Maajtaag Mnobmaadzid
Healthy Start Data Collection System
"A Start of a Healthy Life"

CLIENT ENTER/EDIT FORM

Staff Name: _____

***First Name:** _____ **Middle Initial:** _____ ***Last Name:** _____

***Client Type At Enrollment**

☐ Prenatal…….. Due Date(mm/dd/yyyy):_____(This can be an estimated date when baby will be born)

☐ Infant/Child…….. *Is Infant being served alone: ☐Yes ☐No

☐ Postpartum Mother……* Date of most recent live birth(mm/dd/yyyy)_____(youngest child's date of birth)

☐ Father

☐ Other……*Specify type ☐ Foster parent ☐Adoptive parent ☐Grandparent ☐ Other, Specify_____

***Primary in household:** ☐**Yes** ☐**No** *(Note: an infant/child can only be Primary if being served alone)*

***Associated Primary Adult:** _____*(Note: use "Find Client" to locate Primary)*

***Street Address:**_____ **Street Address 2:**_____

City:**_____ ***State:**_____County:**_____* **Zip Code**_____

***Phone: (____)**_____ ☐**None**

***Site Association:** _____*(drop down option on database)*

***Healthy Start ID:** _____ **(**If previously enrolled use same 4 digit family code)

***Enrollment Date:**_____ (Current Enrollment)

FOR CLIENTS NEW (Never been in program) **skip this box.**

FOR PREVIOUS CLIENT (who has been in program before) use SEARCH CLIENT to search and select.
Be sure to select first chart created (this would be the client's chart with the oldest enrollment date)
***HRSA PPUID:**_____
***HRSA Enrollment Date**:_____

Medicaid ID (optional):_____

***Date of Birth:** (mm/ dd/ yyyy) _____ ☐REFUSED

***How do you currently describe yourself?:** Select one:

☐Female ☐Male ☐Transgender Woman/Transgender Female/Transfeminine
☐Transgender Man/Transgender Male/Transmasculine ☐ I use a different term, Specify_____
☐ Nonbinary ☐Declined to answer

*__What sex were you assigned at birth, on your original birth certificate?__ Select one

☐Male ☐Female ☐Don't Know ☐Refused/Declined to Answer

*__Race: check all that apply__ *(The responses regarding race/ethnicity should reflect what the individual considers themselves to be and are not based on percentages of ancestry)*

☐American Indian or Alaska Native ☐White or Caucasian ☐Black or African American ☐Asian Indian

☐Chinese ☐Filipino ☐ Japanese ☐Vietnamese

☐Korean ☐Other Asian ☐Native Hawaiian

☐ Guamanian or Chamorro ☐Samoan ☐Other Pacific Islander

☐Other, specify_____

☐Declined to answer/Don't know

*__Are you Hispanic, Latino/a, or Spanish origin?__ *Check all that apply*

☐No, not of Hispanic, Latino/a, or Spanish origin

☐Yes, Mexican, Mexican American, Chicano/a

☐Yes, Puerto Rican

☐Yes, Cuban

☐Yes, Another Hispanic, Latino/a, or Spanish origin

☐Declined to answer

☐Unknown / Did not report

*__Current Client Type:__ *(Will only appear once chart is created & used to updated client from prenatal to postpartum)*

☐Prenatal…… enter due date(mm/dd/yy): _____ *(editable)*

☐Infant/Child

☐Postpartum Mother enter date of most recent live birth_____ (youngest child's birthday)

☐Father

☐Other, Specify_____

*__Client History__

☐New Client

☐Current Client/New Pregnancy

☐Previous Client

*__Status:__ ☐Active ☐Exited

*__Family with individuals in the armed services?__ ☐Yes ☐No ☐Unknown

*__Consent:__ ☐Consent Signed ☐Not obtained yet

*__Program Grant:__ Select all that apply. At least one program grant is required

☐__Healthy Start__

☐__Tribal Home Visiting__

☐__State Home Visiting__

☐__Tribal/IHS:__

☐**MIHP**

☐ **FFPSA** *(For now document under "other" and label "FFPSA" in specify box, data system will be updated soon)*

☐**Other, Specify_____**

EVERYTHING BELOW THIS LINE IS STILL REQUIRED BUT CAN BE SAVED AS IN-PROGRESS TO BE COLLECTED AT A LATER TIME HOWEVER, COLLECT AS SOON AS POSSIBLE WITHIN 1 MONTHS TIME.

