Healthy Start Background Information Form | June 2025

OMB Control No. 0915-0338, Expiration Date 09/30/2026

INFORMATION IN THIS BOX IS FOR GRANTEE RECORDS ONLY—DO NOT UPLOAD

Name of Participant/Other Adult: _____ Date of Birth:_____

Name(s) & Date(s) of Birth of Other Linked Participants (up to 2 people, as applicable):

Name of Other Linked PP #1: _____ Date of Birth:_____

Name of Other Linked PP #2: _____ Date of Birth:_____

Name of Interviewer: _____

Names and dates of birth are included above for grantee tracking purposes only and should not be submitted to HRSA.

GENERAL INSTRUCTIONS

- This background form must be completed with all participants enrolled in Healthy Start for preconception, prenatal, postpartum, or parenting/interconception case management/care coordination services; an enrolled father or partner; or an "other adult" who is not enrolled in the program but has primary responsibility for/custody of an enrolled child.
- This form must be administered by a trained case worker or other Healthy Start grantee staff member to ensure consistency in responses across participants. It should not be self-administered or administered by staff who have not received training.
- Every form should include the individual's Unique ID# (UID) in Question G1. Each person's UID should remain the same across phases and years of participation in the program and should be in the format noted in Question G1.
- If there is more than one enrolled participant in the family unit (other than an enrolled child), the UIDs must appear together on this form so that all associated participants can be linked in the database. Participant linkages are made using Question G2 of this form, "other linked primary participant". Enrolled children are linked to participants using the Parent/Child form; do not enter ChildUIDs in this form.

See the next page for additional instructions.

When to complete this form:

- **For enrolled case management/care coordination (CM/CC) participants** (an individual who is enrolling, or is already enrolled in Healthy Start for case management/care coordination services):
  - Complete this form when an individual first enrolls in the Healthy Start program.
  - Update/re-screen this form when the participant enters the prenatal phase, ends the prenatal phase, their enrolled child turns 6 months, and when they exit the Healthy Start program.
- **For "other adults"** (individuals not enrolled in Healthy Start who have primary responsibility for/custody of an enrolled child):
  - Complete this form with the caregiver when the child is enrolled into the program.
  - Update/re-screen this form when the enrolled child turns 6 months, and when the child exits the Healthy Start program.

How to update/re-screen this form:

- To perform a re-screen:
  1. Select "Updated form" in Question G4.
  2. Select a reason for the update from the provided list (example: "enrolled participant enters prenatal phase").
  3. Complete the corresponding "Date of update" field by entering the date the form is being updated/re-screened.
  4. Re-screen Questions 1-20 with the participant/other adult.
- **Other update** – there are three additional re-screening scenarios:
  - Annual re-screening – when a year has elapsed since a participant's/other adult's last screening/update, re-screen the Background form. Select "Updated form" in Question G4, select "Other update" as the reason, complete the "Date of update" field by entering the date the form is being updated, and re-screen Questions 1-20.
  - Re-enrollment – when a participant exits the program for any reason and then enrolls again at a later date ("re-enrolls"), re-screen the Background form. Select "Updated form" in Question G4, select "Other update" as the reason, complete the "Date of update" field by entering the date the form is being updated, and re-screen Questions 1-20. Only re-screen Questions 21-25 with participants who have been or can become pregnant.
  - Updates to single questions or sections – to update/re-screen a single question or section of the form (such as to add an "Other linked primary participant" in Question G2), select "Updated form" in Question G4, select "Other update" as the reason, complete the "Date of update" field by entering the date the form is being updated, and re-screen the applicable question(s).

