Postpartum Enrollment Addendum (with Child Under 18 mos.)

HSID: __ __ __ __- __ __ __ __ -00 Screening Date: mm/dd/yyyy ____________
Staff:_______________

Staff- *Only complete the core data section for clients who were enrolled previously and have transitioned to become postpartum client. If a client is newly enrolling as postpartum, do not complete the Core Data section as this information is already collected on the Enter/Edit Client screen.*

Core Data Questions

Highest level of Education Completed?

- ☐ No formal schooling
- ☐ Less than 8th grade
- ☐ Less than high school diploma
- ☐ High School graduate
- ☐ GED completed
- ☐ Some college/formal training beyond high school
- ☐ Technical training/ trade school or certification
- ☐ Associate's degree
- ☐ College (Bachelor's degree)
- ☐ Graduate Degree
- ☐ Other
- ☐ Don't Know
- ☐ Declined to answer

Currently a Student or in Training? ☐ Yes ☐ No

Employment Status

- ☐ Full Time
- ☐ Part Time < 30 hours per week
- ☐ Not Employed

Total Household Income (yearly): ____________

Adults (18 yrs+): ____________

Children (17 or younger): ____________

Total in Household: system generates using the sum of the number of adults + child(ren) in the household

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Income Category: will populate in system if above information is entered
☐ 50% and under
☐ 51% - 100%
☐ 100% - 133%
☐ 134% - 200%
☐ 201% - 300%
☐ >300%
☐ Unknown

Income level: will populate in system
☐ < 100% FPL
☐ 100%-185% FPL
☐ >185% FPL
☐ Unknown

Housing Status
☐ Not Homeless
☐ Homeless
☐ Unknown/ Did not report

Homeless Situation
☐ Homeless and sharing housing
☐ Homeless and living in emergency or transitional shelter
☐ Homeless with some other arrangement

__________________________End of Core Data Questions________________________________

Staff- *Update If Needed*
Current Address____Phone______________ ☐ None
City_______________________________________ State_____ Zip Code_____________
County__________________________

***Staff:** List children **Youngest (**most recent birth) First.

Child First Name: ___________ Last Name: _____________DOB (mm/dd/yyyy) _________ Age______

Child First Name: ___________ Last Name: _____________DOB (mm/dd/yyyy) _________ Age______

Child First Name: ___________ Last Name: _____________DOB (mm/dd/yyyy) _________ Age______

Child First Name: ___________ Last Name: _____________DOB (mm/dd/yyyy) _________ Age______

Child First Name: ___________ Last Name: _____________DOB (mm/dd/yyyy) _________ Age______

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*Mother's Current Age: _____

*If <age 24, meets CSHCN criteria? Children with Special Health Care needs ☐ Yes ☐ No

*Enrolled in WIC: ☐ Yes ☐ No

Enrolled in MIHP: ☐ Yes Medicaid ID: ________________ ☐ No

FOOD *Needs Nutrition Information: ☐ Yes ☐ No

*In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there was not enough money or food?

☐ Yes ☐ No ☐ Refused

If Yes, how often did this happen?

☐Almost every month. ☐Some months but not very much. ☐In only 1 or 2 months

TRANSPORTATION

*Do you have access to reliable transportation? ☐ Yes ☐ No

If no, please check all concerns that apply. ☐ Potential Unavailability ☐ Unreliable ☐ Not affordable

*Needs transportation assistance ☐ Yes ☐ No

HOUSING

*How many times have you moved in the last 12 months? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

*Do you currently have any concerns or worries about your housing situation?

☐ Yes ☐ No

If Yes, check all that apply. If no skip to next question.

☐No place to live, no regular nighttime residence
☐Eviction or being forced to move out
☐Affordability of current house or apartment
☐Safety of house/apartment
☐Strained relations with other(s) in household
☐Sanitation/waste removal
☐House or apartment is too crowded
☐Pest Control
☐Safety of neighborhood
☐Ease of access into home
☐Code violations
☐Ventilation/air conditioning
☐Lack of continuous function basic utility service (e.g. heat, electricity)

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TELEPHONE:
*How often do you have access to a telephone to make and receive calls where you live?
☐ Always ☐ Sometimes ☐ Never

PHYSICAL ACTIVITY

BMI Calculation: Feet______ Inches: ______ Weight: ______ BMI: co___ System generated_

Physical Activity: In the past 30 days have you participated in any leisure time physical activity, such as walking, biking, swimming or other sports, ect? ☐ Yes ☐ No

In an average week, how often do you participate in at least 30 minutes of physical activity?
☐ Zero times ☐ Once ☐ 2-3 times ☐ 4 times ☐ 5 or more

ORAL HEALTH

How long has it been since you had a dental exam or cleaning?

☐ Within the past year ☐ Within the past 2 years ☐ Within the past 5 years

☐ More than 5 years ☐ Don't know/not sure ☐ Never

MEDICAL CONDITIONS	**Have been treated for or told that you have**	**Date of last visit to health care provider about this condition**	**Follow up needed? Y/N**
Asthma	☐ Yes ☐ No		☐ Yes ☐ No
Group B Strep or Bacterial Vaginosis	☐ Yes ☐ No		☐ Yes ☐ No
Recurring Vag Infections	☐ Yes ☐ No		☐ Yes ☐ No
Sexually transmitted infection:	☐ Yes ☐ No		☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No		☐ Yes ☐ No
Hepatitis B or C	☐ Yes ☐ No		☐ Yes ☐ No
Hypertension	☐ Yes ☐ No		☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No		☐ Yes ☐ No
Continue Next Page.			

