Initial Contact Form

1. Last Name: *

5. Form Date: *

6. Worker: *

2. First Name: *

3. Other Name: (e.g., maiden)

4. Birth Date: *

7. Lives in target area?

- Yes
- No
- Unknown

8. Primary/Preferred Language: *

- English
- Spanish
- Arabic
- Bengali
- Chinese
- French
- Haitian-Creole
- Italian
- Korean
- Polish
- Russian
- Urdu
- Yiddish
- Albanian
- Cantonese
- German
- Greek
- Hindi
- Japanese
- Mandarin
- Tagalog
- Other:

9. Would you like to become pregnant in the next year?

- Yes
- No
- Unsure

Demographics As reported by client.

10a. Sex Assigned At Birth: *

- ○ Female
- ○ Male
- ○ Indeterminate

10b. Gender Identity: *

- ○ Female
- ○ Male
- ○ Non-binary
- ○ Transgender Female
- ○ Transgender Male
- ○ Declined To Answer
- ○ Indeterminate
- ○ Other:

10c. Sexual Orientation:

- ○ Bisexual
- ○ Lesbian, Gay or Homosexual
- ○ Straight or Heterosexual
- ○ Unknown
- ○ Asked, But Unknown
- ○ Other:

11. Ethnicity: *

- ○ Hispanic/Latinx
- ○ Not Hispanic/Latinx
- ○ Declined to self-identify

12. Race: (Check all that apply) *

- ☐ White
- ☐ Black/African-American
- ☐ Asian (Unspecified)
- ☐ Asian (Bangladeshi)
- ☐ Asian (Burmese)
- ☐ Asian (Chinese)
- ☐ Asian (Filipino)
- ☐ Asian (Indian)
- ☐ Asian (Japanese)
- ☐ Asian (Korean)
- ☐ Asian (Nepalese)
- ☐ Asian (Pakistani)
- ☐ Asian (Thai)
- ☐ Asian (Vietnamese)
- ☐ Asian (Bhutanese)
- ☐ Asian (Cambodian)
- ☐ Asian (Hmong)
- ☐ Asian (Indonesian)
- ☐ Asian (Laotian)
- ☐ Asian (Malaysian)
- ☐ Asian (Mongolian)
- ☐ Asian (Sri Lankan)
- ☐ Other Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander (Unspecified)
- ☐ Pacific Islander (Guamanian and Chamorro)
- ☐ Pacific Islander (Native Hawaiian)
- ☐ Pacific Islander (Samoan)
- ☐ Other Pacific Islander
- ☐ Declined to self-identify
- ☐ Unknown
- ☐ Other Race:

13a. Type of referral/recruitment source: *

- ○ Outreach (Street / Door-to-Door)
- ○ Outside Referral to PICHC

13c. Outside Referrer:

Health Care Providers:

Services:

- Group Session Attendance
- Social Media
- Unrecorded
- Other:

13b. If street outreach, specify location:

- Birthing Hospital
- Dental Provider
- Family Planning Provider
- Health Home
- Mental Health / Behavioral Health
- Pediatrician
- Prenatal Care Provider
- Primary Care Physician
- Other Health Care Provider, Specify:

Evidence Based Home Visiting Programs:

- Early Head Start
- Head Start
- Healthy Families New York
- Healthy Start
- Home Instruction for Parents of Preschool Youngsters
- Nurse-Family Partnership
- Parent Child Home Program
- Parents as Teachers
- Other Home Visiting Program, Specify:

- Child Protective Services
- Community - Based Organization
- Coordinated Intake Program
- County Office / Department of Community and Family Services / Social Services
- Faith - Based Organization
- Insurance Navigator
- Managed Care Plan
- Other Client
- Other PICHC Program
- Public Health Nurse / LHD
- Relative / Friend
- School
- Self
- SMHI Light Touch Transfer
- Social Service - Temporary Assistance
- Social Service Agency
- WIC
- Other Service, Specify:

Contact Details Optional.

First Contact

14a. Was the client contacted:

- ○ Missed Calls
- ○ Left Messages
- ○ Appointment Cancelled
- ○ Decided to enroll
- ○ Decided to not enroll
- ○ Other

Other:

Second Contact

15a. Was the client contacted:

- ○ Missed Calls
- ○ Left Messages
- ○ Appointment Cancelled
- ○ Decided to enroll
- ○ Decided to not enroll
- ○ Other

Other:

Third Contact

16a. Was the client contacted:

- ○ Missed Calls
- ○ Left Messages
- ○ Appointment Cancelled
- ○ Decided to enroll
- ○ Decided to not enroll
- ○ Other

Other:

17. Primary Presenting Need:

18. Action Taken: (Check all that apply)

- ☐ Provided information and/or referral
- ☐ Completed Screening Assessment
  (continue to and complete Screening Assessment Form)
- ☐ Will schedule follow-up for Screening Assessment
  (complete Screening Assessment Form at a later date)

Screening/Assessment Form

Client Name:

1. Intake Date: *

2. Worker: *

3a. Living Arrangement: *

- ○ Lives alone or with child/children
- ○ Lives with spouse/partner
- ○ Lives with parent(s)
- ○ Lives with partner's parent(s) or other related adults
- ○ Lives with other unrelated adults
- ○ Lives in foster/group home
- ○ Homeless/no permanent residence
- ○ Refused/Unknown
- ○ Other:

4. Highest Grade Completed: *

- ○ Less than 8th
- ○ 8-11
- ○ High school graduate/GED
- ○ Vocational school after HS
- ○ Some college
- ○ Associates degree
- ○ Bachelor's degree or higher
- ○ Refused/Unknown

5. Currently enrolled in education/training program?

- ○ Yes
- ○ No
- ○ Unknown

6a. Currently is working for pay?

