

# **Information for Home Visiting Evaluation (IHVE) Data Collection Manual**

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## **Information for Home Visiting Evaluation (IHVE) Data Collection Manual**

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## Introduction

**Information for Home Visiting Evaluation (IHVE, pronounced “ivy”)** is the primary data system used by the Minnesota Department of Health (MDH) for collection of Family Home Visiting (FHV) program evaluation data. This document provides guidance to FHV grantees that are required to submit data to IHVE.

This manual includes:

- A description of how IHVE works
- Key concepts and definitions used in IHVE
- IHVE questions and possible responses
- Guidance for answering IHVE questions, including definitions and timing of data collection

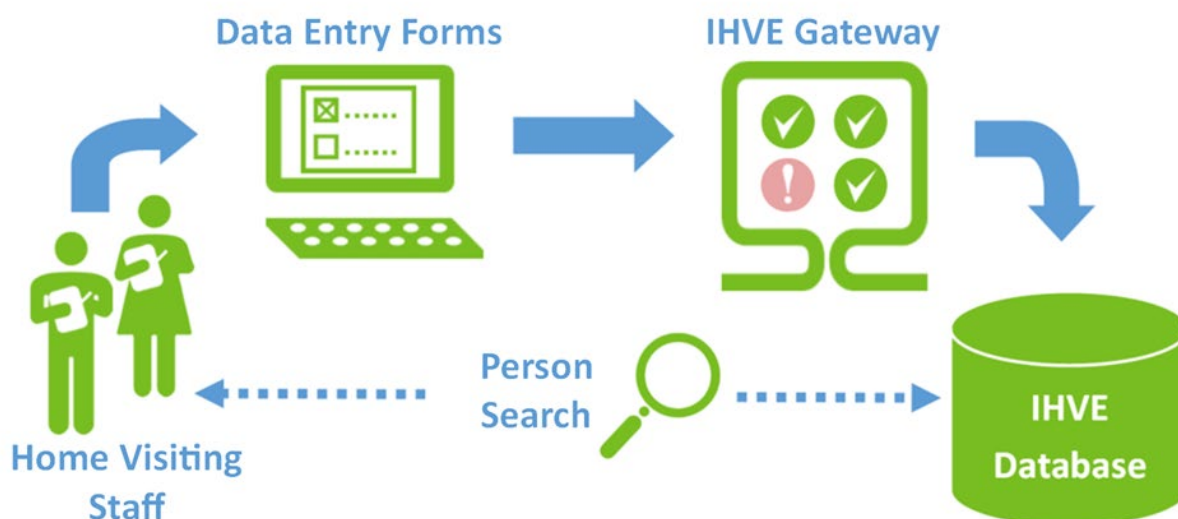
### **Who do I contact with questions?**

Send questions about IHVE to the FHV Evaluation Unit at [Health.FHVDData@state.mn.us](mailto:Health.FHVDData@state.mn.us).

## IHVE Data System Description

The IHVE Data System is made of several components that work together (Figure 1). These components include Data Entry Forms, the IHVE Gateway, and the IHVE Database. Data is entered by Home Visiting Staff into Data Entry Forms and is then submitted to the IHVE Gateway. From the IHVE Gateway, data is saved in the IHVE Database if validation criteria are met.

**Figure 1. IHVE Data System Components**



### Data Entry Forms

Home visiting program staff enter data into IHVE through one of two routes:

- IHVE-compatible data entry forms built into a case management or electronic health record (EHR) system used locally by the home visiting program
- MDH-hosted IHVE forms in the REDCap application

MDH-hosted IHVE forms in REDCap are provided to FHV programs that do not have access to IHVE-compatible data entry forms in an EHR or other data system. For information on which data systems have IHVE-compatible data entry forms, consult the [MDH FHV Evaluation webpage](#) or contact the FHV Evaluation Unit at [Health.FHVDData@state.mn.us](mailto:Health.FHVDData@state.mn.us).

All IHVE data entry forms have built-in data validation to support accurate and complete data submissions. Staff should note prompts for required questions. Some questions have specific follow-up questions that will appear based on the answer that is selected (called “skip logic” or conditional branching questions).

For more details on IHVE data entry forms, refer to:

- Documentation from your data system vendor, if using IHVE-compatible data entry forms in an EHR or other data system

- [IHVE REDCap User Guide](https://www.health.state.mn.us/docs/communities/fhv/redcapuserguide.pdf) (<https://www.health.state.mn.us/docs/communities/fhv/redcapuserguide.pdf>) if using MDH-hosted IHVE forms in REDCap.

## IHVE Gateway and IHVE Database

Data must pass through the IHVE Gateway before it is saved in the IHVE Database. The frequency of data submission to the IHVE Gateway varies depending on the source data system:

- EHRs and other data systems with IHVE-compatible forms typically send data to the IHVE Gateway automatically once data entry is marked as complete by the user (immediately or overnight, depending on the data system).
- Data in the MDH-hosted IHVE forms in the REDCap application is submitted to the IHVE Gateway monthly by FHV Evaluation Unit staff.

When the IHVE Gateway receives data, it validates the data (checks it for errors). If there are no errors, the IHVE Gateway allows the data to enter the IHVE Database. The IHVE Gateway sends a message back to the source system about the successful data submission.

If the data submission does not pass validation, the IHVE Gateway does not allow the data to enter the IHVE Database. The IHVE Gateway returns an error message so that home visiting staff can correct and re-submit the data. Refer to the instructions for your specific data entry system for more details on how to access and resolve error messages.

## IHVE Person Search

The IHVE Database generates a unique ID for each FHV participant<sup>1</sup> with data in the system. The IHVE Person Search allows home visiting staff to check whether an FHV participant already exists within IHVE. If the participant does exist in the IHVE Database, home visiting staff can obtain the participant's unique ID and use that in data submissions about that client. This process improves data quality in IHVE by preventing multiple records for the same person.

Home visiting staff can use the Person Search in two ways:

- Search by participant's name, date of birth, gender, and address: a minimum of first name and last name is required.
- Search by participant's ID number assigned by an FHV program: the locally-assigned participant ID can be used to search, for example in situations when a participant is transferring between home visiting programs.

IHVE Person Search will show the result or results with the highest match to the information entered in the search. Home visiting staff should review the results and determine whether any of the FHV participants listed is the correct match.

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<sup>1</sup> An FHV Participant is a person who is receiving Family Home Visiting services.

To access the IHVE Person Search:

- Users of IHVE-compatible data entry forms in an EHR or other data system should refer to instructions for their specific data system for accessing and using the Person Search.
- Users of MDH-hosted IHVE forms in REDCap must have a valid login to the [MDH IHVE Portal \(https://ihve.web.health.state.mn.us\)](https://ihve.web.health.state.mn.us) to access the Person Search.



## Key Concepts

This section defines important concepts used in IHVE. An expanded list of definitions is provided in the Definitions section at the end of this manual.

**FHV Providers** are agencies or organizations providing FHV services.

**Home visitors** are individual employees of FHV Providers who serve families with home visiting services.

An **FHV Participant** is a person who is receiving FHV services from a home visitor. In IHVE, there are four FHV Participant types:

- **Target Child:** a child who is the primary focus of the FHV program. There can be more than one target child in an FHV Case (see below for definition). Note that Target Children served by FHV should be infants, toddlers, or preschool-aged; children enrolled in Kindergarten or older should not be reported to IHVE. If served by an evidence-based model, Target Children should meet the age criteria for the model.
- **Other Child:** a child (usually a sibling of the Target Child) who is receiving some services from the home visitor but is not the primary focus of the FHV program. This may be a younger child (born after the Target Child), or an older child (born before the Target Child). Note that Other Children served by FHV should be infants, toddlers, or preschool-aged; children enrolled in Kindergarten or older should not be reported to IHVE.
- **Primary Caregiver:** the FHV Participant who has primary responsibility for caring for the Target Child(ren). This person is generally a parent but can also be another family member or a non-relative, including a foster parent. Target Children usually live with their Primary Caregiver. If a family enrolls in FHV because they are expecting their first child, the Primary Caregiver is the person who will have primary caregiving responsibility once the child is born. In co-parenting or multi-generational families, one FHV Participant must be designated in IHVE as the Primary Caregiver for evaluation purposes.
- **Second Caregiver:** an FHV Participant who has a significant role in the Target Child's care but is not designated as the Primary Caregiver in IHVE. This person can be a parent, another family member, or a non-relative.

**Note that only FHV Participants should be reported in IHVE.** Other family or household members who are not served by the FHV program should not be reported in IHVE.

An **FHV Case** is a group of FHV Participants that receives a continuous series of FHV visits together. An FHV Case has a start date and an end date. An FHV Case starts when the first home visit is provided to one or more case members and ends when all case members have been closed from the FHV program.

IHVE has several validation rules related to the composition of an FHV Case.

- An FHV Case must always have one, and only one, Primary Caregiver.
- An FHV Case may have a Second Caregiver, but this is not required.
- An FHV Case may have multiple Target Children.

- Once a Target Child is added to the FHV Case, the case must continue to have one or more Target Children until it closes.
- An FHV Case may have one or more Other Children, but this is not required.

An FHV Participant can be a member of more than one FHV Case. FHV Participants can be added to or removed from an FHV Case while it is open. FHV Participants can also change their participant type while the case is open. For example:

- **Adding a Target Child:** An FHV Case consisting of a pregnant woman (Primary Caregiver) adds a Target Child when the woman gives birth.
- **Removing a Second Caregiver:** An FHV Case has a Primary and a Second Caregiver. The caregivers end their relationship, and the Second Caregiver moves out of the household. The Second Caregiver is no longer receiving FHV services and is closed in IHVE.
- **Changing a Primary Caregiver:** An FHV Case has two parents (Primary and Second Caregiver) and a Target Child. Because of changes in the parents' employment, the Second Caregiver becomes the Primary Caregiver. In this scenario, the former Primary Caregiver can either become the new Second Caregiver, or be removed/closed from the case, depending on whether this person is continuing to receive FHV services.

## Informed Consent and Data Privacy

The FHV Provider must have written informed consent to release each FHV Participant's data before sending that data to IHVE. Each caregiver must provide their own informed consent; an authorized person must provide informed consent on behalf of each Target or Other Child.

IHVE is designed for three possible levels of informed consent by FHV Participants:

- **Full Consent:** send all data elements to IHVE, including direct identifiers (name and street address)
- **Exclude Personal Identifiers:** direct identifiers (name and street address) are not sent to IHVE; all other data elements are sent. This is also known as "limited data."
- **No Consent:** no data about this participant is sent to IHVE. This is also known as "opting out."

FHV Participants can change their level of informed consent to release data to IHVE at any time. If a participant withdraws or revokes their consent to release data to IHVE, no additional data about that participant will be sent to IHVE; however IHVE will retain data already received about that participant because consent was in place at the time the data was sent.

FHV Participants can also control what information is shared with IHVE at the question level. Most multiple-choice questions on the IHVE forms allow "Client declines to answer" as a valid response option when an FHV Participant does not want to answer a specific question. Many non-multiple-choice questions allow empty (blank) responses to allow participants to decline to answer.

For more information, consult [FHV Informed Consent Guidance](https://www.health.state.mn.us/docs/communities/fhv/informconsentguide.pdf) (<https://www.health.state.mn.us/docs/communities/fhv/informconsentguide.pdf>) posted on the MDH website.

### Consent Levels in the MDH-hosted IHVE forms in REDCap

Users of MDH-hosted IHVE forms in REDCap should note that levels of informed consent in these forms work differently from IHVE-compatible forms within EHRs.

The IHVE REDCap forms include Full Consent, Exclude Personal Identifiers, and No Consent as possible consent level options on the Family Intake form. If Exclude Personal Identifiers is selected, questions asking for the participant's name and street address are excluded from subsequent forms to prevent entry of direct identifiers.

If No Consent is selected on the IHVE REDCap forms, the user will receive a message to stop any further data entry for that FHV Case. Entry of person-level data is prevented in this situation because the IHVE REDCap forms are hosted by MDH, and the FHV Provider does not have the participant's permission to share their data with MDH.

## IHVE Data Entry Forms Workflow

Table 1 describes when each IHVE data entry form should be completed. IHVE data collection reflects the following phases of a home visiting program:

- **Intake:** enrollment in the FHV program
- **Visits:** throughout the family's participation in FHV
- **Closure:** exit from the FHV program

In addition to data collected about FHV participants, IHVE collects information about the home visitor serving each family. A completed Home Visitor form must be submitted to IHVE before submitting FHV Participant data associated with that home visitor.

Note that the exact layout, form names, and question order may vary between data systems. Consult the instructions for your specific data entry system for more information.

**Table 1. List of IHVE Data Entry Forms and When To Complete**

Form	When to complete
Home Visitor	Before entering any FHV participant data into IHVE; review and update annually
FHV Case Intake	At the time of the family's enrollment in the FHV program
Primary Caregiver Intake	At the time of the family's enrollment in the FHV program; if the Primary Caregiver changes for the FHV Case
Second Caregiver Intake	At the time of the family's enrollment in the FHV program (only if there is a Second Caregiver); if the Second Caregiver changes for the FHV Case
Target Child Intake	At the time of the family's enrollment in the FHV program (only if there is a Target Child); when a Target Child is added to the FHV Case
Other Child Intake	At the time of the family's enrollment in the FHV program (only if there is an Other Child); when an Other Child is added to the FHV Case
FHV Home Visit	At each home visit
Screening	At each home visit (if one or more screenings was completed during the visit); between home visits (if a screening was completed between visits)
Parent-Child Interaction Assessment	At each home visit (if a Parent-Child Interaction Assessment was completed during the visit)
Referral	At each home visit (if one or more referrals was made during the visit); between home visits (if a referral was made between visits)

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Form	When to complete
Referral Status	At each home visit – update status of each open referral
MIECHV Target Child Visit-Level Data	At each home visit (only if the Target Child has MIECHV grant funding)
Primary Caregiver Health Insurance	Monthly
Primary Caregiver Demographics Update	Every 6 months
Child Age Interval	When a Target Child reaches the age in months indicated on the form: 3 months 6 months 9 months 12 months 15 months 18 months 24 months 30 months 36 months 42 months 48 months 54 months 60 months 66 months
Closure	When an FHV participant exits the FHV program (complete for each participant)

## Tips for Collecting FHV Evaluation Data

MDH relies on home visiting program staff to collect accurate and complete evaluation data from families, so that we can learn more about family outcomes and what works well for FHV programs. Follow these tips when asking evaluation questions during home visits.

- It is important to remain neutral when asking questions. Avoid nodding or other body language that might express agreement or influence how the participant answers the question. Be aware of your tone of voice as well.
- Make sure that the participant has time to think about the question before answering. Repeat the question if needed. If the participant interrupts before you have asked the entire question, ask them to wait until they have heard the entire question, or give them a chance to reconsider their response.
- Some questions ask the caregiver to recall the date when an event happened (for example: the date of their child’s most recent well-child visit). If the caregiver cannot remember the exact date, help the caregiver estimate an approximate date.
  - For example, if the child’s last well-child visit was the 4-month visit, and you are collecting data for the 6-month Child Age Interval form, you might ask the caregiver if the well-child visit happened when the child turned 4 months old, or sometime after. If they remember that the well-child visit happened a few weeks after the child turned 4 months, you can look at a calendar with the caregiver and choose an approximate date for the well-child visit.
- Pay attention to skip patterns and note whether a question is required or optional. This will save hassle during validation and reduce error messages to resolve later.
- Most multiple-choice questions only allow you to choose one response. However, some multiple-choice questions (such as race and health insurance type) allow you to “select all that apply.” In this document, “choose one” questions are indicated by circular bullets, and “choose all that apply” questions are indicated by square bullets. The MDH-hosted IHVE forms in REDCap follow the same convention. IHVE-compatible forms in other data systems may have a similar system; consult the documentation for your system for more information.
- Some questions have an “other” response option and a follow-up question where a write-in response is allowed. Use the “other” category only when none of the other response options are appropriate.
- When entering a write-in response, keep the answer short and concise. Do not enter identifying information such as participant names.