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[GENERAL INFORMATION to be completed by staff:]

G1. This individual's Unique ID#: _____

[Enter as one number: Grantee Org Code + PP + Client's Unique ID (example: 123PP45678)]

G2. Other enrolled participants/"other adults" linked to this individual:

(Enter up to 2 & use format in question G1; do not enter ChildUIDs)

☐ **Other Linked Participant/Adult ID #1:** _____

☐ **Other Linked Participant/Adult ID #2:** _____

- OR -

☐ **No other participants/adults are linked to the individual completing this form**

G3. Date of this participant's <u>FIRST</u> enrollment into Healthy Start case management/care coordination:

(Select only one)

☐ **Initial Enrollment Date:** _____ *(mm/dd/yyyy)*

- OR -

☐ **Not applicable** (individual is an "other adult")

G4. This form is an…

(Select one)

☐ **Initial form** (this is the first time the individual is completing the form)

⇨ ***Date of initial form completion:*** _____ *(mm/dd/yyyy)*

☐ **Updated form** (the individual has completed this form before and is being screened again)

<u>Reason for update</u> *<u>(Select one)</u>***<u>:</u>**

☐ **Enrolled participant enters prenatal phase**

⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*

☐ **Enrolled participant ends prenatal phase**

⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*

☐ **Enrolled child turns 6 months**

⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*

☐ **Enrolled participant is exiting Healthy Start**

⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*

☐ **Other update**

⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*

(ADMINISTRATIVE) *Check the box below if this form is a correction to a version already uploaded to the Healthy Start Monitoring and Evaluation Data System (HSMED). Otherwise, leave this box blank.*

☐ This form is a correction.

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[Staff – Please read the following statement to the participant:]

This questionnaire should take about 25 minutes to complete. Any information you provide will be kept confidential. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits.

Participant General Information

1. Are you currently pregnant?

(Select one)

- ☐ **Yes**
- ☐ **No/Not Applicable**
- ☐ **Don't know**
- ☐ **Declined to answer**

2. Are you currently parenting a child(ren) less than 18 months old?

(Select one)

- ☐ **Yes, I am parenting _____ child(ren)** (enter # of children less than 18 months old) (Staff: Complete a mandatory Parent/Child Form for each child less than 18 months old who is enrolling/enrolled in Healthy Start)
- ☐ **No**
- ☐ **Declined to answer**

Participant Health Care

Next, I'd like to ask you some questions about your current health care. Collecting this information gives us a better idea of our participants' experiences and needs so we can improve the services we offer.

3. During the <u>past 12 months</u>, did you see a doctor, nurse, or other health care professional for PREVENTIVE medical care, such as a physical or well-visit checkup? A preventive check-up is when you are not sick or injured, such as an annual or sports physical, or well-visit. [Staff: Include prenatal and postpartum care visits as preventive visits]

(Select one)

- ☐ **Yes**
- ☐ **No**
- ☐ **Don't know**
- ☐ **Declined to Answer**

4. During the <u>past 12 months</u>, were you EVER covered by ANY kind of health insurance or health coverage plan?

(Select one)

- ☐ **Yes, I was covered all 12 months**
- ☐ **Yes, but I had a gap in coverage**
- ☐ **No**
- ☐ **Don't know**
- ☐ **Declined to answer**

5. What kind of health insurance do you have <u>now</u>?

(Select all that apply)

	Insurance Type	Participant's Response(s)
a.	**Private health insurance from my job or the job of my spouse or partner**	☐
b.	**Private health insurance from my parents**	☐
c.	**Private health insurance from the** <State> **Health Insurance Marketplace or** <state website> **or HealthCare.gov**	☐
d.	**Medicaid (Title XIX)** (Specify state Medicaid name:_____)	☐
e.	**Medicare** (for individuals with disabilities)	☐
f.	**Medicare** (for individuals over age 65)	☐
g.	**CHIP (Title XXI)**	☐
h.	**Subsidized ACA plan** (also called 'subsidized premium or subsidized coverage through the Affordable Care Act')	☐
i.	**TRICARE or other military health care**	☐
j.	**Indian Health Service or tribal**	☐
k.	**Other health insurance** (do not include private plans that only pay for one type of service such as family planning, accidents, or dental care.) (Specify other insurance name: _____)	☐
l.	**I do not have health insurance now**	☐
m.	**Don't know**	☐
n.	**Declined to answer**	☐

Personal Well-Being

Over the next few questions, I'm going to ask you about how you're doing in day-to-day life, that is, your own sense of personal well-being. I'll start with a couple of questions about income because the financial resources available to us can have a big impact on stress in our daily lives.

6. During the <u>past 12 months</u>, what was your yearly total household income before taxes? Include all sources of income for individuals living in your household, including your income, your spouse's or partner's income, your parents' income (if in same household), and any other income you may have received. All information will be kept private and will not affect any services you are now getting.