- ○ Yes
- ○ No
- ○ Unknown

6b. Current job is: (Check all that apply)

- ☐ Full-time
- ☐ Part-time
- ☐ Temporary

7. Receiving any of the following benefits?

(Check all that apply)

- [ ] TANF
- [ ] Emergency Assistance
- [ ] SSI/SSD
- [ ] Food stamps
- [ ] WIC

8. Total number of people in household:

9. Average total monthly income of household:

$

- [ ] Unknown

10. Average total monthly value of benefits:

$

- [ ] Unknown

11a. Usual source of medical care: *

- ○ Doctor/clinician's office
- ○ Hospital outpatient clinic
- ○ Federally qualified health center (FQHC)
- ○ Emergency department
- ○ Urgent care
- ○ None
- ○ Unknown
- ○ Other:

11b. Had well-visit with primary care provider in the past year?

*

12a. Currently has a dental provider? *

- ○ Yes
- ○ No
- ○ Unknown

12b. Had dental visit in the past 6-8 months?

*

- ○ Yes
- ○ No
- ○ Unknown

12c. Has any dental problems? *

- ○ Yes
- ○ No

13a. Currently has health insurance coverage?

*

- ○ Yes
- ○ No
- ○ Unknown

13b. Type of health insurance: (Check all that apply)

- [ ] Medicaid (Fee for Service, Managed Care or Emergency Medicaid)
- [ ] Child Health Plus
- [ ] Private Insurance

- ○ Yes
- ○ No
- ○ Unknown

- ○ Unknown

- ☐ Family Planning Medicaid Extension/Benefit Program (FPEP or FPBP) (family planning only)
- ☐ Unknown
- ☐ Other:

Reproductive History

14. Number of previous pregnancies:
(Include current pregnancy, if applicable) *

15. Delivery/pregnancy end date: (if applicable) (includes live/still birth and miscarriage dates)

16a. Number of previous live births: *

16b. Any previous babies born below normal weight?
(Less than 5 lbs 8 oz)

- Yes
- No
- Unknown

16c. Any previous premature births? (36 weeks or less)

- Yes
- No
- Unknown

16d. Any previous still births or fetal deaths?

17a. Currently pregnant? *

- Yes
- No
- Unknown

17b. If so, expected date of delivery:

18a. If not currently pregnant, would like to become pregnant in the next 12 months?

- Yes
- No
- Unknown
- Unsure

18b. If no, currently taking steps to prevent a pregnancy?

- Yes
- No
- Unknown

18c. If yes, types of birth control used:
(Check all that apply)

- Abstinence
- Birth control pill
- Cervical cap (FemCap)
- Female condom
- Spermicide
- Withdrawal/Other
- Birth control implant (Implanon/Nexplanon)
- Birth control vaginal ring (NuvaRing)
- Condom
- Emergency contraception (morning after pill)
- Tubal ligation (female sterilization)
- Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- Birth control patch (Ortho Evra)
- Birth control shot (Depo-Provera)
- Diaphragm
- IUD (Mirena, Paragard)
- Vasectomy (male sterilization)

- ○ Yes
- ○ No
- ○ Unknown

General Health & Well-Being

19. Taking folic acid supplements? (Or prenatal vitamins, if pregnant)

- Yes
- No
- Unknown

20. Any concerns about a healthy weight?

- Yes
- No
- Unknown

21a. Does potential client use tobacco products or vapes?

- Yes
- No
- Unknown

21b. Does anyone in the household use tobacco products or vapes?

- Yes
- No
- Unknown

22a. Have they traveled recently (approx. past 3-6 months)?

- Yes
- No
- Unknown

22b. If yes, where?

Currently Pregnant Client

23a. Any prenatal visits?

- ○ Yes
- ○ No
- ○ Unknown

23b. If yes, date of first prenatal visit:

23c. Number of prenatal visits:

24. Plan to feed with breast milk?

- ○ Yes
- ○ No
- ○ Unknown

25a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

25b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

26. Has physician indicated any concerns about pregnancy weight gain?

- ○ Yes
- ○ No
- ○ Unknown

27a. Has physician indicated any other concerns about pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

27b. If yes, specify physician's concerns:

28. Selected a method of birth control to discuss with physician?

- ○ Yes
- ○ No

Client with Children Under Twelve Months

29. Do you have any children under twelve months?

*

--Select--

30. Does baby have health insurance?

- Yes
- No
- Unknown

31. Does baby have a primary medical provider?

- Yes
- No
- Unknown

32. Child(ren)'s usual source of medical care:

- Doctor/clinician's office
- Hospital outpatient clinic
- Federally qualified health center (FQHC)
- Emergency department
- Urgent care
- None
- Unknown

33. Currently feeding with breast milk?

- Breast milk only
- Breastmilk and formula/solids
- No

34a. Was child ever fed breast milk?