## FHV Case Intake Form

1. **Home Visitor ID number:**
2. **Date of First Home Visit:**
3. **Was there an interpreter at this home visit?**  
(choose one)
  - 01 Yes
  - 02 No

For each family member participating in the FHV program, complete the following questions.

4. **Type of Family Member Participating in FHV Program**  
(choose one)
  - Primary Caregiver
  - Second Caregiver
  - Target Child
  - Other Child
5. **First name:**
6. **Middle name or initial:**
7. **Last name:**
8. **Previous last name, if applicable:**
9. **Indicate the level of informed consent to share FHV evaluation data for this participant with the State of Minnesota**  
(choose one)
  - 01 Full consent
  - 02 Exclude personal identifiers
  - 03 No consent

## Instructions for the FHV Case Intake Form

**General Guidelines:** Complete this form when the first home visit after the family's enrollment in the FHV program has been completed. One form is completed for each FHV Case.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	Home Visitor ID number:	Unique identifier for home visitor serving this family at intake
2	Date of First Home Visit:	The date of the first home visit after the participant has been determined to be eligible and has been enrolled in home visiting. Follow model guidance if using an evidence-based home visiting model.
3	Was there an interpreter at this home visit?	<a href="#">[Link to Interpreter definition]</a>
4	Type of Family Member Participating in FHV Program	<b>Only report family members who are participating in the FHV program.</b> Participant is defined as a family member who is being directly served by the home visitor and actively participating in home visits. Family members or other persons in the household who are not participating in home visits should not be recorded.  See Key Concepts on page 7 for definitions of specific family member types.
5	First name:	First name of the family member selected in question #4.
6	Middle name or initial:	Middle name or initial of the family member selected in question #4.
7	Last name:	Last Name of the family member selected in question #4.
8	Previous last name, if applicable:	Maiden last name or other previous name of the family member selected in question #4, if applicable.



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<b>Question Number</b>	<b>Questions in the forms</b>	<b>Additional Guidance</b>
9	Indicate the level of informed consent to share FHV evaluation data for this participant with the State of Minnesota	This field tracks the level of consent obtained from the participant (or on the participant's behalf, if the participant is a child) by the family home visiting agency to share data with MDH. See page 8 for more information.

## Primary Caregiver Intake Form

1. **\*Birth date:**

2. **\*Grant or funding source used to serve this participant:**

(choose all that apply)

- 01 MIECHV Formula
- 02 MIECHV Expansion
- 03 TANF
- 04 MN NFP Grant
- 06 MN EBHV Grant
- 07 MCH Block Grant
- 09 Promising Practice FHV Grant
- 08 Other non-MDH funding source

3. **\*Home Visiting Model:**

(choose one)

- 01 Healthy Families America [SKIP to #5]
- 02 Nurse-Family Partnership [SKIP to #5]
- 03 Family Spirit [SKIP to #5]
- 04 Family Connects [SKIP to #5]
- 05 Parents As Teachers [SKIP to #5]
- 06 Early Head Start [SKIP to #5]
- 07 Maternal Early Childhood Sustained Home-visiting [SKIP to #5]
- 66 Other evidence-based early childhood home visiting model eligible for MIECHV
- 77 Other non-model, long-term home visiting program [SKIP to #5]
- 88 Other non-model, short-term or limited home visiting program [SKIP to #5]

4. **\*Specify other evidence-based home visiting model:**

5. **\*How does the participant identify their gender?**

(choose one)

- 01 Male
- 02 Female
- 03 Do not identify as male or female
- 99 Client declines to answer

6. **\*Is the participant a member of any of the following ethnic or cultural groups?**

(choose all that apply)

- 01 Hispanic or Latino/a/x
- 04 Somali
- 05 Hmong
- 77 Other ethnic group
- 99 Client declines to answer

**7. \*How does the participant identify their race?**

(choose all that apply)

- 01 American Indian or Alaska Native
- 02 Asian
- 03 Black or African American
- 04 Native Hawaiian or Other Pacific Islander
- 05 White
- 06 Other race
- 99 Client declines to answer

**8. \*If Other race, specify other race:**

**9. \*If American Indian or Alaska Native, how does the participant describe their tribal affiliation(s)?**

**10. \*What language does the participant speak at home most of the time?**

(choose one)

- 01 English [SKIP to #12]
- 02 Hmong [SKIP to #12]
- 03 Somali [SKIP to #12]
- 04 Spanish [SKIP to #12]
- 05 Amharic [SKIP to #12]
- 06 Arabic [SKIP to #12]
- 07 Burmese [SKIP to #12]
- 08 Karen [SKIP to #12]
- 09 Nepalese [SKIP to #12]
- 10 Oromo [SKIP to #12]
- 77 Other language
- 99 Client declines to answer [SKIP to #12]

**11. \*Specify other language:**

**12. \*Participant's home address:**

Address (number and street or rural route):

City:

State:

Zip Code:

County:

**13. Is the participant homeless?**

(choose one)

- 01 Not homeless
- 02 Homeless [SKIP to #15]
- 88 Unknown [SKIP to #16]
- 98 Not asked at this visit [SKIP to #16]
- 99 Client declines to answer [SKIP to #16]

**14. If Not homeless: Which of the following best describes the participant's living arrangements?**

(choose one)

- 01 Owns or shares own home, condominium, or apartment [SKIP to #16]
- 02 Rents or shares rented home or apartment [SKIP to #16]
- 03 Lives in public housing [SKIP to #16]
- 04 Lives with parent or family member [SKIP to #16]
- 05 Some other arrangement [SKIP to #16]
- 98 Not asked at this visit [SKIP to #16]
- 99 Client declines to answer [SKIP to #16]

**15. If Homeless: Which of the following best describes the participant's living arrangements?**

(choose one)

- 01 Homeless and sharing housing
- 02 Homeless and living in an emergency or transitional shelter
- 03 Some other arrangement
- 98 Not asked at this visit
- 99 Client declines to answer

**16. \*Is the participant enrolling in home visiting because they are pregnant?**

(choose one)

- 01 Yes
- 02 No [SKIP to #19]

**17. \*Is the estimated date of delivery known?**

(choose one)

- 01 Yes
- 02 No [SKIP to #19]

**18. \*What is the estimated date of delivery?**

**19. What is the participant's current marital status?**

(choose one)

- 01 Married
- 02 Divorced
- 03 Widowed
- 04 Separated
- 05 Never Married
- 98 Not asked at this visit
- 99 Client declines to answer

**20. Does the participant currently live with their spouse or partner?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit
- 99 Client declines to answer

**21. Does the participant currently use tobacco, such as cigarettes, cigars, chewing tobacco, or electronic cigarettes (excluding religious or ceremonial use)?**

(choose one)

- 01 Yes
- 02 No [SKIP to #23]
- 98 Not asked at this visit [SKIP to #23]
- 99 Client declines to answer [SKIP to #23]

**22. Is the participant enrolled in a tobacco or smoking cessation program or receiving tobacco cessation counseling?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit
- 99 Client declines to answer

**23. Does the participant have a history of substance abuse or substance abuse treatment?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit
- 99 Client declines to answer

**24. Was the participant found to need substance abuse services based on substance abuse screening or clinical judgement?**

(choose one)

- 01 Yes, needs services
- 02 No, does not need services
- 03 Not assessed
- 98 Not asked at this visit

**25. As a child, was the participant emotionally or physically abused or neglected by a parent or guardian, a family member, or other adult?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**26. Has the participant ever been involved with child welfare services as a child?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**27. Has the participant ever been involved with child welfare services as a parent?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**28. Is the participant currently working?**

(choose one)

- 01 Employed Full-Time (30+ hours/week)
- 02 Employed Part-Time (Less than 30 hours/week)
- 03 Not employed
- 98 Not asked at this visit
- 99 Client declines to answer

**29. Which category best describes the monthly income for the participant's household? Include income from work, cash assistance programs, benefits, rent, cash from friends or relatives, child support, or other sources.**

(choose one)

- 01 \$0 - \$500
- 02 \$501 - \$1,000
- 03 \$1,001 - \$1,500
- 04 \$1,501 - \$2,000
- 05 \$2,001 - \$2,500
- 06 \$2,501 - \$3,000
- 07 \$3,001 - \$4,000
- 08 \$4,001 - \$5,000
- 09 \$5,001 - \$6,000
- 10 \$6,001 - \$7,000
- 11 \$7,001 - \$8,000
- 12 \$8,001 or more
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**30. How many people are in the participant's household (including the caregiver), who are living on the income described above?**

**31. Has anyone in the participant's household ever served in the US Armed Forces, either active duty, Reserves, or National Guard (including the caregiver)?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit
- 99 Client declines to answer

**32. Has the participant ever been to jail or prison?**

(choose one)

- 01 Yes
- 02 No [SKIP to #34]
- 98 Not asked at this visit [SKIP to #34]
- 99 Client declines to answer [SKIP to #34]

**33. In what year was the participant most recently in prison?**

**34. Is the participant currently enrolled in high school, college, or another educational program?**

(choose one)

- 01 Not enrolled in a program [SKIP to #36]
- 02 Grade School, High School or GED program [SKIP to #36]
- 03 Post-high school vocational/certification/technical training [SKIP to #36]
- 04 2 year or 4 year College [SKIP to #36]
- 05 Other
- 98 Not asked at this visit [SKIP to #36]
- 99 Client declines to answer [SKIP to #36]

**35. Specify other educational enrollment:****36. What is the highest level of education the participant has completed?**

(choose one)

- 01 Less than HS Diploma [SKIP to #38]
- 02 High School Diploma or GED [SKIP to #38]
- 03 Some college or post high school training [SKIP to #38]
- 04 Technical training or certificate [SKIP to #38]
- 05 Associate's degree [SKIP to #38]
- 06 Bachelor's degree or higher [SKIP to #38]
- 09 Other
- 98 Not asked at this visit [SKIP to #38]
- 99 Client declines to answer [SKIP to #38]

**37. Specify other educational level completed:****38. While in school, has anyone ever told the participant that they had learning difficulties, a learning disability, or had an IEP (Individual Education Plan)?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**39. Does the participant currently have health insurance?**

(choose one)

- 01 Yes, insured
- 02 No, uninsured [SKIP to #42]
- 03 Client applied for coverage, application is pending
- 88 Client does not know/not sure [SKIP to #42]
- 98 Not asked at this visit [SKIP to #42]
- 99 Client declines to answer [SKIP to #42]



**40. What type of health plan or health insurance does the participant currently have?**

(choose all that apply)

- 01 Private insurance
- 02 Public insurance
- 03 Military health care
- 04 Other health insurance
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**41. If Other health insurance, specify other health insurance:**

**42. Are there any children in the participant's household with disabilities or developmental delays?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

## Instructions for the Primary Caregiver Intake Form

**General Guidelines:** Complete this form at the time of the family’s enrollment in the FHV program. If there is a change in Primary Caregiver during the time the family is enrolled in FHV, complete this form about the new Primary Caregiver.

Questions with an asterisk (\*) are required to be collected at the time of the family’s first visit, or at the time of the first completed home visit after a change in Primary Caregiver. Questions without an asterisk can be answered “Not asked at this visit” if information for that question was not collected during the family’s first home visit.

Home visitors should attempt to collect answers for all questions on the Primary Caregiver Intake form within one month of the family’s first completed home visit.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1*	Birth date:	Primary Caregiver's date of birth.
2*	Grant or funding source used to serve this participant:	<u>[Grant or funding source definition]</u>
3*	Home Visiting Model:	<u>[Home visiting model definition]</u>
4*	Specify other evidence-based home visiting model:	If “Other evidence-based early childhood home visiting model” is selected for the previous question, please write-in the name of the other evidence-based home visiting model.
5*	How does the participant identify their gender?	Primary Caregiver’s gender, choose one response. Participants or caregivers (for questions about a child) should be allowed to choose the response that fits best. Do not answer this question based on the home visitor’s observation or best guess.
6*	Is the participant a member of any of the following ethnic or cultural groups?	Primary Caregiver’s ethnicity, choose all that apply. <u>[Additional information related to response options]</u> “Other ethnic group” includes all ethnicities/ancestries that are not specifically listed. If the participant does not indicate Hispanic or Latino/a/x, Hmong, or Somali ethnicity, choose “Other ethnic group” unless the participant declines to answer.
7*	How does the participant identify their race?	Primary Caregiver’s race, choose all that apply. <u>[Additional information related to response options]</u>
8*	Specify other race:	If “Other” is selected for the previous question, please write-in the other race based on the Caregiver’s self-description.

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Question Number	Questions in the forms	Additional Guidance
9*	If American Indian or Alaska Native, how does the participant describe their tribal affiliation(s)?	<p>If “American Indian or Alaska Native” is selected for question #7, please write-in how the Primary Caregiver describe their tribal affiliation(s). If the participant declines to answer, leave this question blank.</p> <p>Based on Primary Caregiver’s self-report.</p> <p>“Tribal affiliation” is defined as the American Indian tribe or Indigenous community to which the participant reports attachment. The participant does not need to be an enrolled member of a tribe.</p>
10*	What language does the participant speak at home most of the time?	<p>Choose one language that is spoken in the home most of the time by the Primary Caregiver.</p> <p>Note that this question refers to the participant’s spoken language; this may differ from the participant’s primary language for written communication.</p>
11*	Specify other language:	[Open-ended other language instructions]
12*	Participant's home address:	Participant's home address, including Street Address (number and street or rural route), City, State, Zip Code and County of residence.
13	Is the participant homeless?	<p>Indicate whether the Primary Caregiver is homeless at the time the form is completed.</p> <p><u>[Homeless definition]</u></p>
14	If Not homeless: Which of the following best describes the participant's living arrangements?	<p>Indicate the Primary Caregiver’s living arrangement at the time the form is completed.</p> <p>Choose one response.</p> <p><u>[If Not homeless: living arrangements definitions]</u></p>
15	If Homeless: Which of the following best describes the participant's living arrangements?	<p>Indicate the Primary Caregiver’s living arrangement at the time the form is completed.</p> <p>Choose one response.</p> <p><u>[If homeless: living arrangements definitions]</u></p>
16*	Is the participant enrolling in home visiting because they are pregnant?	Describes the Primary Caregiver’s status at the time of enrollment in home visiting in the current FHV model, with the current service provider.
17*	Is the estimated date of delivery known?	Based on Primary Caregiver’s self-report.

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Question Number	Questions in the forms	Additional Guidance
18*	What is the estimated date of delivery?	For Primary Caregivers who are pregnant, report the estimated date of delivery. This may be estimated by adding 280 days to the first day of the last menstrual period (LMP), or reported based on the caregiver’s recall from discussions with their health care provider.
19	What is the participant's current marital status?	Primary Caregiver’s marital status (choose one) at the time the form is completed.
20	Does the participant currently live with their spouse or partner?	Based on Primary Caregiver’s self-report.
21	Does the participant currently use tobacco, such as cigarettes, cigars, chewing tobacco, or electronic cigarettes (excluding religious or ceremonial use)?	This question asks about the participant’s use of commercial tobacco products. Select “No” for this question if the Primary Caregiver’s current use of tobacco is for spiritual or ceremonial purposes (traditional tobacco). See the MDH website for more information: <a href="https://www.health.state.mn.us/communities/tobacco/traditional/index.html">https://www.health.state.mn.us/communities/tobacco/traditional/index.html</a>
22	Is the participant enrolled in a tobacco or smoking cessation program or receiving tobacco cessation counseling?	Based on Primary Caregiver’s self-report.
23	Does the participant have a history of substance abuse or substance abuse treatment?	Based on Primary Caregiver’s self-report.
24	Was the participant found to need substance abuse services based on substance abuse screening or clinical judgement?	Answer this question based on the results of a substance abuse screening tool, or based on the home visitor’s clinical judgement that the caregiver should be referred to substance abuse services. It should not be answered based on participant self-report.
25	As a child, was the participant emotionally or physically abused or neglected by a parent or guardian, a family member, or other adult?	Based on Primary Caregiver’s self-report.

