTIONS.

Pregnancy and Childbirth History

[Enrolled women only]

Next, I'd like to ask you some questions about your pregnancy and childbirth history.

27. *Are you pregnant now?*

Select one only.

- Yes [Participant will need to complete the mandatory Prenatal Form]
- No
- Don't know
- Declined to answer

28. *Have you ever had any of the following?*

Select all that apply.

- Live birth, Number _____
- Pregnancy that did not result in a live birth
 - Ectopic or tubal pregnancy, Number _____
 - Miscarriage (pregnancy ended spontaneously before 20 weeks), Number _____
 - Stillbirth or fetal death (pregnancy ended at 20 weeks or more), Number _____
 - Termination of pregnancy, Number _____
- None of the above (no prior pregnancies)
- Don't know
- Declined to answer

IF PARTICIPANT HAS HAD NO LIVE BIRTHS (QUESTION 28), THIS FORM IS COMPLETE.

IF PARTICIPANT HAS HAD A LIVE BIRTH (QUESTION 28), ASK THE FOLLOWING QUESTIONS REGARDING HER PREVIOUS BIRTHS.

Previous Births

[ONLY ENROLLED WOMEN WHO HAVE HAD A PREVIOUS LIVE BIRTH (QUESTION 28) SHOULD COMPLETE THIS SECTION.]

[Staff: if participant becomes distressed at any point, empathize and provide emotional support. If necessary, complete any additional required Forms at a later time, eg, the next visit.]

Next, I'd like to ask you a few questions about your previous births.

29. A preterm delivery is one that occurs before the 37th week of pregnancy. As far as you know, have you had a preterm delivery in the past?

Select one only.

- Yes, Number of prior preterm deliveries: _____
- No, Number of prior full term deliveries: _____
- Don't know
- Declined to answer

30. Did any of your babies weigh LESS than 5 pounds, 8 ounces [2500 grams] at birth?

Select one.

- Yes, How many babies: _____
- No
- Don't know
- Declined to answer

31. [Staff: skip this question if mother has not had previous babies born less than 5 lb, 8 oz] Thinking about your babies who were born weighing less than 5 pounds, 8 ounces, how many of them weighed LESS THAN 3 pounds, 5 ounces [1500 grams] at birth?

Select one.

- Yes, How many babies: _____
- No
- Don't know
- Declined to answer

32. Did any of your babies weigh more than 9 pounds 4 ounces [4500 grams] at birth?

- Yes, How many babies: _____
- No
- Don't know
- Declined to answer

33. Did any of your babies stay in the hospital after you came home?

Select one only.

- Yes, How many _____, Please specify reason _____

- € No
- € Declined to answer

34. *Sometimes parents lose babies or children after they are born. This is heartbreaking. In order to offer you the best, most sensitive service I can, can you tell me if you've ever lost a baby or child after they were born?*

- € No [this form is complete]
- € Yes [GO TO NEXT QUESTION]
- € Declined to answer [this form is complete]

35. [Staff, if mother indicates the prior loss of a child in previous question, sensitively probe for THE NUMBER of babies/children she has lost]

€ -----

36. [Staff, sensitively probe for the child's or children's AGE(S) AT DEATH and record below:]

- € Number of children who died **within 0 to 27 days** of life (neonatal): _____
- € Number of children who died **28 to 364 days after birth** (infant): _____
- € Number of children who died at **12 months or older** (post-infancy): _____

The Healthy Start Mandatory Background Information Form is Complete.

Thank you!