- Yes
- No
- Unknown

34b. If yes, number of months fed breast milk:

Months

34c. Number of months fed only breast milk:

Months

* Conversions are a follows: (One week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five

35a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives
- Friends
- No one
- Other:

35b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives

- Other:

weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2)

- Friends
- No one
- Other:

36. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
On Back				
Alone				
In Crib				

Alcohol Use (AUDIT-C)

37. How often do you have a drink containing alcohol?

- Never (0)
- Monthly or less (1)
- 2-4 times a month (2)
- 2-3 times a week (3)
- 4 or more times a week (4)

38. How many standard drinks containing alcohol do you have on a typical day?

- 2 or less (0)
- 3 or 4 (1)
- 5 or 6 (2)
- 7 to 9 (3)
- 10 or more (4)

39. How often do you have six or more drinks on one occasion?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

40. Screening Result?

- Positive
- Negative
- Refused

41. Was client referred?

- Yes
- No

42. If another evidence based screening tool was used, what was it?

Substance Use (NIDA)

43. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	○	○	○	○	○
Tobacco Products	○	○	○	○	○
Prescription Drugs for Non-Medical Reasons	○	○	○	○	○
Illegal Drugs	○	○	○	○	○

44. In your lifetime, which of the following substances have you ever used?

- ☐ Cannabis
- ☐ Cocaine
- ☐ Prescription stimulants
- ☐ Methamphetamine
- ☐ Inhalants
- ☐ Sedatives or sleeping pills
- ☐ Hallucinogens
- ☐ Street opioids
- ☐ Prescription opioids
- ☐ Other:

45. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

46. Was client referred?

- ○ Yes
- ○ No

47. If another evidence based screening tool was used, what was it?

Domestic Violence (HITS)

48. How often does your partner...?	Not at all *Score 1*	Rarely *Score 2*	Sometimes *Score 3*	Fairly often *Score 4*	Frequently *Score 5*
Physically hurt you	○	○	○	○	○
Talk down to you	○	○	○	○	○
Threaten you with harm	○	○	○	○	○
Scream or curse at you	○	○	○	○	○

49. If any of the above items are not answered, why?

- ○ Does not want to disclose
- ○ Safety concerns
- ○ No partner
- ○ Other

50. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

- ○ Yes
- ○ No

51. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

52. Was client referred?

- ○ Yes
- ○ No

53. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

54. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling asleep or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	○	○	○	○
Thought that you would be better off dead or of hurting yourself in some way	○	○	○	○

55. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

56. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

57. Was client referred?

- ○ Yes
- ○ No

58. If another evidence based screening tool was used, what was it?

Issues

59. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Alcohol use *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Substance use *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Physical disability/health problems *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Depression *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Other mental illness/disability *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

59. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Domestic violence *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Marital or relationship difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for yourself *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Financial difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Unemployment (self or partner) *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Homelessness/inadequate housing *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

59. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Legal problems *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Social isolation *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Stress or emotional difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Inadequate food, clothing, or household items *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Smoking *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Problems with teeth or gums (e.g. pain, bleeding) *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

59. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Parenting *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Prenatal/postpartum health issues *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for your child *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Concerns about your child's development *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Accessing dental care *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Information

60. Would like more information about...? (Check all that apply)

- [ ] Family planning/contraception
- [ ] Pregnancy testing
- [ ] Safe sex
- [ ] Exercise, opportunities to exercise
- [ ] Nutrition, access to healthy foods
- [ ] HIV testing
- [ ] STD testing
- [ ] Job search/placement assistance
- [ ] Adult basic education or GED preparation
- [ ] ESL (English as a Second Language)
- [ ] Vocational or job skills training
- [ ] Alcohol
- [ ] Basic needs (housing, food, etc)
- [ ] Depression
- [ ] Domestic Violence
- [ ] Health Insurance
- [ ] Illicit Drug Use
- [ ] Preventative Care / Primary Care
- [ ] Smoking

Pregnant or Parenting

- [ ] Child care programs
- [ ] Parenting skills
- [ ] Lead assessment/testing
- [ ] Child development
- [ ] Safe sleep
- [ ] Environmental health/safety
- [ ] Car seat use
- [ ] Healthy pregnancy
- [ ] Feeding with breast milk and child nutrition
- [ ] Immunizations
- [ ] Accessing dental care
- [ ] Birth Plan / Preterm Birth
- [ ] Infant / New Born Care
- [ ] Postpartum Care
- [ ] Prenatal Care

61. Is Non-Birthing Caregiver?

- ( ) Yes
- ( ) No

[redacted]

Child Information & Pregnancy Outcomes Form

Client Name:

1. Form Date: *

2. Worker: *

Pregnancy

3a. Did birthing person/client receive prenatal care?

- Yes
- No
- Unknown

3b. Date or trimester began receiving prenatal care?

- First Trimester
- Second Trimester
- Third Trimester
- Unknown Date / Trimester

4. Did birthing person/client visit dentist during pregnancy?

- Yes
- No
- Unknown

5. Did birthing person/client smoke during pregnancy?

- Yes
- No
- Unknown

6a. Did birthing person/client receive doula support? *

- Yes
- No
- Unknown

6b. If yes, when? Check all that apply:

- Prenatal
- During Labor
- Postpartum

7. Number of births:

Children

8. Last Name: *

9. First Name: *

10. Birth Date: *

11. Living With Non-Birthing Caregiver?

- Yes
- No

12. First Birth? *

- Yes
- No

13. Gestational Age: (In whole weeks) *

Weeks

- Unknown Gestational Age

14. Birth Weight: *

Lbs

Oz

20. Sex Assigned At Birth: *

- Female
- Male
- Indeterminate

21. Ethnicity: *

- Hispanic/Latinx
- Not Hispanic/Latinx
- Declined to self-identify

22. Race: (Check all that apply) *

- White
- Black/African-American
- Asian (Unspecified)
- Asian (Bangladeshi)
- Asian (Burmese)
- Asian (Chinese)
- Asian (Filipino)
- Asian (Indian)
- Asian (Japanese)
- Asian (Korean)
- Asian (Nepalese)
- Asian (Pakistani)
- Asian (Thai)
- Asian (Vietnamese)