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Question Number	Questions in the forms	Additional Guidance
26	Has the participant ever been involved with child welfare services as a child?	Based on Primary Caregiver's self-report of involvement or interaction with the child welfare system, such as an assessment, investigation, or services including Parent Support Outreach Program (PSOP).
27	Has the participant ever been involved with child welfare services as a parent?	Based on Primary Caregiver's self-report of involvement or interaction with the child welfare system, such as an assessment, investigation, or services including Parent Support Outreach Program (PSOP).
28	Is the participant currently working?	<u>[Employment definition]</u>
29	Which category best describes the monthly income for the participant's household? Include income from work, cash assistance programs, benefits, rent, cash from friends or relatives, child support, or other sources.	<u>[Primary Caregiver's household monthly income definition]</u> <u>[Household definition]</u>
30	How many people are in the participant's household (including the caregiver), who are living on the income described above?	<u>[Household definition]</u>
31	Has anyone in the participant's household ever served in the US Armed Forces, either active duty, Reserves, or National Guard (including the caregiver)?	Based on Primary Caregiver's self-report. For this question, this includes a military member's dependent acquired through marriage, adoption, or other action during the course of a member's current tour of assigned duty.
32	Has the participant ever been to jail or prison?	Based on Primary Caregiver's self-report.
33	In what year was the participant most recently in prison?	Based on Primary Caregiver's self-report. Include any incarceration (jail or prison).
34	Is the participant currently enrolled in high school, college, or another educational program?	Based on Primary Caregiver's self-report.

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Question Number	Questions in the forms	Additional Guidance
35	Specify other educational enrollment:	<u>[Open-ended other type of educational program enrollment instructions]</u>
36	What is the highest level of education the participant has completed?	Based on Primary Caregiver's self-report.
37	Specify other educational level completed:	<u>[Open-ended other type of educational program completed instructions]</u>
38	While in school, has anyone ever told the participant that they had learning difficulties, a learning disability, or had an IEP (Individual Education Plan)?	Based on Primary Caregiver's self-report.
39	Does the participant currently have health insurance?	<u>[Insurance status definition]</u>
40	What type of health plan or health insurance does the participant currently have?	<u>[Health plan or health insurance definition]</u>
41	Specify other health insurance:	If "Other health insurance" is selected for the previous question, please write-in the other type of health insurance coverage for the Primary Caregiver.
42	Are there any children in the participant's household with disabilities or developmental delays?	Based on Primary Caregiver's self-report. This includes children who are not the Target Child for the home visiting program.

## Second Caregiver Intake Form

**1. Birth date:**

**2. Grant or funding source used to serve this participant:**

(choose all that apply)

- 01 MIECHV Formula
- 02 MIECHV Expansion
- 03 TANF
- 04 MN NFP Grant
- 06 MN EBHV Grant
- 07 MCH Block Grant
- 09 Promising Practice FHV Grant
- 08 Other non-MDH funding source

**3. Home Visiting Model:**

(choose one)

- 01 Healthy Families America [SKIP to #5]
- 02 Nurse-Family Partnership [SKIP to #5]
- 03 Family Spirit [SKIP to #5]
- 04 Family Connects [SKIP to #5]
- 05 Parents As Teachers [SKIP to #5]
- 06 Early Head Start [SKIP to #5]
- 07 Maternal Early Childhood Sustained Home-visiting [SKIP to #5]
- 66 Other evidence-based early childhood home visiting model eligible for MIECHV
- 77 Other non-model, long-term home visiting program [SKIP to #5]
- 88 Other non-model, short-term or limited home visiting program [SKIP to #5]

**4. Specify other evidence-based home visiting model:**

**5. How does the participant identify their gender?**

(choose one)

- 01 Male
- 02 Female
- 03 Do not identify as male or female
- 99 Client declines to answer

**6. Is the participant a member of any of the following ethnic or cultural groups?**

(choose all that apply)

- 01 Hispanic or Latino/a/x
- 04 Somali
- 05 Hmong
- 77 Other ethnic group
- 99 Client declines to answer

**7. How does the participant identify their race?**

(choose all that apply)

- 01 American Indian or Alaska Native
- 02 Asian
- 03 Black or African American
- 04 Native Hawaiian or Other Pacific Islander
- 05 White
- 06 Other race
- 99 Client declines to answer

**8. If Other race, specify other race:**

**9. If American Indian or Alaska Native, how does the participant describe their tribal affiliation(s)?**

**10. What language does the participant speak at home most of the time?**

(choose one)

- 01 English [STOP, you do not need to complete the rest of this form]
- 02 Hmong [STOP, you do not need to complete the rest of this form]
- 03 Somali [STOP, you do not need to complete the rest of this form]
- 04 Spanish [STOP, you do not need to complete the rest of this form]
- 05 Amharic [STOP, you do not need to complete the rest of this form]
- 06 Arabic [STOP, you do not need to complete the rest of this form]
- 07 Burmese [STOP, you do not need to complete the rest of this form]
- 08 Karen [STOP, you do not need to complete the rest of this form]
- 09 Nepalese [STOP, you do not need to complete the rest of this form]
- 10 Oromo [STOP, you do not need to complete the rest of this form]
- 77 Other language
- 99 Client declines to answer [STOP, you do not need to complete the rest of this form]

**11. Specify other language:**



## Instructions for the Second Caregiver Intake Form

**General Guidelines:** Complete this form at the time of the family’s enrollment in the FHV program, if there is a Second Caregiver participating in FHV services. If there is a change in or addition of a Second Caregiver during the time the family is enrolled in FHV, complete this form about the new Second Caregiver.

All questions on this form are required to be collected at the time of the family’s first visit, or at the time of the first completed home visit after a change in Second Caregiver.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1*	Birth date:	Second Caregiver's date of birth.
2*	Grant or funding source used to serve this participant:	<u>[Grant or funding source definition]</u>
3*	Home Visiting Model:	<u>[Home visiting model definition]</u>
4*	Specify other evidence-based home visiting model:	<u>[Open-ended other evidence-based early childhood home visiting model instructions]</u>
5*	How does the participant identify their gender?	Second Caregiver’s gender, choose one Second Caregiver’s gender.  <u>[Additional information related to response options]</u>
6*	Is the participant a member of any of the following ethnic or cultural groups?	Second caregiver’s ethnicity, choose all that apply.  <u>[Additional information related to response options]</u>  <u>[Additional information related to ethnicity response options]</u>
7*	How does the participant identify their race?	Second caregiver’s race, choose all that apply.  <u>[Additional information related to response options]</u>
8*	Specify other race:	<u>[Open-ended other race instructions]</u>

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Question Number	Questions in the forms	Additional Guidance
9*	If American Indian or Alaska Native, how does the participant describe their tribal affiliation(s)?	<p>If “American Indian or Alaska Native” is selected for question #7, please write-in how the second caregiver describe their tribal affiliation(s). If the participant declines to answer, leave this question blank.</p> <p>Based on Second Caregiver’s self-report.</p> <p><u>[Additional information related to tribal affiliation(s) response options]</u></p>
10*	What language does the participant speak at home most of the time?	<p>Choose one language for the second caregiver that is spoken in the home most of the time.</p> <p><u>[Additional information related to spoken language response options]</u></p>
11*	Specify other language:	<p>If “Other language” is selected for the previous question, please write-in the specific language here.</p>

## Target Child Intake Form

1. **\*Birth date:**

2. **Grant or funding source used to serve this participant:**

(choose all that apply)

- 01 MIECHV Formula
- 02 MIECHV Expansion
- 03 TANF
- 04 MN NFP Grant
- 06 MN EBHV Grant
- 07 MCH Block Grant
- 09 Promising Practice FHV Grant
- 08 Other non-MDH funding source

3. **\*Home Visiting Model:**

(choose one)

- 01 Healthy Families America [SKIP to #5]
- 02 Nurse-Family Partnership [SKIP to #5]
- 03 Family Spirit [SKIP to #5]
- 04 Family Connects [SKIP to #5]
- 05 Parents As Teachers [SKIP to #5]
- 06 Early Head Start [SKIP to #5]
- 07 Maternal Early Childhood Sustained Home-visiting [SKIP to #5]
- 66 Other evidence-based early childhood home visiting model eligible for MIECHV
- 77 Other non-model, long-term home visiting program [SKIP to #5]
- 88 Other non-model, short-term or limited home visiting program [SKIP to #5]

4. **\*Specify other evidence-based home visiting model:**

5. **\*Does the child currently live with the primary caregiver?**

(choose one)

- 01 Yes
- 02 No

6. **\*What is the relationship of the primary caregiver to this child?**

(choose one)

- 01 Biological parent
- 02 Step or adoptive parent
- 03 Foster parent
- 04 Grandparent
- 05 Other family member
- 06 Non-relative caregiver

**7. \*If there is a Second Caregiver participating in FHV: What is the relationship of the second caregiver to this child?**

(choose one)

- 01 Biological parent
- 02 Step or adoptive parent
- 03 Foster parent
- 04 Grandparent
- 05 Other family member
- 06 Non-relative caregiver

**8. \*What is the child's gender?**

(choose one)

- 01 Male
- 02 Female
- 03 Do not identify as male or female
- 99 Client declines to answer

**9. \*Is the child a member of any of the following ethnic or cultural groups?**

(choose all that apply)

- 01 Hispanic or Latino/a/x
- 04 Somali
- 05 Hmong
- 77 Other ethnic group
- 99 Client declines to answer

**10. \*What is the child's race?**

(choose all that apply)

- 01 American Indian or Alaska Native
- 02 Asian
- 03 Black or African American
- 04 Native Hawaiian or Other Pacific Islander
- 05 White
- 06 Other race
- 99 Client declines to answer

**11. \*If Other race, specify other race:**

**12. \*If American Indian or Alaska Native, how does the participant describe the child's tribal affiliation(s)?**

**13. \*What was the child's gestational age at birth, in weeks and days?**

Weeks:

Days:

- Check if gestational age at birth is unknown

**14. \*What was the child's birth weight, in pounds and ounces?**

Pounds:

Ounces:

- Check if child's birth weight is unknown

**15. \*Was this child part of a multiple birth?**

(choose one)

- 01 Yes  
 02 No  
 88 Client does not know/not sure  
 99 Client declines to answer

**16. \*Was this child ever breastfed or fed pumped breast milk?**

(choose one)

- 01 Yes  
 02 No [SKIP to #18]  
 03 Client is not recommended to breastfeed because of a medical condition [SKIP to #18]  
 88 Client does not know/not sure [SKIP to #18]  
 99 Client declines to answer [SKIP to #18]

**17. \* If the Target child is 12 months old or younger, is the child currently being breastfed or receiving breastmilk? [If greater than 12 months old SKIP to #18]**

(choose one)

- 01 Yes  
 02 No  
 03 Client is not recommended to breastfeed because of a medical condition  
 99 Client declines to answer

**18. What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child's health?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #20]  
 02 Hospital emergency room [SKIP to #20]  
 03 Hospital outpatient department [SKIP to #20]  
 04 Federally Qualified Health Center (FQHC) [SKIP to #20]  
 05 Retail store or minute clinic [SKIP to #20]  
 08 Some other place  
 09 None [SKIP to #20]  
 88 Client does not know/not sure [SKIP to #20]  
 98 Not asked at this visit [SKIP to #20]  
 99 Client declines to answer [SKIP to #20]

**19. Specify other usual source of child's medical care:**

**20. What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #22]
- 02 Hospital emergency room [SKIP to #22]
- 03 Hospital outpatient department [SKIP to #22]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #22]
- 05 Retail store or minute clinic [SKIP to #22]
- 08 Some other place
- 09 None [SKIP to #22]
- 88 Client does not know/not sure [SKIP to #22]
- 98 Not asked at this visit [SKIP to #22]
- 99 Client declines to answer [SKIP to #22]

**21. Specify other source of child's preventive care:****22. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #24]
- 98 Not asked at this visit [SKIP to #24]
- 99 Client declines to answer [SKIP to #24]

**23. What was the approximate date of the child's most recent well-child visit?**

**24. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**25. If the Target child is 12 months old or younger, does the caregiver place the child to sleep on their back? [If greater than 12 months old SKIP to #28]**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**26. Does the child share a bed with anyone?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**27. Does the child sleep with soft bedding?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**28. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**29. Does the child currently have health insurance?**

(choose one)

- 01 Yes, insured
- 02 No, uninsured [SKIP to #32]
- 03 Client applied for coverage, application is pending [SKIP to #32]
- 88 Client does not know/not sure [SKIP to #32]
- 98 Not asked at this visit [SKIP to #32]
- 99 Client declines to answer [SKIP to #32]

**30. What type of health plan or health insurance does the child currently have?**

(choose all that apply)

- 01 Private Insurance [SKIP to #32]
- 02 Public Insurance [SKIP to #32]
- 03 Military Health Care [SKIP to #32]
- 04 Other health insurance
- 88 Client does not know/not sure [SKIP to #32]
- 98 Not asked at this visit [SKIP to #32]
- 99 Client declines to answer [SKIP to #32]

**31. If Other health insurance, specify other health insurance:****32. Has anyone in the child's household ever been to jail or prison? Include a mother or father even if they were not living with the child at the time.**

(choose all that apply)

- 01 Yes, the child's mother or mother figure
- 02 Yes, the child's father or father figure
- 03 Yes, the child's sibling
- 04 Yes, another family member living in the household
- 05 Yes, an unrelated adult living in the household
- 06 No one in the household has ever been to jail or prison
- 98 Not asked at this visit
- 99 Client declines to answer



## Instructions for the Target Child Intake Form

**General Guidelines:** Complete this form at the time of the family’s enrollment in the FHV program, if serving a family with one or more Target Children. If a Target Child is added during the time the family is enrolled in FHV, complete this form about the new Target Child. Complete one Target Child Intake for each Target Child.

Questions with an asterisk (\*) are required to be collected at the time of the family’s first visit, or at the time of the first completed home visit after the addition of a new Target Child.

Questions without an asterisk can be answered “Not asked at this visit” if information for that question was not collected during the family’s first home visit.

Home visitors should attempt to collect answers for all questions on the Target Child Intake form within one month of the family’s first completed home visit, or within one month of adding a new Target Child to the FHV Case.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1*	Birth date:	Target Child's date of birth.
2	Grant or funding source used to serve this participant:	<u>[Grant or funding source definition]</u>
3*	Home Visiting Model:	<u>[Home visiting model definition]</u>
4*	Specify other evidence-based home visiting model:	<u>[Open-ended other evidence-based early childhood home visiting model instructions]</u>
5*	Does the child currently live with the primary caregiver?	Indicate the participant’s status as of this visit.
6*	What is the relationship of the primary caregiver to this child?	Choose one response based on Caregiver’s self-report. <b>Update the response to this question if there is a change in Primary Caregiver.</b>
7*	If there is a Second Caregiver participating in FHV: What is the relationship of the second caregiver to this child?	Choose one response based on Caregiver’s self-report. <b>Update the response to this question if there is a change in Second Caregiver.</b>
8*	What is the child’s gender?	Target Child’s gender as reported by caregiver(s), choose one child’s gender.  <u>[Additional information related to response options]</u>

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Question Number	Questions in the forms	Additional Guidance
9*	Is the child a member of any of the following ethnic or cultural groups?	Target Child’s ethnicity as reported by caregiver(s), choose all that apply  <u>[Additional information related to response options]</u>  <u>[Additional information related to ethnicity response options]</u>
10*	What is the child’s race?	Target Child’s race as reported by caregiver(s), choose all that apply.  <u>[Additional information related to response options]</u>
11*	Specify other race:	<u>[Open-ended other race instructions]</u>
12*	If American Indian or Alaska Native, how does the participant describe the child’s tribal affiliation(s)?	If “American Indian or Alaska Native” is selected for question #11, please write-in how the Caregiver describes the Target Child’s tribal affiliation(s). If the participant declines to answer, leave this question blank.  Based on Caregiver’s self-report.  <u>[Additional information related to tribal affiliation(s) response options]</u>
13*	What was the child’s gestational age at birth, in weeks and days?	Report child’s gestational age at birth in weeks and days, based on caregiver(s) report or referral data if available.
14*	What was the child’s birth weight, in pounds and ounces?	Report child’s birth weight in pounds and ounces, based on caregiver(s) report or referral data if available.
15*	Was this child part of a multiple birth?	Select “Yes” if the child is part of a set of twins, triplets, etc.