(Select one)

☐ **_____ dollars**

☐ **Don't know**

☐ **Declined to answer**

7. During the <u>past 12 months</u>, how many people, including yourself, depended on this income? (A pregnant individual counts as one person)

(Select all that apply)

- ☐ **Adults age 18 or older:** _____ (# of adults)
- ☐ **Children age 17 or younger:** _____ (# of children)
- ☐ **Don't know**
- ☐ **Declined to answer**

8. Which of these statements best describes the food situation in your household in the <u>past 12 months</u>?

(Select one)

- ☐ **We could always eat good nutritious meals**
- ☐ **We always had enough to eat but not always the kinds of food we should eat**
- ☐ **Sometimes we didn't have enough to eat**
- ☐ **Often we didn't have enough to eat**
- ☐ **Declined to answer**

9. Has your family consistently had adequate housing over the <u>past 12 months</u>?

(Select one)

- ☐ **Yes**
- ☐ **No**
- ☐ **Declined to answer**

10. Do you feel safe where you are living <u>now</u>?

(Select one)

- ☐ **Most of the time**
- ☐ **Some of the time**
- ☐ **Rarely**
- ☐ **Never**
- ☐ **Declined to answer**

11. In the <u>past 12 months</u>, has lack of transportation kept you from medical appointments, community resources, meetings, work or from getting things needed for daily living?

(Select all that apply)

- ☐ **Yes, it has kept me from medical appointments, getting medications, or other community resources (such as Healthy Start education classes, WIC, etc.)**
- ☐ **Yes, it has kept me from work, school, or getting things that I need for daily living**
- ☐ **No**
- ☐ **Declined to answer**

Next, I'm going to ask you a couple of questions about how your mood has been lately.

12. Over the last 2 weeks, how often have you been bothered by the following problems?

[Staff: Read each item to the individual and check one response for each item. A Total Score of 3 or more indicates possible additional screening and referral is needed.]

	Mood	Not at all	Several Days	More than half the days	Nearly every day	TOTAL	Declined to answer
a.	**Little interest or pleasure in doing things**	☐ 0	☐ 1	☐ 2	☐ 3		☐
b.	**Feeling down, depressed, or hopeless**	☐ 0	☐ 1	☐ 2	☐ 3		☐
					TOTAL SCORE		

13. [Staff: Please indicate whether a referral for follow-up services related to possible depression was provided.]

(Select one)

- ☐ **Yes, a referral for follow-up services was provided or the participant is already receiving services for depression or possible depression**
- ☐ **No, a referral for follow-up services was not provided because…** *(select one reason)*
  - ☐ **The participant's score was less than 3 and did not indicate a need for referral**
  - ☐ **The participant declined referral**
  - ☐ **Unable to administer screening or participant declined to answer**

The next couple questions are sensitive in nature and can be uncomfortable to answer. Please know that I ask everyone the same questions. It's important to answer honestly so we can provide the best services to you. Your answers will not change what I think of you or how we work together. Your answers will not change our relationship or how you're viewed or treated.

The first questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the types of substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

14. In the past 12 months, how often have you…? [Staff: Read the substance types and answers to the individual and check one response for each type of substance.]

	Substance Type	Daily or Almost Daily	Weekly	Monthly	Less than Monthly	Never	Declined to answer
a.	Used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?	☐	☐	☐	☐	☐	☐
b.	**For women:** Had 3 or more drinks containing alcohol in one day? **For men**: Had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.	☐	☐	☐	☐	☐	☐
c.	Used any cannabis product?	☐	☐	☐	☐	☐	☐
d.	Used any illicit drugs including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?	☐	☐	☐	☐	☐	☐
e.	Used any prescription medications just for the feeling, more than prescribed, or that were not prescribed for you? Prescription medications that may be used this way include: Opioid pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)	☐	☐	☐	☐	☐	☐

15. [Staff: Please indicate whether a referral for follow-up services related to cigarette/tobacco use was provided. Follow-up services may include further screening, education, and/or intervention.]