- [ ] Unknown Birth Weight

15. Was a live birth? *

- ( ) Yes
- ( ) No

16. Type of Delivery: *

- ( ) Vaginal
- ( ) Cesarean

17. Was in an intensive care unit? *

- ( ) Yes
- ( ) No

18. Was infant alive at hospital discharge? *

- ( ) Yes
- ( ) No
- ( ) Infant not yet discharged

19. Was infant receiving breast milk at discharge?

- ( ) Yes
- ( ) No
- ( ) Unknown

- [ ] Asian (Bhutanese)
- [ ] Asian (Cambodian)
- [ ] Asian (Hmong)
- [ ] Asian (Indonesian)
- [ ] Asian (Laotian)
- [ ] Asian (Malaysian)
- [ ] Asian (Mongolian)
- [ ] Asian (Sri Lankan)
- [ ] Other Asian
- [ ] American Indian/Alaska Native
- [ ] Native Hawaiian/Pacific Islander (Unspecified)
- [ ] Pacific Islander (Guamanian and Chamorro)
- [ ] Pacific Islander (Native Hawaiian)
- [ ] Pacific Islander (Samoan)
- [ ] Other Pacific Islander
- [ ] Declined to self-identify
- [ ] Unknown
- [ ] Other:

23. Date of death (if applicable):

Medical

24a. Has Insurance Coverage? *

- ○ Yes
- ○ No
- ○ Unknown

24b. Insurance Type: (Check all that apply) *

- ☐ Medicaid (Fee for Service, Managed Care or Emergency Medicaid)
- ☐ Child Health Plus
- ☐ Private Insurance
- ☐ Unknown
- ☐ Other:

25a. Post-partum visit scheduled? *

- ○ Yes
- ○ No
- ○ Has already attended
- ○ Unknown

25b. If already attended, was it within 8 weeks of birth?

*

- ○ Yes
- ○ No

25c. If already attended, was it within 12 weeks of birth?

*

- ○ Yes
- ○ No

25d. If already attended, specify when:

26. Has birthing person/client selected a contraceptive method to discuss with their doctor?

- ○ Yes
- ○ No
- ○ Unknown



Update Form

Client Name:

1. Form Date: *

2. Worker: *

3a. Living Arrangement: *

- Lives alone or with child/children
- Lives with spouse/partner
- Lives with parent(s)
- Lives with partner's parent(s) or other related adults
- Lives with other unrelated adults
- Lives in foster/group home
- Homeless/no permanent residence
- Refused/Unknown
- Other:

4a. Usual source of medical care: *

- Doctor/clinician's office
- Hospital outpatient clinic
- Federally qualified health center (FQHC)
- Emergency department
- Urgent care
- None
- Unknown

5a. Currently has health insurance coverage? *

- Yes
- No
- Unknown

5b. Type of health insurance: (Check all that apply)

- Medicaid (Fee for Service, Managed Care or Emergency Medicaid)
- Child Health Plus
- Private Insurance
- Family Planning Medicaid Extension/Benefit Program (FPEP or FPBP) (family planning only)
- Unknown
- Other:

5c. Any period of no health insurance coverage since last update? *

- Yes
- No
- Unknown

- [ ] Other:

6. Receiving any of the following benefits?

(Check all that apply)

- [ ] TANF
- [ ] Emergency Assistance
- [ ] SSI/SSD
- [ ] Food stamps
- [ ] WIC

Reproductive History

7a. Been pregnant since last follow-up?
(Exclude pregnancy at program intake) *

- ○ Yes
- ○ No
- ○ Unknown

7b. If yes, currently pregnant? *

- ○ Yes
- ○ No
- ○ Unknown

7c. If so, expected date of delivery:

7d. If not pregnant since last follow-up or program intake, please list most recent delivery/pregnancy end date:
(if applicable) (includes live/still birth and miscarriage dates)

8a. If not currently pregnant, would like to become pregnant in the next 12 months?

- ○ Yes
- ○ No
- ○ Unknown
- ○ Unsure

8b. If no, have you been consistently using birth control since last follow-up?

- ○ Yes
- ○ No
- ○ Unknown

8c. If yes, types of birth control used since the last follow-up:
(Check all that apply)

- ☐ Abstinence
- ☐ Birth control pill
- ☐ Cervical cap (FemCap)
- ☐ Female condom
- ☐ Spermicide
- ☐ Withdrawal/Other
- ☐ Birth control implant (Implanon/Nexplanon)
- ☐ Birth control vaginal ring (NuvaRing)
- ☐ Condom
- ☐ Emergency contraception (morning after pill)
- ☐ Tubal ligation (female sterilization)
- ☐ Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- ☐ Birth control patch (Ortho Evra)
- ☐ Birth control shot (Depo-Provera)
- ☐ Diaphragm
- ☐ IUD (Mirena, Paragard)
- ☐ Vasectomy (male sterilization)

General Health & Well Being

9. Taking folic acid supplements? (Or prenatal vitamins, if pregnant)

- Yes
- No
- Unknown

10. Any concerns about a healthy weight?

- Yes
- No
- Unknown

11a. Does potential client use tobacco products or vapes?

- Yes
- No
- Unknown

11b. Does anyone in the household use tobacco products or vapes?

- Yes
- No
- Unknown

12a. Have they traveled recently (approx. past 3-6 months)?

- Yes
- No
- Unknown

12b. If yes, where?

Currently Pregnant Client

13a. Any prenatal visits?