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Question Number	Questions in the forms	Additional Guidance
16*	Was this child ever breastfed or fed pumped breast milk?	<p>Select “01 Yes” if the child was fed any human milk, including donor milk.</p> <p>Select “03 Participant is not recommended to breastfeed because of a medical condition” if the participant has a contraindication to breastfeeding or giving the infant their pumped breastmilk.</p> <ul style="list-style-type: none"> <li>• Infant diagnosed with galactosemia</li> <li>• HIV positive status of mother</li> <li>• Mother taking antiretroviral medications</li> <li>• Mother has untreated, active TB</li> <li>• Mother is infected with human T-cell lymphotropic virus type I or type II (HTLV-I or HTLV-II)</li> <li>• Mother is using or is dependent on an illicit drug</li> <li>• Mother is taking prescribed cancer chemotherapy agents</li> <li>• Mother is undergoing radiation therapies</li> </ul> <p>See Contraindications to breastfeeding:  <a href="https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/Contraindications-to-breastfeeding.html">https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/Contraindications-to-breastfeeding.html</a> for more information.</p>
17*	If the Target child is 12 months old or younger, is the child currently being breastfed or receiving breastmilk?	See guidance for previous question above
18	What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child’s health?	<u>[Source of medical care definition]</u>
19	Specify other usual source of child’s medical care:	<u>[Open-ended some other place instructions]</u>
20	What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?	<u>[Source of medical care definition]</u>
21	Specify other source of child’s preventive care:	<u>[Open-ended some other place instructions]</u>

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Question Number	Questions in the forms	Additional Guidance
22	Which well-child visit did the child have most recently?	Choose one response. See the Bright Futures/American Academy of Pediatrics Periodicity Schedule for more information: <a href="https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx">https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx</a>
23	What was the approximate date of the child’s most recent well-child visit?	Approximate or estimated date of the child’s most recent well-child visit, based on participant report.  If the caregiver cannot recall the exact date, please provide the approximate date or best guess.
24	Is the child up-to-date on immunizations according to the CDC schedule?	See <a href="https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html">https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html</a> for immunizations currently recommended for each age
25	If the Target child is 12 months old or younger, does the caregiver place the child to sleep on their back?	Based on caregiver(s) self-report of whether they always, sometimes, or never engage in this sleep practice.
26	Does the child share a bed with anyone?	Based on caregiver(s) self-report of whether they always, sometimes, or never engage in this sleep practice.
27	Does the child sleep with soft bedding?	Based on caregiver(s) self-report of whether they always, sometimes, or never engage in this sleep practice.
28	Do family members read to, tell stories to, or sing to the child every day during a typical week?	To accurately assess this measure, caregivers should be asked if their children were (1) read to, (2) told stories to, and/or (3) sang songs to <b>every day</b> during a typical week. Note that the measure asks parents to reflect on a typical week and then to report if at least one of the activities occurred each day during the week. Any combination of these activities over the week meets the criteria and indicates caregiver support of early language and literacy activities.  The family member(s) reading, singing, or telling stories to the child can be any family member, not just the Primary Caregiver.

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Question Number	Questions in the forms	Additional Guidance
29	Does the child currently have health insurance?	<u>[Insurance status definition]</u>
30	What type of health plan or health insurance does the child currently have?	<u>[Health plan or health insurance definition]</u>
31	Specify other health insurance:	If “Other health insurance” is selected for the previous question, please write-in the other type of health insurance coverage for the Target Child.
32	Has anyone in the child’s household ever been to jail or prison? Include a mother or father even if they were not living with the child at the time.	Choose one response based on Caregiver’s self-report.

## Other Child Intake Form

**1. Birth date:**

**2. Grant or funding source used to serve this participant:**

(choose all that apply)

- 01 MIECHV Formula
- 02 MIECHV Expansion
- 03 TANF
- 04 MN NFP Grant
- 06 MN EBHV Grant
- 07 MCH Block Grant
- 09 Promising Practice FHV Grant
- 08 Other non-MDH funding source

**3. Home Visiting Model:**

(choose one)

- 01 Healthy Families America [SKIP to #5]
- 02 Nurse-Family Partnership [SKIP to #5]
- 03 Family Spirit [SKIP to #5]
- 04 Family Connects [SKIP to #5]
- 05 Parents As Teachers [SKIP to #5]
- 06 Early Head Start [SKIP to #5]
- 07 Maternal Early Childhood Sustained Home-visiting [SKIP to #5]
- 66 Other evidence-based early childhood home visiting model eligible for MIECHV
- 77 Other non-model, long-term home visiting program [SKIP to #5]
- 88 Other non-model, short-term or limited home visiting program [SKIP to #5]

**4. Specify other evidence-based home visiting model:**

**5. Does the child currently live with the primary caregiver?**

(choose one)

- 01 Yes
- 02 No

**6. What is the relationship of the primary caregiver to this child?**

(choose one)

- 01 Biological parent
- 02 Step or adoptive parent
- 03 Foster parent
- 04 Grandparent
- 05 Other family member
- 06 Non-relative caregiver

**7. If there is a Second Caregiver participating in FHV: What is the relationship of the second caregiver to this child?**

(choose one)

- 01 Biological parent
- 02 Step or adoptive parent
- 03 Foster parent
- 04 Grandparent
- 05 Other family member
- 06 Non-relative caregiver

**8. What is the child's gender?**

(choose one)

- 01 Male
- 02 Female
- 03 Do not identify as male or female
- 99 Client declines to answer

**9. Is the child a member of any of the following ethnic or cultural groups?**

(choose all that apply)

- 01 Hispanic or Latino/a/x
- 04 Somali
- 05 Hmong
- 77 Other ethnic group
- 99 Client declines to answer

**10. What is the child's race?**

(choose all that apply)

- 01 American Indian or Alaska Native
- 02 Asian
- 03 Black or African American
- 04 Native Hawaiian or Other Pacific Islander
- 05 White
- 06 Other race
- 99 Client declines to answer

**11. If Other race, specify other race:****12. If American Indian or Alaska Native, how does the participant describe the child's tribal affiliation(s)?**

## Instructions for the Other Child Intake form

**General Guidelines:** Complete this form at the time of the family’s enrollment in the FHV program, if there is an Other Child participating in FHV services. If an Other Child is added during the time the family is enrolled in FHV, complete this form about the new Other Child.

All questions on this form are required to be collected at the time of the family’s first visit, or at the time of the first completed home visit after the addition of an Other Child to the FHV Case.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	Birth date:	Other Child's date of birth.
2	Grant or funding source used to serve this participant:	<u>[Grant or funding source definition]</u>
3	Home Visiting Model:	<u>[Home visiting model definition]</u>
4	Specify other evidence-based home visiting model:	<u>[Open-ended other evidence-based early childhood home visiting model instructions]</u>
5	Does the child currently live with the primary caregiver?	Indicate the Other Child’s status as of this visit.
6	What is the relationship of the primary caregiver to this child?	Choose one response based on Caregiver’s self-report. <b>Update the response to this question if there is a change in Primary Caregiver.</b>
7	If there is a Second Caregiver participating in FHV: What is the relationship of the second caregiver to this child?	Choose one response based on Caregiver’s self-report. <b>Update the response to this question if there is a change in Second Caregiver.</b>
8	What is the child’s gender?	Other Child’s gender as reported by caregiver(s), choose one child’s gender.  <u>[Additional information related to response options]</u>



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Question Number	Questions in the forms	Additional Guidance
9	Is the child a member of any of the following ethnic or cultural groups?	<p>Other Child's ethnicity as reported by caregiver(s), choose all that apply.</p> <p><u>[Additional information related to response options]</u></p> <p><u>[Additional information related to ethnicity response options]</u></p>
10	What is the child's race?	<p>Other Child's race as reported by caregiver(s), choose all that apply.</p> <p><u>[Additional information related to response options]</u></p>
11	Specify other race:	<u>[Open-ended other race instructions]</u>
12	If American Indian or Alaska Native, how does the participant describe the child's tribal affiliation(s)?	<p>If "American Indian or Alaska Native" is selected for question #11, please write-in how the Caregiver describes the Other Child's tribal affiliation(s). If the participant declines to answer, leave this question blank.</p> <p>Based on Caregiver's self-report.</p> <p><u>[Additional information related to tribal affiliation(s) response options]</u></p>

## FHV Home Visit form

1. Home Visitor ID number:
2. Date of Home Visit:
3. Was there an interpreter at this home visit?  
(choose one)
  - 01 Yes
  - 02 No

**Reminder:** Update the FHV Case information if any of the following has changed as of this visit:

- Participant Name
- Member Type
- Consent Level
- Funding Type
- Home Visiting Model or Program Type

**Reminder:** If new participants are being added to the FHV Case, complete the appropriate intake form for each new participant.

**Reminder:** If participants are being removed from the FHV Case, complete the Closure form for each exiting participant.

## Instructions for the FHV Home Visit Form

**General Guidelines:** Complete this form for each completed home visit. A home visit can be delivered in-person or by using videoconference technology. Do not complete this form for phone, email, or text communications between the home visitor and the family.

If there have been changes in the name, member type, consent level, funding source, FHV model or program type for any family members, also make sure to update the FHV Case information in your data entry system.

If a new participant is added to the FHV Case, complete the relevant intake form for that participant.

If a participant is being removed from the FHV Case, complete the Closure form for that participant.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	Home Visitor ID number:	Unique identifier for home visitor serving this family at this visit
2	Date of Home Visit:	The date of the first home visit after the participant has been determined to be eligible and has been enrolled in home visiting. Follow model guidance if using an evidence-based home visiting model.
3	Was there an interpreter at this home visit?	<u>[Interpreter definition]</u>

## Primary Caregiver Health Insurance Form

**1. Since last month, has the participant had a change in health insurance?**

(choose one)

- 01 Yes, change in insurance coverage
- 02 No change in insurance coverage [STOP, you do not need to complete the rest of this form]
- 98 Not asked at this visit [STOP, you do not need to complete the rest of this form]

**2. What type of health plan or health insurance does the participant currently have?**

(choose all that apply)

- 01 Private insurance
- 02 Public insurance
- 03 Military health care
- 04 Other health insurance
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**3. If Other health insurance, specify other health insurance:**

## Instructions for the Primary Caregiver Health Insurance Form

**General Guidelines:** Complete this form monthly.

**Item Instructions:**

Question Number	Questions in the forms	Additional Guidance
1	Since last month, has the participant had a change in health insurance?	<u>[Insurance status definition]</u>
2	What type of health plan or health insurance does the participant currently have?	<u>[Health plan or health insurance definition]</u>
3	Specify other health insurance:	<u>[Open-ended other health insurance instructions]</u>

## MIECHV Target Child Visit-Level Data Form

**1. Did the caregiver have any concerns regarding the child's development, behavior, or learning?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit

**2. Has the child been taken to the emergency room (ER) for an injury since the last home visit?**

(choose one)

- 01 Yes
- 02 No [STOP, you do not need to complete the rest of this form]

**3. Report the approximate date of each ER visit:**

## Instructions for the MIECHV Target Child Visit-Level Data Form

**General Guidelines:** Complete this form for each completed home visit, if the FHV Case has a MIECHV-funded Target Child. Complete one form for each MIECHV-funded Target Child.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	Did the caregiver have any concerns regarding the child's development, behavior, or learning?	Document whether the home visitor asked the caregiver(s) about developmental, behavioral, or learning concerns during the home visit.
2	Has the child been taken to the emergency room (ER) for an injury since the last home visit?	<p>Please include visits to the hospital emergency department only, and <b>do not</b> include visits to urgent care centers or primary care clinics.</p> <p>Causes of child injury include</p> <ul style="list-style-type: none"> <li>• motor vehicle accidents;</li> <li>• near-suffocation;</li> <li>• near-drowning;</li> <li>• poisoning;</li> <li>• choking;</li> <li>• swallowing of harmful objects such as magnets or batteries;</li> <li>• fire, burns, or scalding;</li> <li>• falls;</li> <li>• firearms or weapons;</li> <li>• animal bites;</li> <li>• injuries from playground equipment or toys;</li> <li>• crushing by furniture (dressers, bookcases, televisions);</li> <li>• intentional injuries or child maltreatment.</li> </ul>
3	Report the approximate date of each ER visit:	Report emergency room visit dates for the target child. If the caregiver(s) cannot recall exact dates, please report approximate dates.

## Screening Form

**1. Were any screenings completed during this home visit, or as a follow-up to this home visit?**

(choose one)

- 01 Yes
- 02 No [STOP, you do not need to complete the rest of this form]

**2. What was the screening date?**

**3. Which family member was screened?**

**4. What type of screening was given?**

(choose one)

- 01 Mental Health Screening – Including Depression, Anxiety, Substance Use [SKIP to #6]
- 02 Intimate Partner Violence Screening [SKIP to #9]
- 03 Developmental Screening [SKIP to #12]
- 04 Social-Emotional Screening [SKIP to #15]
- 99 Other type of screening

**5. Specify other type of screening:** [Write-in response below and then SKIP to #18]

**6. What Mental Health Screening tool was used?**

(choose one)

- 01 Edinburgh Postnatal Depression Scale (EPDS) [SKIP to #8]
- 02 Patient Health Questionnaire-9 (PHQ-9) [SKIP to #8]
- 03 Patient Health Questionnaire-4 (PHQ-4) [SKIP to #8]
- 04 Patient Health Questionnaire-2 (PHQ-2) [SKIP to #8]
- 05 Postpartum Depression Screening Scale (PDSS) [SKIP to #8]
- 06 Center for Epidemiological Studies Depression Scale (CES-D) [SKIP to #8]
- 07 Center for Epidemiological Studies Depression Scale Revised (CESD-R) [SKIP to #8]
- 08 Generalized Anxiety Disorder-7 (GAD-7) [SKIP to #8]
- 09 Screening, Brief Intervention and Referral to Treatment (SBIRT) [SKIP to #8]
- 10 Tolerance, Worried, Eye-opener, Amnesia, Cut down (TWEAK) [SKIP to #8]
- 11 Tolerance, Annoyance, Cut down, Eye-opener (T-ACE) [SKIP to #8]
- 12 Cut down, Annoyed, Guilty, Eye-opener (CAGE) [SKIP to #8]
- 13 CAGE Adapted to Include Drugs (CAGE-AID) [SKIP to #8]
- 99 Other screening tool

**7. Specify other Mental Health Screening Tool used:**

**8. What was the screening result?**

(choose one)

- 01 Concern identified [STOP, you do not need to complete the rest of this form]
- 02 No concern identified [STOP, you do not need to complete the rest of this form]



**9. What Intimate Partner Violence screening tool was used?**

(choose one)