(Select one)

- ☐ **Yes, a referral for follow-up services was provided or the participant is already receiving services for tobacco cessation**
- ☐ **No, a referral for follow-up services was not provided because…** *(select one reason)*
  - ☐ **The participant did not use any tobacco products in the last 12 months**
  - ☐ **The participant no longer uses tobacco products**
  - ☐ **The participant declined referral**
  - ☐ **Unable to administer screening or participant declined to answer**

We are concerned about the safety of all participants. Please answer the following questions so that we can help you if needed.

16. During the past 12 months, has anyone… [Staff: Read each item to the individual and check all responses that apply for each item.]

	During the past 12 months has anyone…	Current or Former Intimate Partner	Other Family Member	Someone Else	No-one	Declined to answer
a.	Threatened you or made you feel unsafe in some way?	☐	☐	☐	☐	☐
b.	Made you feel frightened for your safety or your family's safety because of their anger or threats?	☐	☐	☐	☐	☐
c.	Tried to control your daily activities, for example, control who you could talk to or where you could go?	☐	☐	☐	☐	☐
d.	Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?	☐	☐	☐	☐	☐
e.	Forced you to take part in touching or any sexual activity when you did not want to?	☐	☐	☐	☐	☐

17. [Staff: Please indicate whether a referral for follow-up services related to interpersonal violence was provided.]

(Select one)

- ☐ **Yes, a referral for follow-up services was provided or the participant is already receiving appropriate services**
- ☐ **No, a referral for follow-up services was not provided because…** *(Select one reason)*
  - ☐ **The participant did not indicate experiencing interpersonal violence**
  - ☐ **The participant declined referral**
  - ☐ **Unable to administer screening or participant declined to answer**

[Staff: If any of the above screenings were not completed, please screen on the next visit.]

- **"Other adults": This form is now complete. Complete the Parent/Child Form for the enrolled child.**
- **CM/CC participants: Complete the "Reproductive Health" section below.**

Reproductive Health

Next, I have a few questions about your thoughts on having (more) children. This information will help me support you in making decisions about whether and when you might have (more) children.

18. Do you want any (more) children?

(Select one)

- ☐ **Yes** [Complete Q18a]
- ☐ **No** [Skip to Q19]
- ☐ **Don't know** [Skip to Q19]
- ☐ **Declined to answer** [Skip to Q19]

18a. How long do you plan to wait until you/your partner becomes pregnant (again)?

(Select one)

- ☐ **0 – 11 months**
- ☐ **12 – 17 months**
- ☐ **18 – 23 months**
- ☐ **24 months +**
- ☐ **Unable to get pregnant/Partner unable to get pregnant**
- ☐ **Don't know**
- ☐ **Declined to answer**

19. Are you currently using a condom to prevent sexually transmitted infections?

(Select one)

- ☐ **Yes**
- ☐ **No**
- ☐ **No – Married or partnered**
- ☐ **No – Not sexually active**
- ☐ **Declined to answer**

20. What kind of birth control are you currently using to keep from getting pregnant before you are ready? If you are currently pregnant/expecting, what method do you plan to use to prevent becoming pregnant again before you are ready?

(Select all that apply)

- ☐ **Tubes tied or blocked** (female sterilization or Essure®)
- ☐ **Vasectomy** (male sterilization)
- ☐ **Birth control pills**
- ☐ **Condoms**
- ☐ **Shots/injections** (Depo-Provera®)
- ☐ **Contraceptive patch/vaginal ring** (OrthoEvra®/NuvaRing®)
- ☐ **IUD** (Mirena®, ParaGard®, Liletta®, or Skyla®)
- ☐ **Contraceptive implant in the arm** (Nexplanon® or Implanon®)
- ☐ **Natural family planning** (including rhythm method)
- ☐ **Withdrawal** ("pulling out")
- ☐ **Not having sex** (abstinence)
- ☐ **Unable to get pregnant/Partner unable to get pregnant**
- ☐ **None**
- ☐ **Declined to answer**

[Staff: A satisfactory reproductive life plan (RLP) is defined by an individual's responses to Questions 18, 18a, & 20. That is, if the individual doesn't want (more) children (Q18), they have identified a method of birth control to use to prevent pregnancy (Q20); if the participant does want (more) children (Q18), they have thought about their spacing (Q18a), and how to prevent pregnancy until they are ready (Q20). If the individual's responses leave them vulnerable to unplanned pregnancies, provide education and support to assist them in developing a satisfactory RLP.]

- **CM/CC male participants: This form is now complete. Complete the Parent/Child Form if he has an enrolled child.**
- **CM/CC female participants: Complete the "Pregnancy and Childbirth History" and "Previous Births" section below.**

Pregnancy and Childbirth History

[Staff – Complete with enrolled participants who have been or can become pregnant only]

Next, I'd like to ask you some questions about your pregnancy and childbirth history.

21. Have you ever had any of the following?

(Select all that apply and enter appropriate number)

- ☐ **Live birth** – **How many?** _____ (# of live births)
  - ⇨ **How many were singleton births?**_____ (# of singleton live births)
  - [Staff: A "singleton" birth is the birth of only one child during a single delivery]
- ☐ **Pregnancy that did not result in a live birth** *(check all that apply and enter number)*
  - ☐ **Ectopic or tubal pregnancy** – Number: _____
  - ☐ **Miscarriage** (pregnancy ended spontaneously before 20 weeks) Number: _____
  - ☐ **Stillbirth or fetal death** (pregnancy ended at 20 weeks or more) Number: _____
  - ☐ **Termination of pregnancy**, Number: _____
- ☐ **None of the above** – I have not had a pregnancy in the past
- ☐ **Declined to answer**

- **If participant hasn't had a live birth, had only pregnancies that did not result in a live birth, or declined to answer Question 21, this form is complete.**
- **If participant has had a live birth (Question 21), complete the "Previous Births" section below.**

Previous Births

[Staff – Complete only for enrolled participants who have had a previous live birth (Q21). If participant becomes distressed at any point, use your judgement about continuing the interview. If necessary, complete this form and any additional required forms within 30 days of first beginning this interview]

To finish, I'd like to ask you a few questions about your previous births.

22. A preterm birth is one that occurs before the 37th week of pregnancy. Have you had a preterm birth in the past?

(Select one)

- ☐ **Yes - How many?** _____ (# of preterm births)
- ☐ **No**
- ☐ **Don't know**
- ☐ **Declined to answer**

23. Did any of your babies weigh LESS than 5 pounds, 8 ounces* [2500 grams] *at birth?

(Select one)

- ☐ **Yes** [Complete Q23a] –
  - ⇨ **How many?** _____ (# of low birthweight babies)
  - ⇨ **How many were multiples (such as twins or triplets)?** _____ (# of babies)
- ☐ **No** [Skip to Q24]
- ☐ **Don't know** [Skip to Q24]
- ☐ **Declined to answer** [Skip to Q24]

23a. Of your babies who were born weighing less than 5 pounds, 8 ounces, did any of them weigh LESS THAN 3 pounds, 5 ounces* [1500 grams] *at birth?

(Select one)

- ☐ **Yes - How many?** _____ (# of babies)
- ☐ **No**
- ☐ **Don't know**
- ☐ **Declined to answer**

24. Did any of your babies weigh more than 9 pounds 4 ounces [4500 grams] at birth?

(Select one)

- ☐ **Yes, How many?** _____ (# of babies)
- ☐ **No**
- ☐ **Don't know**
- ☐ **Declined to answer**

25. In order to offer you the best, most sensitive service I can, can you tell me if you've ever lost a baby or child after they were born?

(Select one)

- ☐ **Yes** [Complete Q25a & Q25b]
- ☐ **No** [this form is complete]
- ☐ **Declined to answer** [this form is complete]

25a. [Staff: If participant indicates the prior loss of a child in previous question, sensitively ask about the number of babies/children.]

- ☐ **Number of babies/children participant has lost:** _____
- ☐ **Declined to answer**

25b. [Staff: Sensitively ask about the child's or children's age(s) at death and record below:]

- ☐ **Number of children who died within 0 to 27 days of life** (neonatal): _____
- ☐ **Number of children who died 28 to 364 days after birth** (infant): _____
- ☐ **Number of children who died at 12 months/365 days or older** (post-infancy): _____
- ☐ **Declined to answer**

The Healthy Start Background Information Form is Complete. Thank you!