- ○ Yes
- ○ No
- ○ Unknown

13b. If yes, date of first prenatal visit:

13c. Number of prenatal visits:

14. Plan to feed with breast milk?

- ○ Yes
- ○ No
- ○ Unknown

15a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

15b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

16. Has physician indicated any concerns about pregnancy weight gain?

- ○ Yes
- ○ No
- ○ Unknown

17a. Has physician indicated any other concerns about pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

17b. If yes, specify physician's concerns:

18. Selected a method of birth control to discuss with physician?

- ○ Yes
- ○ No

Client with Children Under Twelve Months

19. Do you have any children under twelve months?

*

--Select--

20. Does baby have health insurance?

- Yes
- No
- Unknown

21. Does baby have a primary medical provider?

- Yes
- No
- Unknown

22. Child(ren)'s usual source of medical care:

- Doctor/clinician's office
- Hospital outpatient clinic
- Federally qualified health center (FQHC)
- Emergency department
- Urgent care
- None
- Unknown

23. Currently feeding with breast milk?

- Breast milk only
- Breastmilk and formula/solids
- No

24a. Was child ever fed breast milk?

- Yes
- No
- Unknown

24b. If yes, number of months fed breast milk:

Months

24c. Number of months fed only breast milk:

Months

* Conversions are a follows: (One week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five

25a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives
- Friends
- No one
- Other:

25b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives

- Other:

weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2)

- Friends
- No one
- Other:

26. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
On Back				
Alone				
In Crib				

Alcohol Use (AUDIT-C)

27. How often do you have a drink containing alcohol?

- ○ Never (0)
- ○ Monthly or less (1)
- ○ 2-4 times a month (2)
- ○ 2-3 times a week (3)
- ○ 4 or more times a week (4)

28. How many standard drinks containing alcohol do you have on a typical day?

- ○ 2 or less (0)
- ○ 3 or 4 (1)
- ○ 5 or 6 (2)
- ○ 7 to 9 (3)
- ○ 10 or more (4)

29. How often do you have six or more drinks on one occasion?

- ○ Never (0)
- ○ Less than monthly (1)
- ○ Monthly (2)
- ○ Weekly (3)
- ○ Daily or almost daily (4)

30. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

31. Was client referred?

- ○ Yes
- ○ No

32. If another evidence based screening tool was used, what was it?

Substance Use (NIDA)

33. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	○	○	○	○	○
Tobacco Products	○	○	○	○	○
Prescription Drugs for Non-Medical Reasons	○	○	○	○	○
Illegal Drugs	○	○	○	○	○

34. In your lifetime, which of the following substances have you ever used?

- [ ] Cannabis
- [ ] Cocaine
- [ ] Prescription stimulants
- [ ] Methamphetamine
- [ ] Inhalants
- [ ] Sedatives or sleeping pills
- [ ] Hallucinogens
- [ ] Street opioids
- [ ] Prescription opioids
- [ ] Other:

35. Screening Result?

- ( ) Positive
- ( ) Negative
- ( ) Refused

36. Was client referred?

- ( ) Yes
- ( ) No

37. If another evidence based screening tool was used, what was it?

Domestic Violence (HITS)

38. How often does your partner...?	Not at all *Score 1*	Rarely *Score 2*	Sometimes *Score 3*	Fairly often *Score 4*	Frequently *Score 5*
Physically hurt you	○	○	○	○	○
Talk down to you	○	○	○	○	○
Threaten you with harm	○	○	○	○	○
Scream or curse at you	○	○	○	○	○

39. If any of the above items are not answered, why?

- ○ Does not want to disclose
- ○ Safety concerns
- ○ No partner
- ○ Other

40. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

- ○ Yes
- ○ No

41. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

42. Was client referred?

- ○ Yes
- ○ No

43. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

44. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling asleep or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	○	○	○	○
Thought that you would be better off dead or of hurting yourself in some way	○	○	○	○

45. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

46. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

47. Was client referred?

- ○ Yes
- ○ No

48. If another evidence based screening tool was used, what was it?

Issues

49. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Alcohol use *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Substance use *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Physical disability/health problems *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Depression *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Other mental illness/disability *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

49. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Domestic violence *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Marital or relationship difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for yourself *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Financial difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Unemployment (self or partner) *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Homelessness/inadequate housing *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

49. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Legal problems *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Social isolation *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Stress or emotional difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Inadequate food, clothing, or household items *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Smoking *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Problems with teeth or gums (e.g. pain, bleeding) *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

49. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Parenting *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Prenatal/postpartum health issues *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for your child *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Concerns about your child's development *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Accessing dental care *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Information

50. Would like more information about...? (Check all that apply)

- [ ] Family planning/contraception
- [ ] Pregnancy testing
- [ ] Safe sex
- [ ] Exercise, opportunities to exercise
- [ ] Nutrition, access to healthy foods
- [ ] HIV testing
- [ ] STD testing
- [ ] Job search/placement assistance
- [ ] Adult basic education or GED preparation
- [ ] ESL (English as a Second Language)
- [ ] Vocational or job skills training
- [ ] Alcohol
- [ ] Basic needs (housing, food, etc)
- [ ] Depression
- [ ] Domestic Violence
- [ ] Health Insurance
- [ ] Illicit Drug Use
- [ ] Preventative Care / Primary Care
- [ ] Smoking

Pregnant or Parenting

- [ ] Child care programs
- [ ] Parenting skills
- [ ] Lead assessment/testing
- [ ] Child development
- [ ] Safe sleep
- [ ] Environmental health/safety
- [ ] Car seat use
- [ ] Healthy pregnancy
- [ ] Feeding with breast milk and child nutrition
- [ ] Immunizations
- [ ] Accessing dental care
- [ ] Birth Plan / Preterm Birth
- [ ] Infant / New Born Care
- [ ] Postpartum Care
- [ ] Prenatal Care

[redacted]

Encounter Form

Client Name:

1. Encounter Date: *

2. Worker: *

3. Length of Visit:

Hrs

Mins

4a. Type of Contact: *

- In-person
- Phone
- E-mail
- Text
- Videoconferencing

4b. If in-person, where did it occur?

- Client home
- Other:

Specify other location

5. Who was present at visit? (Check all that apply)

- Client
- Client's partner
- Client's parent(s)
- Client's child(ren)
- Other:

Activities (Check all that apply)

For each client encounter, the Community Health Worker is responsible for ensuring that all materials and information provided is easily understandable (appropriate literacy level), is accessible in the clients' preferred language including use of a language line, and provides clients with basic health information and services needed to make appropriate health decisions.

Health Care:

Family Functioning:

- [ ] Provide general health information
- [ ] Provide family planning/optimal birth spacing info
- [ ] Provide child health information
- [ ] Provide dental health information
- [ ] Provide nutrition/food preparation information
- [ ] Provide safe sex or STD information
- [ ] Provide information of health providers or services
- [ ] Provide advocacy/support or accompany to medical providers and services
- [ ] Provide information on smoking cessation
- [ ] Completed / Reviewed Birth Plan
- [ ] Reproductive Life Plan
- [ ] Immunizations
- [ ] Completed / Reviewed Postpartum Plan

Prenatal/New Parent:

- [ ] Provide education/info re: prenatal care/pregnancy
- [ ] Discuss feelings about baby
- [ ] Provide labor and delivery support
- [ ] Address infant basic care needs (sleeping, bathing, etc)
- [ ] Provide safe sleep information
- [ ] Provide infant feeding information and support
- [ ] Provide breastfeeding information and support
- [ ] Provide information/equipment relating to child safety (car seats, child proofing homes, etc.)
- [ ] Discuss alcohol impacts during pregnancy
- [ ] Discuss Shaken Baby Syndrome
- [ ] Provide support to parents re: stresses of parenting
- [ ] Infant weight check
- [ ] Car seat check
- [ ] Address issues re: violence in the home
- [ ] Discuss family relations
- [ ] Discuss substance use issues
- [ ] Discuss mental health issues
- [ ] Teach, foster communication skills
- [ ] Home Safety checklist

Concrete Activities:

- [ ] Arrange for transportation
- [ ] Provide or arrange for food, clothes, diapers, or household goods
- [ ] Address legal needs
- [ ] Provide info and/or assistance with housing
- [ ] Translation
- [ ] Discuss child support issues
- [ ] Discuss visitation issues
- [ ] Discuss parental rights issues

Program Activities:

- [ ] Complete forms
- [ ] Assess needs, develop or review family service plan
- [ ] Complete client satisfaction survey

Crisis Intervention:

- [ ] Help resolve problems and handle crises

Other Activities:

- [ ] Other:

- [ ] Crib check/crib for kids
- [ ] Cesarean incision
- [ ] Post-partum mother care
- [ ] Preterm birth: signs, symptoms, prevention
- [ ] Provide information on child development

Self-Sufficiency:

- [ ] Teach to use public transportation or provide maps or directions
- [ ] Teach how to use calendar or appointment book
- [ ] Address needs for child care
- [ ] Provide advocacy/support and/or accompany to non-medical providers or services
- [ ] Arrange appointment for health care services
- [ ] Job search/placement assistance
- [ ] Adult basic education or GED preparation
- [ ] ESL (English as a Second Language)
- [ ] Vocational or job skills training

Client Medical Visits

Type of Visit *	**Date of Visit ***	**Reason for Visit**	**Weeks Pregnant** (if applicable)
Specify:			
Specify:			
Specify:			
Specify:			
Specify:			

* Records missing required fields will not be saved.

Type of Visit Codes:

1. Annual OBGYN exam
2. Prenatal visit
3. Postpartum visit
4. Routine physical
5. Urgent Care
6. Dental visit
99. Other

Baby Medical Visits

Type of Visit *	**Date of Visit ***	**Reason for Visit**	**Child's Age** (in months)	**Lead screening done at this visit?**
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				

* Records missing required fields will not be saved.

Type of Visit Codes:

1. Well-baby visit
2. Urgent Care
3. Non-well baby visit
4. Dental
99. Other

Baby Immunizations

Type of Immunization(s) *	**Date ***	**Child's Age** (in months)

* Records missing required fields will not be saved.

Type of Immunization Codes:

1. Hepatitis B
2. Rotavirus
3. Diphtheria, tetanus, & acellular pertussis
4. Haemophilus influenzae type b
5. Pneumococcal conjugate
6. Inactivated poliovirus
7. Influenza
8. Measles, mumps, rubella
9. Varicella
10. Hepatitis A
11. Meningococcal
12. Tetanus, diphtheria, & acellular pertussis
13. Human papillomavirus
14. Meningococcal B
15. Pneumococcal polysaccharide
16. COVID-19
17. RSV

Referrals

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				

* Records missing required fields will not be saved.

Service Codes:

Health Care

1. Adult primary care
2. Child primary care
3. Dental services
4. Early Intervention
5. Family Planning
6. Immunization
7. Lead Testing
8. Mental Health Services
9. Postpartum Care
10. Prenatal Care
11. Other, Specify

Family & Social Support Referrals

12. Breastfeeding
13. Car Seat
14. Childcare
15. Child Development
16. Child Support
17. Clothing / Baby Care Items
18. Domestic Violence
19. Educational Attainment
20. Employment / Vocational Services
21. Environmental Health / Safety
22. English as a Second Langauge (ESL)
23. Family Resource Center
24. Food Pantry
25. Furniture
26. Health Insurance
27. HEAP
52. Doula

Home Visiting

28. Early Head Start
29. Head Start
30. Healthy Families New York
31. Healthy Start
32. Home Instruction for Parents of Preschool Youngsters
33. Nurse-Family Partnership
34. Parent Child Home Program
35. Parents as Teachers
36. Public Health Nurse / LHD
37. Other Home Visiting Program, Specify

Other Services

38. Housing
39. Immigration Services
40. Legal Services
41. Nutrition, General
42. Safe Sleep
43. Smoking Cessation
44. SNAP (Food Stamps)
45. Substance Use
46. Support Groups
47. TANF/DSS Cash Assistance
48. Translation
49. Transportation
50. WIC
51. Other, Specify

Family Member Codes:

1. Client
2. Client's partner
3. Other biological parent of enrolled child (non-partner)
4. Enrolled child
5. Other child
6. Other relative
7. Non-relative



Discharge Form

Client Name:

1. Discharge Date: *

2. Worker: *

3a. Discharge Reason: *

- ○ Client has met their goals
- ○ Program unable to locate or make contact
- ○ Participant non-compliant or unresponsive
- ○ Participant refused
- ○ Transferred/referred to another PICHC program
- ○ Transferred/referred to a prevention/home visiting program
- ○ Client deceased
- ○ Client unavailable due to school or employment
- ○ CHW left, client refused new CHW
- ○ Safety issues for worker
- ○ Program terminated due to mental health issues
- ○ Family or other household member objects to program
- ○ Out of geographical target area

3d. Living Arrangement:

- ○ Lives alone or with child/children
- ○ Lives with spouse/partner
- ○ Lives with parent(s)
- ○ Lives with partner's parent(s) or other related adults
- ○ Lives with other unrelated adults
- ○ Lives in foster/group home
- ○ Homeless/no permanent residence
- ○ Refused/Unknown
- ○ Other:

4a. Usual source of medical care: *

- ○ Doctor/clinician's office
- ○ Hospital outpatient clinic
- ○ Federally qualified health center (FQHC)
- ○ Emergency department
- ○ Urgent care
- ○ None

5a. Currently has health insurance coverage?

*

- ○ Yes
- ○ No
- ○ Unknown

5b. Type of health insurance: (Check all that apply)

- ☐ Medicaid (Fee for Service, Managed Care or Emergency Medicaid)
- ☐ Child Health Plus
- ☐ Private Insurance
- ☐ Family Planning Medicaid Extension/Benefit Program (FPEP or FPBP) (family planning only)
- ☐ Unknown
- ☐ Other:

- Child deceased
- Other:

3b. Deceased Client Specification:

- Birthing Client Death Before Labor
- Birthing Client Death During Labor
- Birthing Client Death Postpartum
- Non-Birthing Caregiver Deceased

3c. Client Satisfaction Survey Completed?

- Yes
- No

- Unknown
- Other:

5c. Any period of no health insurance coverage since last update?

*

- Yes
- No
- Unknown

Reproductive History

6a. Been pregnant since last follow-up?

(Exclude pregnancy at program intake)

- ○ Yes
- ○ No
- ○ Unknown

6b. If yes, currently pregnant? *

- ○ Yes
- ○ No
- ○ Unknown

6c. If so, expected date of delivery:

6d. If not pregnant since last follow-up or program intake, please list most recent delivery/pregnancy end date:

(if applicable) (includes live/still birth and miscarriage dates)

7a. If not currently pregnant, would like to become pregnant in the next 12 months?

- ○ Yes
- ○ No
- ○ Unknown
- ○ Unsure

7b. If no, have you been consistently using birth control since last follow-up?

- ○ Yes
- ○ No
- ○ Unknown

7c. If yes, types of birth control used since the last follow-up:

(Check all that apply)

- ☐ Abstinence
- ☐ Birth control pill
- ☐ Cervical cap (FemCap)
- ☐ Female condom
- ☐ Spermicide
- ☐ Withdrawal/Other
- ☐ Birth control implant (Implanon/Nexplanon)
- ☐ Birth control vaginal ring (NuvaRing)
- ☐ Condom
- ☐ Emergency contraception (morning after pill)
- ☐ Tubal ligation (female sterilization)
- ☐ Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- ☐ Birth control patch (Ortho Evra)
- ☐ Birth control shot (Depo-Provera)
- ☐ Diaphragm
- ☐ IUD (Mirena, Paragard)
- ☐ Vasectomy (male sterilization)

General Health & Well Being

8. Taking folic acid supplements? (Or prenatal vitamins, if pregnant)

- Yes
- No
- Unknown

9. Any concerns about a healthy weight?

- Yes
- No
- Unknown

10a. Does potential client use tobacco products or vapes?

- Yes
- No
- Unknown

10b. Does anyone in the household use tobacco products or vapes?

- Yes
- No
- Unknown

11a. Have they traveled recently (approx. past 3-6 months)?

- Yes
- No
- Unknown

11b. If yes, where?

Currently Pregnant Client

12a. Any prenatal visits?

- ○ Yes
- ○ No
- ○ Unknown

12b. If yes, date of first prenatal visit:

12c. Number of prenatal visits:

13. Plan to feed with breast milk?

- ○ Yes
- ○ No
- ○ Unknown

14a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

14b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

15. Has physician indicated any concerns about pregnancy weight gain?

- ○ Yes
- ○ No
- ○ Unknown

16a. Has physician indicated any other concerns about pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

16b. If yes, specify physician's concerns:

17. Selected a method of birth control to discuss with physician?

- ○ Yes
- ○ No

Client with Children Under Twelve Months

18. Do you have any children under twelve months?

--Select--

19. Does baby have health insurance?

- Yes
- No
- Unknown

20. Does baby have a primary medical provider?

- Yes
- No
- Unknown

21. Child(ren)'s usual source of medical care:

- Doctor/clinician's office
- Hospital outpatient clinic
- Federally qualified health center (FQHC)
- Emergency department
- Urgent care
- None
- Unknown

22. Currently feeding with breast milk?

- Breast milk only
- Breastmilk and formula/solids
- No

23a. Was child ever fed breast milk?