- 01 Humiliation, Afraid, Rape, Kick (HARK) [SKIP to #11]
- 02 HARK plus Child (HARK-C) [SKIP to #11]
- 03 Hurt-Insult-Threaten-Scream (HITS) [SKIP to #11]
- 04 Relationship Assessment Tool (RAT) [SKIP to #11]
- 05 Conflict Tactics Scale (CTS) [SKIP to #11]
- 99 Other screening tool

**10. Specify other IPV Screening Tool used:****11. What was the screening result?**

- 01 Concern identified [STOP, you do not need to complete the rest of this form]
- 02 No concern identified [STOP, you do not need to complete the rest of this form]

**12. What Developmental Screening tool was used?**

(choose one)

- 01 Ages and Stages Questionnaire-3 (ASQ-3) [SKIP to #14]
- 02 Parents' Evaluation of Developmental Status (PEDS) [SKIP to #14]
- 03 PEDS – Developmental Milestones (PEDS:DM) [SKIP to #14]
- 99 Other screening tool

**13. Specify other Developmental Screening Tool used:****14. What was the screening result?**

(choose one)

- 01 Concern identified [STOP, you do not need to complete the rest of this form]
- 02 No concern identified [STOP, you do not need to complete the rest of this form]

**15. What Social-Emotional Screening tool was used?**

(choose one)

- 01 Ages and Stages Questionnaire SE-2 (ASQ:SE-2) [SKIP to #17]
- 02 Pediatric Symptom Checklist (PSC) [SKIP to #17]
- 99 Other screening tool

**16. Specify other Social-Emotional Screening Tool used:****17. What was the screening result?**

- 01 Concern identified [STOP, you do not need to complete the rest of this form]
- 02 No concern identified [STOP, you do not need to complete the rest of this form]

**18. Specify tool used for other screening type:****19. What was the screening result?**

- 01 Concern identified
- 02 No concern identified

## Instructions for the Screening Form

**General Guidelines:** Complete this form for each screening that was provided to a participant. Multiple Screening forms can be completed for a single home visit.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	Were any screenings completed during this home visit, or as a follow-up to this home visit?	<p>Screenings reported to MDH should be limited to those that were performed by the home visitor, or those where the home visitor has access to the screening results and can verify that the screening was administered correctly.</p> <p>Screenings are typically performed during the home visit. Screenings performed between home visits (for example after this home visit and before the next home visit or program closure) should be included in the most recently completed home visit.</p> <p>Screenings administered over the phone or via other non face-to-face methods can be reported if the screening tool protocol allows the tool to be administered by those means.</p> <p>Only report screenings that were completed. If a screening was attempted but not completed, the response to this question should be “No”.</p>
2	What was the screening date?	Enter the date that the screening was completed. If the screening was completed outside of a home visit, report the actual date of screening.
3	Which family member was screened?	Indicate which participant was screened.
4	What type of screening was given?	Choose one response to indicate the type of screening that was provided.
5	Specify other type of screening:	If “Other type of screening” is selected for the previous question, please write-in the name of the other type of screening.
6	What Mental Health Screening tool was used?	Choose one response to indicate the specific screening tool used. Select “Other screening tool” only when the tool used is not listed.

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Question Number	Questions in the forms	Additional Guidance
7	Specify other Mental Health Screening Tool used:	If "Other screening tool" is selected for the previous question, please write-in the name of the other Mental Health Screening Tool used.
8	What was the screening result?	Choose one response ("Concern identified" or "No concern identified") based on the result of the screening tool.
9	What Intimate Partner Violence screening tool was used?	Choose one response to indicate the specific screening tool used. Select "Other screening tool" only when the tool used is not listed.
10	Specify other IPV Screening Tool used:	If "Other screening tool" is selected for the previous question, please write-in the name of the other IPV Screening Tool used.
11	What was the screening result?	Choose one response ("Concern identified" or "No concern identified") based on the result of the screening tool.
12	What Developmental Screening tool was used?	Choose one response to indicate the specific screening tool used. Select "Other screening tool" only when the tool used is not listed.
13	Specify other Developmental Screening Tool used:	If "Other screening tool" is selected for the previous question, please write-in the name of the other Developmental Screening Tool used.
14	What was the screening result?	Choose one response ("Concern identified" or "No concern identified") based on the result of the screening tool. If using ASQ-3: report Positive results as "Concern identified," report Monitor or Negative results as "No Concern Identified"
15	What Social-Emotional Screening tool was used?	Choose one response to indicate the specific screening tool used. Select "Other screening tool" only when the tool used is not listed.
16	Specify other Social-Emotional Screening Tool used:	If "Other screening tool" is selected for the previous question, please write-in the name of the other Social-Emotional Screening Tool used.

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Question Number	Questions in the forms	Additional Guidance
17	What was the screening result?	Choose one response ("Concern identified" or "No concern identified") based on the result of the screening tool. If using ASQ-SE2: report Positive results as "Concern identified," report Monitor or Negative results as "No Concern Identified"
18	Specify tool used for other screening type:	If "Other type of screening" is selected for question #4, please write-in the name of the tool used for other screening type.
19	What was the screening result?	Choose one response ("Concern identified" or "No concern identified") based on the result of the screening tool.

## Parent-Child Interaction Assessment Form

**1. Was a validated Parent-Child Interaction tool used during this home visit?**

(choose one)

- 01 Yes
- 02 No [STOP, you do not need to complete the rest of this form]

**2. Which family members were observed with the PCI tool?**

**3. What Parent-Child Interaction Observation tool was used?**

(choose one)

- 01 CHEERS Check-In [SKIP to #5]
- 02 DANCE [SKIP to #11]
- 03 HOME Inventory [SKIP to #16]
- 04 KIPS [SKIP to #22]
- 05 NCAST PCI Teaching Scale [SKIP to #34]
- 06 NCAST PCI Feeding Scale [SKIP to #40]
- 07 PICCOLO [SKIP to #46]
- 99 Other tool

**4. Specify other Parent-Child Interaction Tool used:**

The data entry system will prompt the user to enter the domain-level scores for the completed Parent-Child Interaction tool. The number of domains and valid score values vary depending on the tool selected.

## Instructions for the Parent-Child Interaction Assessment Form

**General Guidelines:** Complete this form for each Parent-Child Interaction Assessment that is completed during a home visit.

**Item Instructions:**

Question Number	Questions in the forms	Additional Guidance
1	Was a validated Parent-Child Interaction tool used during this home visit?	Only record PCI assessments that were completed. If a PCI assessment was attempted but not completed, the response to this question should be "No".
2	Which family members were observed with the PCI tool?	Most PCI tools involve a specific caregiver and child; please record all participants involved. There should be at least two participants.
3	What Parent-Child Interaction Observation tool was used?	Choose one response to indicate the specific tool used. Select "Other tool" only when the tool used is not listed.
4	Specify other Parent-Child Interaction Tool used:	If "Other tool" is selected for the previous question, please write-in the name of the other Parent-Child Interaction Tool used.

## Referral Form

### 1. Were any referrals offered during this home visit, or as a follow-up to this home visit?

(choose one)

- 01 Yes
- 02 No [STOP, you do not need to complete the rest of this form]

### 2. What was the referral date?

### 3. Which family member was referred?

### 4. What type of referral was offered?

(choose one)

#### Social Services and Financial Supports:

- 01 Health Insurance (MNSure, Medical Assistance) [STOP, you do not need to complete the rest of this form]
- 02 Financial Assistance (MFIP, cash assistance) [STOP, you do not need to complete the rest of this form]
- 03 Housing Services (rent assistance, Section 8, public housing) [STOP, you do not need to complete the rest of this form]
- 04 Energy Assistance [STOP, you do not need to complete the rest of this form]
- 05 Transportation Assistance [STOP, you do not need to complete the rest of this form]
- 06 Child Care Assistance [STOP, you do not need to complete the rest of this form]
- 07 Employment services/Workforce Center [STOP, you do not need to complete the rest of this form]
- 08 Supplemental Nutrition Assistance Program (SNAP) [STOP, you do not need to complete the rest of this form]
- 09 Women, Infants, and Children (WIC) [STOP, you do not need to complete the rest of this form]
- 10 Food shelf, pantry, or resource [STOP, you do not need to complete the rest of this form]
- 11 Other charitable services (clothing, furniture, household goods) [STOP, you do not need to complete the rest of this form]
- 12 Adoption Services [STOP, you do not need to complete the rest of this form]
- 13 Legal Services [STOP, you do not need to complete the rest of this form]

#### Crisis Intervention:

- 21 Emergency assistance [STOP, you do not need to complete the rest of this form]
- 22 Parent Support Outreach Program (PSOP) [STOP, you do not need to complete the rest of this form]
- 23 Mental Health Crisis Services [STOP, you do not need to complete the rest of this form]
- 24 Intimate Partner Violence/Domestic Violence Services/Women's Shelter [STOP, you do not need to complete the rest of this form]

**Health Care Services:**

- 41 Primary Care Provider [STOP, you do not need to complete the rest of this form]
- 42 Health Care Specialist Provider [STOP, you do not need to complete the rest of this form]
- 43 Dental Provider [STOP, you do not need to complete the rest of this form]
- 44 Breastfeeding/Lactation Support [STOP, you do not need to complete the rest of this form]
- 45 Public Health Clinic [STOP, you do not need to complete the rest of this form]
- 46 Family Planning Clinic [STOP, you do not need to complete the rest of this form]
- 47 Pregnancy support program [STOP, you do not need to complete the rest of this form]
- 48 Tobacco/Smoking Cessation [STOP, you do not need to complete the rest of this form]
- 49 Mental Health Services [STOP, you do not need to complete the rest of this form]
- 50 Substance Abuse Services [STOP, you do not need to complete the rest of this form]

**Child Development and Parenting Support:**

- 61 Early Intervention/Part C [STOP, you do not need to complete the rest of this form]
- 62 Early Childhood Family Education (ECFE) [STOP, you do not need to complete the rest of this form]
- 63 Early Childhood Mental Health [STOP, you do not need to complete the rest of this form]
- 64 Head Start/Early Head Start [STOP, you do not need to complete the rest of this form]
- 65 School Readiness or Preschool program [STOP, you do not need to complete the rest of this form]
- 66 Home Visitor Individualized Support for Child Development [STOP, you do not need to complete the rest of this form]
- 67 Parenting support group/Mothers and Babies group [STOP, you do not need to complete the rest of this form]

**Other Services:**

- 81 High School/Alternative High School [STOP, you do not need to complete the rest of this form]
- 82 Adult Basic Education [STOP, you do not need to complete the rest of this form]
- 83 General Educational Development (GED) Program or Adult High School Diploma Program [STOP, you do not need to complete the rest of this form]
- 84 English as a Second Language (ESL) Program [STOP, you do not need to complete the rest of this form]
- 99 Other Provider or Community Services

**5. Specify other provider or community services:**



## Instructions for the Referral Form

**General Guidelines:** Complete this form for each referral that is offered to a participant or the family. If a referral was offered to the family, record the referral recipient as the Primary Caregiver.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	Were any referrals offered during this home visit, or as a follow-up to this home visit?	<p><b>Referral Offered</b> = the family was given referral information by the home visitor, or a referral was made to a service either with the family, or on the family's behalf, by the home visitor. The offer of a referral should include a discussion of the types of services available, what to expect, and providing the family with resources for contacting the service provider; it can also include the home visitor offering to make a phone call with the family to the service provider, or other efforts to connect the family with the service provider.</p> <p>Offered referrals that are declined or refused by the family still "count" as referrals and should be reported to IHVE. The outcome of a referral, including that a family declined the referral, should be documented on the Referral Status Form.</p>
2	What was the referral date?	Enter the date that the referral was offered. If the referral was provided outside of a home visit, report the actual date of referral.
3	Which family member was referred?	<p>Referrals that are for the family, such as for housing and food support, can be reported as referrals for the Primary Caregiver only instead of for each participant in the family separately.</p> <p>Referrals for services for individual family members should be reported as referrals for those individual family members. For example: a referral to a health care provider for an issue that a Target Child is experiencing should be reported as a referral for that Target Child.</p>
4	What type of referral was offered?	Choose one response.

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Question Number	Questions in the forms	Additional Guidance
5	Specify other provider or community services:	If "Other Provider or Community Services" is selected for the previous question, please write-in the name of the other provider or community services.

## Referral Status Form

### 1. What is the current status of this referral?

(choose one)

- 01 Not yet in process – family has not acted on referral [STOP, you do not need to complete the rest of this form]
- 02 In process – family has contacted service provider and is awaiting action [STOP, you do not need to complete the rest of this form]
- 03 Scheduled – family has an appointment scheduled with service provider [STOP, you do not need to complete the rest of this form]
- 04 Complete – family received at least one service or appointment from service provider
- 05 Declined – family is not pursuing services [SKIP to #3]
- 06 Unavailable – referral provider was contacted and cannot provide services to family [SKIP to #3]
- 07 Ineligible – referral provider was contacted and family is not eligible for services [SKIP to #3]
- 08 Not assessed at this visit [STOP, you do not need to complete the rest of this form]

### 2. If referral status = complete: What was the date of the first appointment or services from the referral provider?

### 3. If referral status = declined, unavailable or ineligible: Specify reason why referral was not completed (e.g. declined, unavailable, or ineligible)

## Instructions for the Referral Status Form

**General Guidelines:** Update the referral status for each open referral at the time of each home visit.

**Open referrals** are those with a status of 01 (Not yet in process – family has not acted on referral), 02 (In process – family has contacted service provider and is awaiting action), 03 (Scheduled – family has an appointment scheduled with service provider), or 08 (Not assessed at this visit).

**Closed referrals** are those with a status of 04 (Complete – family received at least one service or appointment from service provider), 05 (Declined – family is not pursuing services), 06 (Unavailable – referral provider was contacted and cannot provide services to family), or 07 (Ineligible – referral provider was contacted and family is not eligible for services). Once one of these statuses has been recorded for a referral, no further updates to the status of the referral are necessary.

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	What is the current status of this referral?	Indicate the status of this referral as of this home visit. This status may be the same as or different from the status as of the previous home visit.
2	If referral status = complete: What was the date of the first appointment or services from the referral provider?	If the exact date of initial services from the referral provider is unknown, please provide the family's or home visitor's best estimate of the date when services first took place.
3	If referral status = declined, unavailable or ineligible: Specify reason why referral was not completed (e.g. declined, unavailable, or ineligible)	(Optional) Provide more information about why the referral was not completed.

## Demographic Update Form

### 1. Participant's home address:

Address (number and street or rural route):

City:

State:

Zip Code:

County:

### 2. Is the participant homeless?

(choose one)

- 01 Not homeless
- 02 Homeless [SKIP to #4]
- 88 Unknown [SKIP to #5]
- 98 Not asked at this visit [SKIP to #5]
- 99 Client declines to answer [SKIP to #5]

### 3. If Not homeless: Which of the following best describes the participant's living arrangements?

(choose one)

- 01 Owns or shares own home, condominium, or apartment [SKIP to #5]
- 02 Rents or shares rented home or apartment [SKIP to #5]
- 03 Lives in public housing [SKIP to #5]
- 04 Lives with parent or family member [SKIP to #5]
- 05 Some other arrangement [SKIP to #5]
- 98 Not asked at this visit [SKIP to #5]
- 99 Client declines to answer [SKIP to #5]

### 4. If Homeless: Which of the following best describes the participant's living arrangements?

(choose one)

- 01 Homeless and sharing housing
- 02 Homeless and living in an emergency or transitional shelter
- 03 Some other arrangement
- 98 Not asked at this visit
- 99 Client declines to answer

### 5. What is the participant's current marital status?

(choose one)

- 01 Married
- 02 Divorced
- 03 Widowed
- 04 Separated
- 05 Never Married
- 98 Not asked at this visit
- 99 Client declines to answer

**6. Does the participant currently live with their spouse or partner?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit
- 99 Client declines to answer

**7. Does the participant currently use tobacco, such as cigarettes, cigars, chewing tobacco, or electronic cigarettes (excluding religious or ceremonial use)?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit
- 99 Client declines to answer

**8. Is the participant currently working?**

(choose one)

- 01 Employed Full-Time (30+ hours/week)
- 02 Employed Part-Time (Less than 30 hours/week)
- 03 Not employed
- 98 Not asked at this visit
- 99 Client declines to answer

**9. Which category best describes the monthly income for the participant's household? Include income from work, cash assistance programs, benefits, rent, cash from friends or relatives, child support, or other sources.**

(choose one)

- 01 \$0 - \$500
- 02 \$501 - \$1,000
- 03 \$1,001 - \$1,500
- 04 \$1,501 - \$2,000
- 05 \$2,001 - \$2,500
- 06 \$2,501 - \$3,000
- 07 \$3,001 - \$4,000
- 08 \$4,001 - \$5,000
- 09 \$5,001 - \$6,000
- 10 \$6,001 - \$7,000
- 11 \$7,001 - \$8,000
- 12 \$8,001 or more
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**10. How many people are in the participant's household (including the caregiver), who are living on the income described above?**

**11. Has anyone in the participant's household ever served in the US Armed Forces, either active duty, Reserves, or National Guard (including the caregiver)?**

(choose one)

- 01 Yes
- 02 No
- 98 Not asked at this visit
- 99 Client declines to answer

**12. Is the participant currently enrolled in high school, college, or another educational program?**

(choose one)

- 01 Not enrolled in a program [SKIP to #14]
- 02 Grade School, High School or GED program [SKIP to #14]
- 03 Post-high school vocational/certification/technical training [SKIP to #14]
- 04 2 year or 4 year College [SKIP to #14]
- 05 Other
- 98 Not asked at this visit [SKIP to #14]
- 99 Client declines to answer [SKIP to #14]

**13. Specify other educational enrollment:****14. What is the highest level of education the participant has completed?**

(choose one)

- 01 Less than HS Diploma [SKIP to #16]
- 02 High School Diploma or GED [SKIP to #16]
- 03 Some college or post high school training [SKIP to #16]
- 04 Technical training or certificate [SKIP to #16]
- 05 Associate's degree [SKIP to #16]
- 06 Bachelor's degree or higher [SKIP to #16]
- 09 Other
- 98 Not asked at this visit [SKIP to #16]
- 99 Client declines to answer [SKIP to #16]

**15. Specify other educational level completed:****16. Are there any children in the participant's household with disabilities or developmental delays?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

## Instructions for the Demographic Update Form

**General Guidelines:** Complete these questions about the Primary Caregiver every six months.

**Item Instructions:**

Question Number	Questions in the forms	Additional Guidance
1	Participant's home address:	[Address format instructions]
2	Is the participant homeless?	Indicate whether the Primary Caregiver is homeless at the time the form is completed.  <u>[Homeless definition]</u>
3	If Not homeless: Which of the following best describes the participant's living arrangements?	Indicate the Primary Caregiver's living arrangement at the time the form is completed.  Choose one response.  <u>[If Not homeless: living arrangements definitions]</u>
4	If Homeless: Which of the following best describes the participant's living arrangements?	Indicate the Primary Caregiver's living arrangement at the time the form is completed.  Choose one response.  <u>[If homeless: living arrangements definitions]</u>
5	What is the participant's current marital status?	<u>[Additional information related to marital status response options]</u>
6	Does the participant currently live with their spouse or partner?	Based on Primary Caregiver's self-report.
7	Does the participant currently use tobacco, such as cigarettes, cigars, chewing tobacco, or electronic cigarettes (excluding religious or ceremonial use)?	<u>[Additional information related to tobacco use response options]</u>
8	Is the participant currently working?	<u>[Employment definition]</u>



IHVE DATA COLLECTION MANUAL

Question Number	Questions in the forms	Additional Guidance
9	Which category best describes the monthly income for the participant's household? Include income from work, cash assistance programs, benefits, rent, cash from friends or relatives, child support, or other sources.	<p><u>[Primary Caregiver's household monthly income definition]</u></p> <p><u>[Household definition]</u></p>
10	How many people are in the participant's household (including the caregiver), who are living on the income described above?	<p><u>[Household definition]</u></p>
11	Has anyone in the participant's household ever served in the US Armed Forces, either active duty, Reserves, or National Guard (including the caregiver)?	<p>Based on Primary Caregiver's self-report.</p> <p><u>[Military member definition]</u></p>
12	Is the participant currently enrolled in high school, college, or another educational program?	<p>Based on Primary Caregiver's self-report.</p>
13	Specify other educational enrollment:	<p>If "Other" is selected for the previous question, please write-in the other type of educational program enrollment.</p>
14	What is the highest level of education the participant has completed?	<p>Based on Primary Caregiver's self-report.</p>
15	Specify other educational level completed:	<p>If "Other" is selected for the previous question, please write-in the other type of educational program completed.</p>
16	Are there any children in the participant's household with disabilities or developmental delays?	<p>Based on Primary Caregiver's self-report.</p> <p><u>[Any children definition]</u></p>

## Child Age Interval Forms

### 3 Month Age Interval Form

**1. Did the child's biological mother have a postpartum visit with a healthcare provider after childbirth?**

(choose one)

- 01 Yes
- 02 No [SKIP to #3]
- 88 Client does not know/not sure [SKIP to #3]
- 98 Not asked at this visit [SKIP to #3]
- 99 Client declines to answer [SKIP to #3]

**2. Date of postpartum visit (MM/DD/YYYY):**

**3. Is the child currently being breastfed or receiving breastmilk?**

(choose one)

- 01 Yes
- 02 No
- 03 Client is not recommended to breastfeed because of a medical condition
- 98 Not asked at this visit
- 99 Client declines to answer

**4. "We worried whether our food would run out before we got money to buy more." In the past 12 months, was this often true, sometimes true, or never true for the child's household?**

(choose one)

- 01 Often true
- 02 Sometimes true
- 03 Never true
- 98 Not asked at this visit
- 99 Client declines to answer

**5. "The food we bought just didn't last, and we didn't have money to get more." In the past 12 months, was this often true, sometimes true, or never true for the child's household?**

(choose one)

- 01 Often true
- 02 Sometimes true
- 03 Never true
- 98 Not asked at this visit
- 99 Client declines to answer

**6. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #8]
- 98 Not asked at this visit [SKIP to #8]
- 99 Client declines to answer [SKIP to #8]

**7. What was the approximate date of the child's most recent well-child visit?****8. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**9. Does the caregiver place the child to sleep on their back?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**10. Does the child share a bed with anyone?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**11. Does the child sleep with soft bedding?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**12. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

## 6 Month Age Interval Form

### 1. Is the child currently being breastfed or receiving breastmilk?

(choose one)

- 01 Yes
- 02 No
- 03 Client is not recommended to breastfeed because of a medical condition
- 98 Not asked at this visit
- 99 Client declines to answer

### 2. What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child's health?

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #4]
- 02 Hospital emergency room [SKIP to #4]
- 03 Hospital outpatient department [SKIP to #4]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #4]
- 05 Retail store or minute clinic [SKIP to #4]
- 08 Some other place
- 09 None [SKIP to #4]
- 88 Client does not know/not sure [SKIP to #4]
- 98 Not asked at this visit [SKIP to #4]
- 99 Client declines to answer [SKIP to #4]

### 3. Specify other usual source of child's medical care:

### 4. What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #6]
- 02 Hospital emergency room [SKIP to #6]
- 03 Hospital outpatient department [SKIP to #6]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #6]
- 05 Retail store or minute clinic [SKIP to #6]
- 08 Some other place
- 09 None [SKIP to #6]
- 88 Client does not know/not sure [SKIP to #6]
- 98 Not asked at this visit [SKIP to #6]
- 99 Client declines to answer [SKIP to #6]

### 5. Specify other source of child's preventive care:

**6. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #8]
- 98 Not asked at this visit [SKIP to #8]
- 99 Client declines to answer [SKIP to #8]

**7. What was the approximate date of the child's most recent well-child visit?****8. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**9. Does the caregiver have a dentist that they can take their child to?**

(choose one)

- Yes
- No
- Client does not know/not sure
- Not asked at this visit
- Client declines to answer

**10. Does the caregiver place the child to sleep on their back?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**11. Does the child share a bed with anyone?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**12. Does the child sleep with soft bedding?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**13. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**14. Does the child currently have health insurance?**

(choose one)

- 01 Yes, insured
- 02 No, uninsured [STOP, you do not need to complete the rest of this form]
- 03 Client applied for coverage, application is pending
- 88 Client does not know/not sure [STOP, you do not need to complete the rest of this form]
- 98 Not asked at this visit [STOP, you do not need to complete the rest of this form]
- 99 Client declines to answer [STOP, you do not need to complete the rest of this form]

**15. What type of health plan or health insurance does the child currently have?**

(choose all that apply)

- 01 Private Insurance
- 02 Public Insurance
- 03 Military Health Care
- 04 Other health insurance
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**16. If Other health insurance, specify other health insurance:**



## 9 Month Age Interval Form

**1. Is the child currently being breastfed or receiving breastmilk?**

(choose one)

- 01 Yes
- 02 No
- 03 Client is not recommended to breastfeed because of a medical condition
- 98 Not asked at this visit
- 99 Client declines to answer

**2. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #4]
- 98 Not asked at this visit [SKIP to #4]
- 99 Client declines to answer [SKIP to #4]

**3. What was the approximate date of the child's most recent well-child visit?**

**4. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**5. Does the caregiver place the child to sleep on their back?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**6. Does the child share a bed with anyone?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**7. Does the child sleep with soft bedding?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**8. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

## 12 Month Age Interval Form

**1. Is the child currently being breastfed or receiving breastmilk?**

(choose one)

- 01 Yes
- 02 No
- 03 Client is not recommended to breastfeed because of a medical condition
- 98 Not asked at this visit
- 99 Client declines to answer

**2. “We worried whether our food would run out before we got money to buy more.” In the past 12 months, was this often true, sometimes true, or never true for the child’s household?**

(choose one)

- 01 Often true
- 02 Sometimes true
- 03 Never true
- 98 Not asked at this visit
- 99 Client declines to answer

**3. “The food we bought just didn’t last, and we didn’t have money to get more.” In the past 12 months, was this often true, sometimes true, or never true for the child’s household?**

(choose one)

- 01 Often true
- 02 Sometimes true
- 03 Never true
- 98 Not asked at this visit
- 99 Client declines to answer

**4. What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child’s health?**

(choose one)

- 01 Doctor’s or Nurse Practitioner’s Office [SKIP to #6]
- 02 Hospital emergency room [SKIP to #6]
- 03 Hospital outpatient department [SKIP to #6]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #6]
- 05 Retail store or minute clinic [SKIP to #6]
- 08 Some other place
- 09 None [SKIP to #6]
- 88 Client does not know/not sure [SKIP to #6]
- 98 Not asked at this visit [SKIP to #6]
- 99 Client declines to answer

**5. Specify other usual source of child’s medical care:**

**6. What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #8]
- 02 Hospital emergency room [SKIP to #8]
- 03 Hospital outpatient department [SKIP to #8]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #8]
- 05 Retail store or minute clinic [SKIP to #8]
- 08 Some other place
- 09 None [SKIP to #8]
- 88 Client does not know/not sure [SKIP to #8]
- 98 Not asked at this visit [SKIP to #8]
- 99 Client declines to answer [SKIP to #8]

**7. Specify other source of child's preventive care:****8. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #10]
- 98 Not asked at this visit [SKIP to #10]
- 99 Client declines to answer [SKIP to #10]

**9. What was the approximate date of the child's most recent well-child visit?****10. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**11. Does the caregiver have a dentist that they can take their child to?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**12. Does the caregiver place the child to sleep on their back?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**13. Does the child share a bed with anyone?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**14. Does the child sleep with soft bedding?**

(choose one)

- 01 Always
- 02 Sometimes
- 03 Never
- 98 Not asked at this visit
- 99 Client declines to answer

**15. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**16. Does the child currently have health insurance?**

(choose one)

- 01 Yes, insured
- 02 No, uninsured [SKIP to #19]
- 03 Client applied for coverage, application is pending
- 88 Client does not know/not sure [SKIP to #19]
- 98 Not asked at this visit [SKIP to #19]
- 99 Client declines to answer [SKIP to #19]

**17. What type of health plan or health insurance does the child currently have?**

(choose all that apply)

- 01 Private Insurance [SKIP to #19]
- 02 Public Insurance [SKIP to #19]
- 03 Military Health Care [SKIP to #19]
- 04 Other health insurance
- 88 Client does not know/not sure [SKIP to #19]
- 98 Not asked at this visit [SKIP to #19]
- 99 Client declines to answer [SKIP to #19]

**18. Specify other health insurance:****19. In the last 12 months, has the primary caregiver ever been separated from the child (other than vacation or respite), such as because the caregiver went to jail or prison, because of inpatient alcohol or substance abuse treatment, because of hospitalization, or for any other reason?**

(choose all that apply)

- 01 Yes, because caregiver was in jail or prison
- 02 Yes, because caregiver was in inpatient substance abuse
- 03 Yes, because caregiver was hospitalized
- 04 Yes, other reason (please specify)
- 05 No, caregiver was not separated from child
- 98 Not asked at this visit
- 99 Client declines to answer

**20. If Yes, other reason, specify other reason for caregiver's separation from child:**

**15 Month Age Interval Form****1. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #3]
- 98 Not asked at this visit [SKIP to #3]
- 99 Client declines to answer [SKIP to #3]

**2. What was the approximate date of the child's most recent well-child visit?****3. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**4. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

## 18 Month Age Interval Form

**1. What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child's health?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #3]
- 02 Hospital emergency room [SKIP to #3]
- 03 Hospital outpatient department [SKIP to #3]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #3]
- 05 Retail store or minute clinic [SKIP to #3]
- 08 Some other place
- 09 None [SKIP to #3]
- 88 Client does not know/not sure [SKIP to #3]
- 98 Not asked at this visit [SKIP to #3]
- 99 Client declines to answer [SKIP to #3]

**2. Specify other usual source of child's medical care:**

**3. What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #5]
- 02 Hospital emergency room [SKIP to #5]
- 03 Hospital outpatient department [SKIP to #5]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #5]
- 05 Retail store or minute clinic [SKIP to #5]
- 08 Some other place
- 09 None [SKIP to #5]
- 88 Client does not know/not sure [SKIP to #5]
- 98 Not asked at this visit [SKIP to #5]
- 99 Client declines to answer [SKIP to #5]

**4. Specify other source of child's preventive care:**



**5. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #7]
- 98 Not asked at this visit [SKIP to #7]
- 99 Client declines to answer [SKIP to #7]

**6. What was the approximate date of the child's most recent well-child visit?****7. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**8. Does the caregiver have a dentist that they can take their child to?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**9. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**10. Does the child currently have health insurance?**

(choose one)

- 01 Yes, insured
- 02 No, uninsured [STOP, you do not need to complete the rest of this form]
- 03 Client applied for coverage, application is pending
- 88 Client does not know/not sure [STOP, you do not need to complete the rest of this form]
- 98 Not asked at this visit [STOP, you do not need to complete the rest of this form]
- 99 Client declines to answer [STOP, you do not need to complete the rest of this form]

**11. What type of health plan or health insurance does the child currently have?**

(choose all that apply)

- 01 Private Insurance
- 02 Public Insurance
- 03 Military Health Care
- 04 Other health insurance
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**12. If Other health insurance, specify other health insurance:**

## 24/36/48/60 Month Age Interval Form

**1. “We worried whether our food would run out before we got money to buy more.” In the past 12 months, was this often true, sometimes true, or never true for the child’s household?**

(choose one)

- 01 Often true
- 02 Sometimes true
- 03 Never true
- 98 Not asked at this visit
- 99 Client declines to answer

**2. “The food we bought just didn’t last, and we didn’t have money to get more.” In the past 12 months, was this often true, sometimes true, or never true for the child’s household?**

(choose one)

- 01 Often true
- 02 Sometimes true
- 03 Never true
- 98 Not asked at this visit
- 99 Client declines to answer

**3. What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child’s health?**

(choose one)

- 01 Doctor’s or Nurse Practitioner’s Office [SKIP to #5]
- 02 Hospital emergency room [SKIP to #5]
- 03 Hospital outpatient department [SKIP to #5]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #5]
- 05 Retail store or minute clinic [SKIP to #5]
- 08 Some other place
- 09 None [SKIP to #5]
- 88 Client does not know/not sure [SKIP to #5]
- 98 Not asked at this visit [SKIP to #5]
- 99 Client declines to answer [SKIP to #5]

**4. Specify other usual source of child’s medical care:**

**5. What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #7]
- 02 Hospital emergency room [SKIP to #7]
- 03 Hospital outpatient department [SKIP to #7]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #7]
- 05 Retail store or minute clinic [SKIP to #7]
- 08 Some other place
- 09 None [SKIP to #7]
- 88 Client does not know/not sure [SKIP to #7]
- 98 Not asked at this visit [SKIP to #7]
- 99 Client declines to answer [SKIP to #7]

**6. Specify other source of child's preventive care:**

**7. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #9]
- 98 Not asked at this visit [SKIP to #9]
- 99 Client declines to answer [SKIP to #9]

**8. What was the approximate date of the child's most recent well-child visit?**

**9. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**10. Does the caregiver have a dentist that they can take their child to?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**11. Do family members read to, tell stories to, or sing to the child every day during a typical week?(choose one)**

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**12. Does the child currently have health insurance?**

(choose one)

- 01 Yes, insured
- 02 No, uninsured [SKIP to #15]
- 03 Client applied for coverage, application is pending
- 88 Client does not know/not sure [SKIP to #15]
- 98 Not asked at this visit [SKIP to #15]
- 99 Client declines to answer [SKIP to #15]

**13. What type of health plan or health insurance does the child currently have?**

(choose all that apply)

- 01 Private Insurance [SKIP to #15]
- 02 Public Insurance [SKIP to #15]
- 03 Military Health Care [SKIP to #15]
- 04 Other health insurance
- 88 Client does not know/not sure [SKIP to #15]
- 98 Not asked at this visit [SKIP to #15]
- 99 Client declines to answer [SKIP to #15]

**14. Specify other health insurance:**

**15. In the last 12 months, has the primary caregiver ever been separated from the child (other than vacation or respite), such as because the caregiver went to jail or prison, because of inpatient alcohol or substance abuse treatment, because of hospitalization, or for any other reason?**

(choose all that apply)

- 01 Yes, because caregiver was in jail or prison
- 02 Yes, because caregiver was in inpatient substance abuse treatment
- 03 Yes, because caregiver was hospitalized
- 04 Yes, other reason (please specify)
- 05 No, caregiver was not separated from child
- 98 Not asked at this visit
- 99 Client declines to answer

**16. If Yes, other reason, specify other reason for caregiver's separation from child:**

## 30/42/54/66 Month Age Interval Form

**1. What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child's health?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #3]
- 02 Hospital emergency room [SKIP to #3]
- 03 Hospital outpatient department [SKIP to #3]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #3]
- 05 Retail store or minute clinic [SKIP to #3]
- 08 Some other place
- 09 None [SKIP to #3]
- 88 Client does not know/not sure [SKIP to #3]
- 98 Not asked at this visit [SKIP to #3]
- 99 Client declines to answer [SKIP to #3]

**2. Specify other usual source of child's medical care:****3. What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?**

(choose one)

- 01 Doctor's or Nurse Practitioner's Office [SKIP to #5]
- 02 Hospital emergency room [SKIP to #5]
- 03 Hospital outpatient department [SKIP to #5]
- 04 Federally Qualified Health Center (FQHC) [SKIP to #5]
- 05 Retail store or minute clinic [SKIP to #5]
- 08 Some other place
- 09 None [SKIP to #5]
- 88 Client does not know/not sure [SKIP to #5]
- 98 Not asked at this visit [SKIP to #5]
- 99 Client declines to answer [SKIP to #5]

**4. Specify other source of child's preventive care:**

**5. Which well-child visit did the child have most recently?**

(choose one)

- 01 1st week visit
- 02 1 month visit
- 03 2 month visit
- 04 4 month visit
- 05 6 month visit
- 06 9 month visit
- 07 12 month visit
- 08 15 month visit
- 09 18 month visit
- 10 2 years-old visit
- 77 30 month visit
- 11 3 years-old visit
- 12 4 years-old visit
- 13 5 years-old visit
- 88 Client does not know/not sure [SKIP to #7]
- 98 Not asked at this visit [SKIP to #7]
- 99 Client declines to answer [SKIP to #7]

**6. What was the approximate date of the child's most recent well-child visit?****7. Is the child up-to-date on immunizations according to the CDC schedule?**

(choose one)

- 01 Yes, all recommended immunizations
- 02 No, not up-to-date
- 03 Has not received all immunizations because of contraindications
- 98 Not asked at this visit
- 99 Client declines to answer

**8. Does the caregiver have a dentist that they can take their child to?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer



**9. Do family members read to, tell stories to, or sing to the child every day during a typical week?**

(choose one)

- 01 Yes
- 02 No
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**10. Does the child currently have health insurance?**

(choose one)

- 01 Yes, insured
- 02 No, uninsured [STOP, you do not need to complete the rest of this form]
- 03 Client applied for coverage, application is pending
- 88 Client does not know/not sure [STOP, you do not need to complete the rest of this form]
- 98 Not asked at this visit [STOP, you do not need to complete the rest of this form]
- 99 Client declines to answer [STOP, you do not need to complete the rest of this form]

**11. What type of health plan or health insurance does the child currently have?**

(choose all that apply)

- 01 Private Insurance
- 02 Public Insurance
- 03 Military Health Care
- 04 Other health insurance
- 88 Client does not know/not sure
- 98 Not asked at this visit
- 99 Client declines to answer

**12. If Other health insurance, specify other health insurance:**

## Instructions for the Child Age Interval Forms

**General Guidelines:** Complete child age interval forms when the child reaches the age indicated on the form. Forms may be completed within one month of the date that the child reaches the age interval – for example, the 3 month form can be completed within a 2-month window beginning when the child turns 2 months 0 days and ending when the child is 3 months 30 days.

Do not complete child age interval forms for age intervals when the family is not enrolled in FHV, or when the family is not receiving home visits (because the family is unreachable or other reasons). For example, if there are no home visits during the 2-month window when the 3-month form can be completed, and the family re-engages in FHV after the 2-month window has ended, skip the 3-month form and resume data collection with the 6-month form.

### Item Instructions:

Intervals	Questions in the forms	Additional Guidance
3	Did the child's biological mother have a postpartum visit with a healthcare provider after childbirth?	Based on participant self-report. This question asks about a postpartum visit for maternal health; it may occur in conjunction with a child's well-child visit.
3	Date of postpartum visit:	Enter the approximate date of the mother's postpartum visit. If the exact date cannot be recalled, report the mother's best guess.
3, 6, 9, 12	Is the child currently being breastfed or receiving breastmilk?	<p>Select "01 Yes" if the child was fed any human milk, including donor milk.</p> <p>Select "03 Participant is not recommended to breastfeed because of a medical condition" if the participant has a contraindication to breastfeeding or giving the infant their pumped breastmilk.</p> <ul style="list-style-type: none"> <li>• Infant diagnosed with galactosemia</li> <li>• HIV positive status of mother</li> <li>• Mother taking antiretroviral medications</li> <li>• Mother has untreated, active TB</li> <li>• Mother is infected with human T-cell lymphotropic virus type I or type II (HTLV-I or HTLV-II)</li> <li>• Mother is using or is dependent on an illicit drug</li> <li>• Mother is taking prescribed cancer chemotherapy agents</li> <li>• Mother is undergoing radiation therapies</li> </ul> <p>See Contraindications to breastfeeding:  <a href="https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/Contraindications-to-breastfeeding.html">https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/Contraindications-to-breastfeeding.html</a> for more information.</p>

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Intervals	Questions in the forms	Additional Guidance
3, 12, 24, 36, 48, 60	“We worried whether our food would run out before we got money to buy more.” In the past 12 months, was this often true, sometimes true, or never true for the child’s household?	Choose one response.
3, 12, 24, 36, 48, 60	“The food we bought just didn’t last, and we didn’t have money to get more.” In the past 12 months, was this often true, sometimes true, or never true for the child’s household?	Choose one response.
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	What kind of place does the child usually go if she or he is sick, or if the caregiver needs advice about the child’s health?	<u>[Source of medical care definition]</u>
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	Specify other usual source of child’s medical care:	<u>[Open-ended some other place instructions]</u>
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	What kind of place does the child usually go when she or he needs routine or preventive care, such as a well-child visit?	<u>[Source of medical care definition]</u>
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	Specify other source of child’s preventive care:	<u>[Open-ended some other place instructions]</u>
All	Which well-child visit did the child have most recently?	Choose one response. See the Bright Futures/American Academy of Pediatrics Periodicity Schedule for more information: <a href="https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx">https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx</a>

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Intervals	Questions in the forms	Additional Guidance
All	What was the approximate date of the child's most recent well-child visit?	<u>[Date recall instructions]</u>
All	Is the child up-to-date on immunizations according to the CDC schedule?	<u>[Immunization schedule]</u>
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	Does the caregiver have a dentist that they can take their child to?	Choose one response.
3, 6, 9, 12	Does the caregiver place the child to sleep on their back?	Based on caregiver self-report of whether they always, sometimes, or never engage in this sleep practice.
3, 6, 9, 12	Does the child share a bed with anyone?	Based on caregiver self-report of whether they always, sometimes, or never engage in this sleep practice.
3, 6, 9, 12	Does the child sleep with soft bedding?	Based on caregiver self-report of whether they always, sometimes, or never engage in this sleep practice.
All	Do family members read to, tell stories to, or sing to the child every day during a typical week?	<u>[Question implementation instructions]</u>
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	Does the child currently have health insurance?	<u>[Insurance status definition]</u>
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	What type of health plan or health insurance does the child currently have?	<u>[Health plan or health insurance definition]</u>
6, 12, 18, 24, 30, 36, 42, 48, 54, 60, 66	Specify other health insurance:	<u>[Open-ended other health insurance instructions]</u>

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Intervals	Questions in the forms	Additional Guidance
12, 24, 36, 48, 60	In the last 12 months, has the primary caregiver ever been separated from the child (other than vacation or respite), such as because the caregiver went to jail or prison, because of inpatient alcohol or substance abuse treatment, because of hospitalization, or for any other reason?	Choose all that apply.
12, 24, 36, 48, 60	Specify other reason for caregiver's separation from child:	(Optional) If other reason for separation was selected for the previous question, provide a brief description of the reason.

## FHV Closure Form

**1. Date of FHV Program Closure:**

**2. What is the primary reason this participant is being closed from the FHV program?**

(choose one)

- 01 Completed program/Met goals
- 02 Caregiver returning to work or school
- 03 Child entering Head Start/preschool/Kindergarten
- 04 Caregiver no longer wants to receive services
- 05 Program is no longer able to provide services
- 06 Home visitor can no longer locate or contact client
- 07 Moved out of program's service area
- 08 Miscarriage/stillbirth/fetal death
- 09 Death of child
- 10 Loss of custody or termination of parental rights
- 11 Transfer to another agency
- 12 Death of caregiver
- 13 Incarceration of caregiver
- 14 Caregiver is no longer living with child
- 77 Other reason

**3. (Optional) If Other reason: Specify other primary closure reason:**

**4. (Optional) What is the secondary reason this participant is being closed from the FHV program, if any?**

(choose one)

- 01 Completed program/Met goals
- 02 Caregiver returning to work or school
- 03 Child entering Head Start/preschool/Kindergarten
- 04 Caregiver no longer wants to receive services
- 05 Program is no longer able to provide services
- 06 Home visitor can no longer locate or contact client
- 07 Moved out of program's service area
- 08 Miscarriage/stillbirth/fetal death
- 09 Death of child
- 10 Loss of custody or termination of parental rights
- 11 Transfer to another agency
- 12 Death of caregiver
- 13 Incarceration of caregiver
- 14 Caregiver is no longer living with child
- 77 Other reason

**5. (Optional) If Other reason: Specify other secondary closure reason:**

## Instructions for the FHV Closure Form

**General Guidelines:** Complete this form for each participant at the time of their exit from the FHV program.

**Item Instructions:**

Question Number	Questions in the forms	Additional Guidance
1	Date of FHV Program Closure:	Date that the participant was closed from the FHV program
2	What is the primary reason this participant is being closed from the FHV program?	<p>If more than one of these reasons applies, report the primary reason the participant is exiting from the FHV program from the perspective of the home visitor.</p> <p>“Caregiver no longer wants to receive services” includes: caregiver is no longer interested in program; caregiver is dissatisfaction with program or home visitor; caregiver is ending services due to influence/pressure from other family members</p> <p>“Program is no longer able to provide services” includes: loss of home visitor due to resignation or funding and program cannot accommodate this participant; program cannot accommodate participant’s schedule; other reasons related to program capacity.</p>
3	Specify other primary closure reason:	If “Other reason” is selected for the previous question, please write-in the other primary closure reason.
4	What is the secondary reason this participant is being closed from the FHV program, if any?	<p>Responding to this question is optional and not required. If there is a secondary reason why, report the secondary reason the participant is exiting from the FHV program from the perspective of the home visitor.</p> <p><u>[Additional information related to reason for closure response options]</u></p>
5	Specify other secondary closure reason:	If “Other reason” is selected for the previous question, please write-in the other secondary closure reason.

## FHV Home Visitor Form

**1. Start date for this home visitor's employment with the FHV Provider organization (MM/DD/YYYY):**

**2. End date for this home visitor's employment with the FHV Provider organization (MM/DD/YYYY):**

**3. What age group is the home visitor in?**

(choose one)

- 01 Under 25
- 02 25 to 29
- 03 30 to 34
- 04 35 to 39
- 05 40 to 44
- 06 45 to 49
- 07 50 to 54
- 08 55 to 59
- 09 60 to 64
- 10 65 and older
- 99 Declines to answer

**4. What is the highest level of education the home visitor has completed?**

(choose one)

- 01 Less than HS Diploma [SKIP to #6]
- 02 High School Diploma or GED [SKIP to #6]
- 03 Some college or post high school training [SKIP to #6]
- 04 Technical training or certificate [SKIP to #6]
- 05 Associate's degree [SKIP to #6]
- 06 Bachelor's degree or higher [SKIP to #6]
- 09 Other
- 99 Declines to answer[SKIP to #6]

**5. Specify other educational level completed:**

**6. What licensure, certification, or endorsement does the home visitor have, if any?**

(choose all that apply)

- 01 Licensed Practical Nurse (LPN)
- 02 Registered Nurse (RN)
- 03 Certified Public Health Nurse (PHN)
- 04 Advanced Practice Registered Nurse (APRN)
- 05 Licensed Social Worker (LSW)
- 06 Licensed Graduate Social Worker (LGSW)
- 07 Licensed Independent Social Worker (LISW)
- 08 Licensed Independent Clinical Social Worker (LICSW)
- 09 Community Health Worker (CHW)



- 10 Certified Health Education Specialist (CHES)
- 11 Master Certified Health Education Specialist (MCHES)
- 12 Infant Family Associate (IMH-E Level 1)
- 13 Infant Family Specialist (IMH-E Level 2)
- 14 Infant Mental Health Specialist (IMH-E Level 3)
- 15 Infant Mental Health Mentor (IMH-E Level 4)
- 16 Certified Lactation Counselor (CLC)
- 17 International Board Certified Lactation Consultant (IBCLC)
- 18 Child Passenger Safety Technician (CPST)
- 19 Child Development Associate (CDA)
- 20 Home Visitor Child Development Associate (HV CDA)
- 21 Family Service Credential
- 77 Other
- 88 None
- 99 Declines to answer

**7. If Other, specify other licensure, certification, or endorsement completed:**

**8. What evidence-based home visiting model is the home visitor trained in, if any?**

(choose one)

- 01 Healthy Families America [SKIP to #13]
- 02 Nurse-Family Partnership [SKIP to #13]
- 03 Family Spirit [SKIP to #13]
- 04 Family Connects [SKIP to #13]
- 05 Parents As Teachers [SKIP to #13]
- 06 Early Head Start [SKIP to #13]
- 07 Maternal Early Childhood Sustained Home-visiting [SKIP to #13]
- 66 Other evidence-based home visiting model
- 88 None [SKIP to #13]
- 99 Declines to answer [SKIP to #13]

**9. Specify other evidence-based home visiting model:**

**10. If the home visitor is not trained in an evidence-based home visiting model, will the home visitor be trained in a model while working for this organization?**

(choose one)

- 01 Yes
- 02 No [SKIP to #13]
- 88 Unknown [SKIP to #13]
- 99 Declines to answer [SKIP to #13]

**11. Specify which model the home visitor will be trained in:**

(choose one)

- 01 Healthy Families America [SKIP to #13]
- 02 Nurse-Family Partnership [SKIP to #13]
- 03 Family Spirit [SKIP to #13]
- 04 Family Connects [SKIP to #13]
- 05 Parents As Teachers [SKIP to #13]
- 06 Early Head Start [SKIP to #13]
- 07 Maternal Early Childhood Sustained Home-visiting [SKIP to #13]
- 66 Other evidence-based home visiting model
- 99 Declines to answer [SKIP to #13]

**12. Specify other evidence-based home visiting model:****13. How much experience providing home visiting services does the home visitor have, in years and months?**

Years:

Months:

- Check if home visitor declines to provide length of experience providing home visiting services

**14. How does the home visitor identify their gender?**

(choose one)

- 01 Male
- 02 Female
- 03 Does not identify as male or female
- 99 Declines to answer

**15. Is the home visitor a member of any of the following ethnic or cultural groups?**

(choose all that apply)

- 01 Hispanic or Latino/a/x
- 04 Somali
- 05 Hmong
- 77 Other ethnic group
- 99 Declines to answer

**16. How does the home visitor identify their race?**

(choose all that apply)

- 01 American Indian or Alaska Native
- 02 Asian
- 03 Black or African American
- 04 Native Hawaiian or Other Pacific Islander
- 05 White
- 06 Other race
- 99 Declines to answer

**17. (Optional) If Other race, specify other race:**

**18. (Optional) If American Indian or Alaska Native, how does the home visitor describe their tribal affiliation(s)?**

**19. What language(s) does the home visitor use when serving families?**

(choose all that apply)

- 01 English
- 02 Hmong
- 03 Somali
- 04 Spanish
- 05 Amharic
- 06 Arabic
- 07 Burmese
- 08 Karen
- 09 Nepalese
- 10 Oromo
- 77 Other language
- 99 Client declines to answer

**20. If Other language, specify other language used by home visitor when serving families:**

## Instructions for the FHV Home Visitor Form

**General Guidelines:** Home visitors should complete this form at the time of hire by the FHV Provider, and update annually.

Please review the Home Visitor Notice of Collection of Private Data available on the MDH website: <https://www.health.state.mn.us/docs/communities/fhv/datacollection.pdf>

### Item Instructions:

Question Number	Questions in the forms	Additional Guidance
1	Start date for this home visitor's employment with the FHV Provider organization:	Enter the home visitor's employment start date with their current agency.
2	End date for this home visitor's employment with the FHV Provider organization:	Responding to this question is not required. If the visitor is currently employment with the FHV Provider organization, do <b>not</b> enter a date.
3	What age group is the home visitor in?	Choose one response.
4	What is the highest level of education the home visitor has completed?	Choose one response.
5	Specify other educational level completed:	If "Other" is selected for the previous question, please write-in the name of the other educational level completed.
6	What licensure, certification, or endorsement does the home visitor have, if any?	Choose all that apply.
7	Specify other licensure, certification, or endorsement completed:	If "Other" is selected for the previous question, please write-in the name of the other licensure, certification, or endorsement completed.

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Question Number	Questions in the forms	Additional Guidance
8	What evidence-based home visiting model is the home visitor trained in, if any?	Choose one response. Report an EBHV model if the home visitor has <b>completed</b> the training required by the model developer for home visitors. If the home visitor is trained in more than one model, report the model that the home visitor is currently providing services in. Do not report training in stand-alone curricula (e.g. Growing Great Kids) as an EBHV model; home visitors who have completed GGK as part of their HFA training should report HFA as their model (if they have completed all other HFA training requirements).
9	Specify other evidence-based home visiting model:	If “Other evidence-based early childhood home visiting model” is selected for the previous question, please write-in the name of the other evidence-based home visiting model.
10	If the home visitor is not trained in an evidence-based home visiting model, will the home visitor be trained in a model while working for this organization?	Choose one response.
11	Specify which model the home visitor will be trained in:	Choose one response.
12	Specify other evidence-based home visiting model:	<u>[Open-ended other evidence-based home visiting model instructions]</u>
13	How much experience providing home visiting services does the home visitor have, in years and months?	Answer with the length of the home visitor’s experience in years and months (for example, 5 years 6 months). If the home visitor declines to answer, check the box next to “Check if home visitor declines to provide length of experience providing home visiting services” and leave the years and months blank.
14	How does the home visitor identify their gender?	Choose one response.

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Question Number	Questions in the forms	Additional Guidance
15	Is the home visitor a member of any of the following ethnic or cultural groups?	Choose one response. "Other ethnic group" includes all ethnicities/ancestries that are not specifically listed. If the home visitor does not indicate Hispanic, Latino/a/x, Hmong, or Somali ethnicity, choose "Other ethnic group" unless the home visitor declines to answer.
16	How does the home visitor identify their race?	Choose all that apply.
17	(Optional) if Other race, Specify other race:	If "Other" is selected for the previous question, please write-in the other race based on the home visitor's self-description.
18	(Optional) If American Indian or Alaska Native, how does the home visitor describe their tribal affiliation(s)?	"Tribal affiliation" is defined as the American Indian tribe or Indigenous community to which the home visitor reports attachment. The home visitor does not need to be an enrolled member of a tribe.
19	What language(s) does the home visitor use when serving families? Select all that apply.	Choose all that apply. Note that the language(s) used by the home visitor when serving families may differ from that primarily spoken by the home visitor.
20	Specify other language used by home visitor when serving families:	[Open-ended other language instructions]

## Definitions

**Interpreter:** is defined as a paid professional or paraprofessional interpreter participating in the home visit to translate between the home visitor and the family. Do not include family members or others who are not paid to provide interpreter services.

**Employed full-time** is defined as working 30 or more hours per week. This may be at one job, or a combination of two or more jobs.

- If employment hours vary from week to week, ask the Primary Caregiver to select a response based on the average number of hours worked per week.
- If employment is seasonal, report level of employment at the time of assessment.
- If the Primary Caregiver is on parental leave from a job and will return to that job at the end of the leave, respond to this question according to the number of hours worked prior to the parental leave.

### FHV Model and Program Types

Choose the home visiting model or program type being used to deliver FHV services to the participant. Select only one model or program type for each participant. Note that participants within a case may have different FHV model or program types; for example, a family may have a Primary Caregiver and a Target Child served with a particular FHV Model, plus an Other Child served with other (non-model) long-term home visiting.

- **Specific models (Healthy Families America, Nurse-Family Partnership, Family Spirit, Family Connects, Parents As Teachers, Early Head Start, Maternal Early Childhood Sustained Home-visiting, Other evidence-based early childhood home visiting model eligible for MIECHV)** should only be indicated if the service provider is accredited, affiliated, or otherwise recognized by the model developer as an implementing agency, the home visitor is trained in the model, and the participant meets model criteria for enrollment in the program.
- **Other, long-term home visiting program:** Includes early childhood home visiting services that are comprehensive in scope and intended to achieve long-term outcomes, but are not provided using one of the home visiting models listed above. FHV services that use a curriculum (such as Growing Great Kids) but are not provided by a program accredited/affiliated with a model developer should be reported in this category.
- **Other, short-term/limited:** Includes early childhood home visiting services for screening, assessment, and/or referral purposes, achieving short-term goals, or another limited purpose. This includes universal or targeted postpartum home visiting programs that are intended to last a short period of time, that may refer families to long-term FHV programs or other services.

### Household Size and Income

**Household:** is defined as a group of related or non-related individuals who are living together as one economic unit, sharing income and consumption of goods and/or services, who stay there at least 4 nights per week on average and contribute to the support of the child or Primary Caregiver. Tenants/boarders shall not be counted as members of the household. Note that the household may include persons who are not participating in the FHV program.

**Pregnant women should be counted as two (2) people when determining household size.**

**Household monthly income definition:**

Include the total of all income received by all members of the Primary Caregiver's household, monthly, before taxes (gross income). Include income from:

- work
- rent from tenants/boarders
- cash assistance from friends/relatives
- child support payments
- MFIP and other cash assistance programs
- Social Security (SSI/SSDI/OAI)
- Unemployment benefits

If it is easier for the caregiver to provide annual income, divide the annual amount by 12 to estimate monthly income.

**Housing Status**

**Homeless:** is defined as lacking a fixed, regular, and adequate nighttime residence. This includes participants that are currently living with someone else temporarily due to economic hardship or lack of alternatives.

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

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

**Homeless - 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; individuals who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.

**Not Homeless, Owns or shares own home, apartment, etc.:** individuals who own their housing, or share housing with the homeowner on a long-term basis.

**Not Homeless, Rents or shares rented home or apartment:** individuals who rent their housing, or share housing with a renter on a long-term basis.

**Not Homeless, Lives in public housing:** individuals who live in an affordable public housing unit under the US Dept of Housing and Urban Development (HUD) public housing program.

**NOTE:** this does **not** include Section 8 housing assistance/housing choice vouchers. Individuals using housing choice vouchers to rent housing should be reported under "Rents or shares rented home or apartment."

**Not Homeless, Lives with parent or family member:** individuals who live with a parent or family member, who are not reported under "Owns or shares own home" or "rents or shares rented home." This includes adolescent Primary Caregivers who are living with their parent(s) or other family members, where the parent(s) or family members are the homeowner or renter.



**Not Homeless - Some other arrangement:** individuals who are not homeless as defined above, and who do not fall into the other categories.

### Insurance Coverage

**Insurance Status:** Note that insurance status is different from access to health care services. An uninsured participant may be receiving care from a safety net provider such as an FQHC or Community Health Center. Indian Health Service is not an insurance program.

**Participant applied for coverage, application is pending:** Select this response if the caregiver has completed and submitted an application for health insurance coverage (such as MNSure, MN Health Care Programs, or private insurance), and is currently waiting for a decision from the insurer.

Home visitors who encounter families who do not have health insurance coverage are encouraged to refer to [MNSure \(https://www.mnsure.org/\)](https://www.mnsure.org/).

### Health Plan or Health Insurance

**Private Insurance** includes group insurance coverage such as through a job, and individual plans purchased through MNSure.

**Public Insurance** includes any Minnesota Health Care Programs (MHCP): Medical Assistance (MA), Prepaid Medical Assistance Program (PMAP), and MinnesotaCare.

**Military Health Care** includes TRICARE, CHAMPVA, or other military health insurance.

### Sources of Medical Care definition:

**Target Child's usual source of medical care:** the particular medical professional, doctor's office, clinic, health center, or other place where a person would usually go if sick or in need of advice about their child's health.

**Federally Qualified Health Centers (FQHCs):** A list of Minnesota FQHCs can be found on the MDH website: <https://www.health.state.mn.us/facilities/underserved/healthcenter.html>

### Grant or Funding Source

Select all MDH grants or funding sources that are used to provide FHV services to this participant. If non-MDH funding, such as grants not administered by MDH, third-party reimbursement, or local tax levy funding, is used to provide FHV services to this participant, select "Other non-MDH funding source" (alone or in addition to MDH grant funding). See comments below regarding specific MDH funding sources.

- **MIECHV Formula and MIECHV Expansion:** Strong Foundations grantees should use these categories as directed by MDH. Participants in these categories should be members of a MIECHV household as defined below.
- **MN NFP Grant:** Strong Foundations grantees should use this category as directed by MDH.
- **MN EBHV Grant:** Strong Foundations grantees should use this category as directed by MDH.
- **TANF:** Use this category if the participant is eligible to be served by an FHV TANF grant.
- **MCH Block Grant:** Use this category if the participant was served by MCH Block Grant (Title V) funding.
- **Promising Practice FHV Grant:** Use this category if the participant was served by Promising Practice FHV Grant funding.

**MIECHV household:** A household or family served by a trained home visitor implementing services with fidelity to the model who is funded at 0.25 FTE or greater by MIECHV grants (personnel costs, including salary/wages and benefits). MIECHV households should reside in one of the at-risk communities identified in the most recent MIECHV Needs Assessment.

**Other terms**

**Incarceration:** Incarceration refers to a participant who is in jail or prison for a significant period of time that would prevent the individual from engaging in family home visiting services.

## Version History

Version Number	Release Date	Changes
N/A	12/31/2019	Original version
1.1	6/30/2023	<p>Form changes:</p> <ul style="list-style-type: none"> <li>FHV Case Intake Form: Fixed typo - should be "Date of First Home Visit" not "Date of Home Visit"</li> <li>All Intake forms and Home Visitor Form: Added Maternal Early Childhood Sustained Home-visiting (MECSH) model to all model questions</li> <li>All Intake forms: Added Promising Practice FHV Grant to all grant or funding source questions</li> <li>Home Visitor Form Fixed skip pattern error: if trained in any model for question 8, then should skip to question 13, not question 10</li> </ul> <p>Guidance updates:</p> <ul style="list-style-type: none"> <li>FHV Model and Program Types: Added note that different family members can have different FHV model/program types; clarified criteria for indicating that a participant is being served with a model</li> <li>Key Concepts, Target Child and Other Child: added note about upper age limit ("Note that Other Children served by FHV should be infants, toddlers, or preschool-aged; children enrolled in Kindergarten or older should not be reported to IHVE.")</li> <li>Primary Caregiver Intake, question 21 ("Does the participant currently use tobacco, such as cigarettes, cigars, chewing tobacco, or electronic cigarettes (excluding religious or ceremonial use)?"): Added guidance that this question is asking about the Primary Caregiver's use of commercial tobacco.</li> <li>Primary Caregiver Intake, questions 26 and 27 ("Has the participant ever been involved with child welfare services as a child/as a parent?"): Updated guidance to "Based on Primary Caregiver's self-report of involvement or interaction with the child welfare system, such as an assessment, investigation, or services including Parent Support Outreach Program (PSOP)."</li> <li>Primary Caregiver Intake, question 32 ("In what year was the participant most recently in prison?"): Added guidance "Include any incarceration (jail or prison)."</li> <li>Screening Form, questions 8, 11, 14, 17, 19 ("What was the screening result?"): Updated guidance to "Choose one response ("Concern identified" or "No concern identified") based on the result of the screening tool." Kept additional guidance for ASQ-3 and ASQ-SE results.</li> <li>Intake forms, Grant or Funding Source question guidance: Updated guidance for MIECHV Formula, MIECHV Expansion, MN NFP Grant, and MN EBHV Grant to align with 2023 Strong Foundations grant awards. Added guidance for Promising Practices FHV Grant awards.</li> </ul>