Diabetes: Non-insulin dependent Insulin dependent Gestational (if hx of GDM ask about BS screen)	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No		 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Family Hx Breast Cancer	☐ Yes ☐ No		☐ Yes ☐ No
Fecal Occult blood test (FOBT)/colon cancer screening	☐ Yes ☐ No		☐ Yes ☐ No
Mental Illness: depression, bipolar, other	☐ Yes ☐ No		☐ Yes ☐ No
Other:	☐ Yes ☐ No		☐ Yes ☐ No

SUBSTANCE USE

*Are you currently in treatment for Alcohol, Drug, or Substance Use?
☐ Yes ☐ No ☐ Refused

*Does anyone in the household use tobacco products in the home?
☐ Yes ☐ No ☐ Refused

DEPRESSION SCREENING *(EPDS): Postpartum with youngest child 18 months and under

Instructions: I'd like to ask you some follow-up questions about how you're feeling. I'm going to read you some statements and responses. For each statement, please let me know which response is closest to how you've been in the past 7 days

*I have been able to laugh and see the funny side of things:
☐As much as I always could (0)
☐Not quite so much now (1)
☐Definitely not so much now (2)
☐Hardly at all (3)

*I have looked forward with enjoyment to things
☐As much as I ever did (0)
☐Rather less than I used to (1)
☐Definitely less than I use to (2)
☐Hardly at all (3)

*I blamed myself unnecessarily when things went wrong
☐No, never (0)
☐Not very often (1)
☐Yes, some of the time (2)
☐Yes, most of the time (3)

*I have been anxious or worried for no good reason
☐No, not at all (0)
☐Hardly ever (1)
☐Yes, sometimes (2)
☐Yes, very often (3)

*I have felt scared or panicky for no very good reason
☐No, not at all (0)
☐No, not much (1)
☐Yes, sometimes (2)
☐Yes, quite a lot (3)

*Things have been getting the best of me
☐No, I have been coping as well as ever (0)
☐No, most of the time I have coped quite well (1)
☐Yes, sometimes I haven't been coping as well as usual (2)
☐Yes, most of the time I haven't been able to cope (3)

*I have been so unhappy that I have had difficulty sleeping
☐No, not at all (0)
☐Not very often (1)
☐Yes, sometimes (2)
☐Yes, most of the time (3)

*I have felt sad or miserable
☐No, not at all (0)
☐Not very often (1)
☐Yes, quite often (2)
☐Yes, most of the time (3)

*I have been so unhappy that I have been crying
☐No, never (0)
☐Only occasionally (1)
☐Yes, quite often (2)
☐Yes, most of the time (3)

*The thought of harming myself has occurred to me
□Never (0)
□Hardly ever (1)
□Sometimes (2)
□Yes, quite often (3)

Staff: Maximum Score 30 possible. Always look at last question (Suicidal thoughts) for addition urgent follow-up.

Total EPDS: Calculated Table

***Staff**: Please indicate which response best reflects the need for referral and/or follow-up services related to possible depression.

□ Participants total score was less than 11 and so did not indicate a need for referral
□ Participants total score of 11 or more indicates that additional screening and referral is needed, and referral was provided.
□ Participants total score of 11 or more indicates that additional screening and referral is needed, but referral was not provided because client is already receiving services for possible depression.
□ Participant's total score of 11 or more indicates that additional screening and referral is needed, but referral was not provided because client declined referral

STRESS (PERCEIVED STRESS SCALE)

*In the last month, how often have you felt that you were unable to control the important things in your life?□ Never (0) □ Almost Never (1) □ Sometimes (2) □ Fairly Often (3) □ Very Often (4)

*In the last month, how often have you felt confident about your ability to handle your personal problems? □ Never (4) □ Almost Never (3) □ Sometimes (2) □ Fairly Often (1) □ Very Often (0)

*In the last month, how often have you felt that things were going your way?
□ Never (4) □ Almost Never (3) □ Sometimes (2) □ Fairly Often (1) □ Very Often (0)

*In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? □ Never (0) □ Almost Never (1) □ Sometimes (2) □ Fairly Often (3) □ Very Often (4)

Higher Score, Higher the stress:
Total Perceived Stress Score: ____________

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ABUSE/ VIOLENCE

Are you in a relationship now? ☐ Yes ☐ No ☐ Refused
Do you feel safe in your present relationship? ☐ Yes ☐ No ☐ Refused

*As a child have you ever been involved with Children's Protective Services?
☐ Yes ☐ No ☐ Refused

*Have you ever been involved with Children's Protective Services with any of your children?
☐ Yes ☐ No ☐ Refused

BREASTFEEDING

*Have you ever breastfed any of your children? Yes No

*Are medical unable to breastfeed? Yes No

FORM END.

NOTES: