Postpartum Enrollment Addendum (with Child Over 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_______________________________

Current Address_______________________________________ Phone_____________ ☐ None
City_______________________________________ State_____ Zip Code____________
County________________________

*Staff: List children in order of **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_______

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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
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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 PP CLIENT WITH YOUNGEST CHILD OLDER THAN 18 MONTHS:

*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

*In the past 12 months, how often have you?

*a. Used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?
☐ Daily or Almost Daily
☐ Weekly
☐ Monthly
☐ Less than Monthly
☐ Never
☐ Declined to answer

*b. For women: Had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine 5oz, 1 beer (12 oz), or 1 single shot of liquor
☐ Daily or Almost Daily
☐ Weekly
☐ Monthly
☐ Less than Monthly
☐ Never
☐ Declined to answer

*c. Used Marijuana?
☐ Daily or Almost Daily
☐ Weekly
☐ Monthly
☐ Less than Monthly
☐ Never
☐ Declined to answer

*d. Used any illicit drugs including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?
☐ Daily or Almost Daily
☐ Weekly
☐ Monthly
☐ Less than Monthly
☐ Never
☐ Declined to answer

*e. Used any prescription medications just for the feeling, more than prescribed, or that were not prescribed to you?
☐ Daily or Almost Daily
☐ Weekly
☐ Monthly
☐ Less than Monthly
☐ Never

DEPRESSION SCREENING (PHQ 2) Postpartum with child over 18 months

*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.

*a. Little interest or pleasure in doing things
☐ Not at all (0)
☐ Several days (1)
☐ More than half the days (2)
☐ Nearly every day (3)
☐ Declined to answer (0)

*b. Feeling down, depressed, or hopeless
☐ Not at all (0)
☐ Several days (1)
☐ More than half the days (2)
☐ Nearly every day (3)
☐ Declined to answer (0)

Total Score: ______________ [system generated]

*Staff: Please indicate which response best reflects the need for referral 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 NOT PROVIDED because: Client is already receiving services for possible depression
☐ Participant's total score of 3 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:

ABUSE/ VIOLENCE FOR PP CLIENT WITH YOUNGEST CHILD OLDER THAN 18 MONTHS:

Are you in a relationship now? ☐ Yes ☐ No ☐ Refused

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

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*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

* 19. During the past 12 months, has anyone
a. Threatened you or made you feel unsafe in some way

☐ Current of Former Intimate Partner
☐ Other Family Member
☐ Someone Else
☐ No-one
☐ Declined to answer

b. Made you feel frightened for your safety or your family's safety because of their anger or threats?

☐ Current of Former Intimate Partner
☐ Other Family Member
☐ Someone Else
☐ No-one
☐ Declined to answer

c. Tried to control your daily activities, for example, control who you could talk to or where you could go?

☐ Current of Former Intimate Partner
☐ Other Family Member
☐ Someone Else
☐ No-one
☐ Declined to answer

d. Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?

☐ Current of Former Intimate Partner
☐ Other Family Member
☐ Someone Else
☐ No-one
☐ Declined to answer

e. Forced you to take part in touching or any sexual activity when you did not want to?
☐ Current of Former Intimate Partner
☐ Other Family Member
☐ Someone Else
☐ No-one
☐ Declined to answer

* 20. Staff: Indicate IPV screening status below:

☐ Screening completed (all questions 19a-e answered)
☐ Screening not completed due to:
    ☐ Presence of partner
    ☐ Presence of Family Member or friend
    ☐ Participant declined to answer one or more questions
    ☐ Other Reason, Specify_______________________________________

BREASTFEEDING

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

*Are medical unable to breastfeed? ☐ Yes ☐ No

FORM END.

NOTES: