

HEALTHY START-FAMILY SPIRIT CHILD 2 YEAR ASSESSMENT

HSID: _____ - _____ - ____ Date: (mm/dd/yyyy) _____ Staff: _____

Location of visit: Home Office Other

Child's First Name: _____ Child's Last Name: _____

Change Client Contact Information (update if needed)

Current Address: _____ Phone _____ None
City: _____ State _____ Zip Code _____ County _____

Current Age: _____ Meets CSHCN criteria? Yes, specify _____ No

Primary Insurance Coverage Medicaid MI-Child Private None

Medical Home: Yes No

Medical Home Description:

Tribal Clinic Private Practice
 Hospital Based Primary Care Center Community Health Center (other than tribe)
 Other, Specify _____

Immunization Status:

Up to Date Not up to date (needs catch-up) Waiver Cannot be ascertained

Is the child up to date on well-child visits?

Up to Date Not up to date (needs visits) Cannot be ascertained
Other, specify _____

Has the child been to the Emergency Room in the past year? Yes. No

If yes how many times _____

Reason _____

Has the child received medical care for an injury or ingestion in past year? Yes. No

If yes how many times _____

Reason _____

Have any of the following health & development issues been identified?

Asthma.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused
Mental Health Issue (ASQ-SE).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused
Failure to Thrive/ lack of growth (growth chart).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused
Developmental Delay (ASQ-3)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused

Have any of the following Home Environment and Exposure issues been identified?

Family Violence/Intentional Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused
Homelessness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused

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Unstable

Housing Yes No Refused
Unmet basic needs (food, diapers, ect.) Yes. No Refused
Live in or frequent visit house built before 1978 Yes No Refused
Peeling/chipping paint or remodeling underway Yes No Refused
Adult in house whose job/hobby involves Yes No Refused
Exposure to lead (auto repair, plumber, potter)

Exposed to 2nd hand smoke in home Daily Weekly Monthly < Monthly Never
Rides in car with someone smoking Daily Weekly Monthly < Monthly Never

Over the past year, how often have you or another adult in the household read to your child?

Never Less than weekly 1-4 days/week Most 5 days/week to everyday

Referrals to Early Childhood or other Programs Made: Yes No Refused

If yes, referred to : Early Head Start/Head Start. Early On Tribal Child Program

Other Day Care/ Child Care Other, specify _____