***Primary Language**: **Select One** (*Defined as the language spoken in the home the majority of the time.)*

☐English
☐Spanish
☐Arabic
☐Other….. *specify _____
☐Any Native American Language……*specify _____
☐Unknown/did not report

***Secondary Language Spoken at Home: Select All that Apply** (2nd language in home spoken a minority of the time) Primary and Secondary should not be the same. Example, If English is selected as Primary language above, and no other language is spoken at home, then select "None" for this section.

☐English….
☐Spanish
☐Any Native American Language…….*specify _____
☐Arabic
☐Other……*specify) _____
☐None
☐Unknown/did not report

***How well do you speak English?**

☐ Very Well
☐ Well
☐ Not Well
☐ Not at all
☐ Declined to answer

***Highest Level of Education Completed**: (at what education level did the client finish schooling)

☐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
☐Associates degree
☐College (bachelor's degree)

☐Graduate Degree
☐Other
☐Don't know
☐Declined to answer

***Currently a student or in training**: ☐Yes ☐No ☐ Unknown

***Marital Status:**
☐Single
☐Not married but living with partner
☐Legally married
☐Separated
☐Divorced
☐Widowed
☐Unknown/ Did not report

***Employment Status:** (Employed a participant who works for pay during the reporting period)
☐Full Time ☐Part Time < 30 hours per week☐Not Employee ☐Unknown

Income at time of Enrollment. Only count income that supports the whole family

***Total Household Income (yearly):** _____ Leave out commas and spaces

***Adults (18 yrs+): _____ *Children (17 or younger): _____**

***Total in Household: _____**(system generates, sum # of adults + # of child(ren) in the household)

***Income Category** *(system generates using household information above)*
☐ 50% and under ☐ 51-100% ☐ 101-133% ☐ 134-200% ☐ 201-300% ☐ >300% ☐ Unknown

***Income level:** *(system generates using household information above)*
☐<100%FPL ☐ 100%-185%FPL ☐>185 %FPL ☐Unknown

***Insurance Status at enrollment**: *(Note: Indian Health Service (IHS) is not considered Health Insurance)*
☐Medicaid or CHIP ☐TriCare ☐Private Insurance ☐Not Insured ☐Unknown/Did not Report

***Has access to IHS, CHS, UIHP facility:** (Indian Health Service, Contract health Services, Urban Indian Health Program)
☐Yes ☐No ☐Unknown

***Housing Status**
☐**Not Homeless** (go to Do you live in below)
☐**Homeless:** (Go to Homeless Situation below) participants who lack a fixed, regular, and adequate nighttime residence. Report the participant as homeless if they were homeless for one or more days during the month prior to data collection.
☐**Unknown/Did not Report**

***Do you live in:**
☐**House** ☐**Apartment** ☐**Mobile Home** ☐**Group Home**

***Homeless Situation:**

☐**Homeless and sharing housing:** individuals who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason

☐**Homeless and living in emergency or transition shelter** individuals who are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement

☐**Homeless with some other arrangement.** individuals who are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; individuals who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); individuals who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.

COMPLETE THIS SECTION WHEN CLIENT IS EXITING PROGRAM ENTIRELY.

Family Spirit Exit

***Enter date of exit _____**

***Location of exit ☐Home ☐Office ☐Clinic ☐Hospital ☐Telephone ☐Video/Tele-health ☐Other, required specify_____**

***Status of Exit:**

☐Completed Program

☐Declined Services Withdrawal Specify Reason:_____

☐Moved New Address_____

☐Lost to Follow Up/Unable to Contact

☐Infant/Child Death; Cause_____ , Age at death (days)_____.

☐New Pregnancy

☐Other….. required Specify_____

Additional comments regarding the participants exit:

Satisfaction Survey given to Participant: ☐Yes ☐No

END OF FORM