- Yes
- No
- Unknown

23b. If yes, number of months fed breast milk:

Months

23c. Number of months fed only breast milk:

Months

* Conversions are a follows: (One week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five

24a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives
- Friends
- No one
- Other:

24b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives

Other:

weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2)

Friends

No one

Other:

25. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
On Back				
Alone				
In Crib				

Alcohol Use (AUDIT-C)

26. How often do you have a drink containing alcohol?

- ○ Never (0)
- ○ Monthly or less (1)
- ○ 2-4 times a month (2)
- ○ 2-3 times a week (3)
- ○ 4 or more times a week (4)

27. How many standard drinks containing alcohol do you have on a typical day?

- ○ 2 or less (0)
- ○ 3 or 4 (1)
- ○ 5 or 6 (2)
- ○ 7 to 9 (3)
- ○ 10 or more (4)

28. How often do you have six or more drinks on one occasion?

- ○ Never (0)
- ○ Less than monthly (1)
- ○ Monthly (2)
- ○ Weekly (3)
- ○ Daily or almost daily (4)

29. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

30. Was client referred?

- ○ Yes
- ○ No

31. If another evidence based screening tool was used, what was it?

Substance Use (NIDA)

32. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	○	○	○	○	○
Tobacco Products	○	○	○	○	○
Prescription Drugs for Non-Medical Reasons	○	○	○	○	○
Illegal Drugs	○	○	○	○	○

33. In your lifetime, which of the following substances have you ever used?

- [ ] Cannabis
- [ ] Cocaine
- [ ] Prescription stimulants
- [ ] Methamphetamine
- [ ] Inhalants
- [ ] Sedatives or sleeping pills
- [ ] Hallucinogens
- [ ] Street opioids
- [ ] Prescription opioids
- [ ] Other:

34. Screening Result?

- ( ) Positive
- ( ) Negative
- ( ) Refused

35. Was client referred?

- ( ) Yes
- ( ) No

36. If another evidence based screening tool was used, what was it?

Domestic Violence (HITS)

37. How often does your partner...?	**Not at all** *Score 1*	**Rarely** *Score 2*	**Sometimes** *Score 3*	**Fairly often** *Score 4*	**Frequently** *Score 5*
Physically hurt you	○	○	○	○	○
Talk down to you	○	○	○	○	○
Threaten you with harm	○	○	○	○	○
Scream or curse at you	○	○	○	○	○

38. If any of the above items are not answered, why?

- ○ Does not want to disclose
- ○ Safety concerns
- ○ No partner
- ○ Other

39. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

- ○ Yes
- ○ No

40. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

41. Was client referred?

- ○ Yes
- ○ No

42. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

43. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling asleep or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	○	○	○	○
Thought that you would be better off dead or of hurting yourself in some way	○	○	○	○

44. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

45. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

46. Was client referred?

- ○ Yes
- ○ No

47. If another evidence based screening tool was used, what was it?

Issues

48. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Alcohol use *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Substance use *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Physical disability/health problems *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Depression *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Other mental illness/disability *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

48. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Domestic violence *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Marital or relationship difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for yourself *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Financial difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Unemployment (self or partner) *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Homelessness/inadequate housing *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

48. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Legal problems *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Social isolation *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Stress or emotional difficulties *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Inadequate food, clothing, or household items *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Smoking *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Problems with teeth or gums (e.g. pain, bleeding) *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

48. Issue...	Currently experiencing?*	Would like assistance?	Was information given?	Was client referred?
Parenting *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Prenatal/postpartum health issues *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for your child *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Concerns about your child's development *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Accessing dental care *	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No



ASQ Form

1. Infant: *

2. Worker: *

3. Date: *

4. Interval: *

- 2 Months
- 4 Months
- 6 Months
- 9 Months
- 12 Months
- 18 Months
- at least 18 Months under 24 Months
- at least 24 Months under 36 Months
- at least 36 Months under 48 Months
- at least 48 Months under 60 Months

5. Infant is currently receiving services:

*

- Yes
- No

6. Parent declined further screening:

*

- Yes
- No

7. Was a referral made?: *

- Yes
- No

8. Referral not needed at this time:

*

- Yes
- No

9. Monitoring prior to referral:

*

- Yes
- No

10. Was another evidence based screening tool used?:

*

--Select--

11. What was the alternate tool?

Communication:

Gross Motor:

Fine Motor:

Problem Solving:

Personal / Social:

Training Form

Date: *

Training Type: *

Topic:

Workers: (Check all that apply) *

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Outreach Event, Group Session and Collaborative Projects, Coordinated Outreach and Referrals Form

Date: *

Start Time:

End Time:

Title:

Workers: (Check all that apply)

- Johnson, Megan
- Bucciero, Jill
- Fabian, Ana
- Busa, Janeen
- Akhtar, Niala

Location:

Type:

If Coordinated Outreach:

Number of partners engaged:

Event Description:

If Group Session:

Number of attendees: *

Session Topic:

Number of Attending PICHC Clients *

Number of Attending Non-PICHC Clients *

If Collaborative Project

Please describe the Collaborative Project: *

Project Complete?

Community Action Board Related?

Developed any new formal or informal written agreements with partners?

If yes, describe the agreement and the organization involved and nature of agreement:

Is Agreement Formal or Informal?

If Formal Written Agreement, What Type?

Agreement Date: *

Topics	Specify

Topics	Specify

Topic Codes:

1. Alcohol
2. Basic Needs (housing, food, etc)
3. Birth Plan
4. Breastfeeding
5. Child Development / Infant Care
6. Depression
7. Domestic Violence
8. Exercise / Nutrition
9. Family Planning / Reproductive Health
10. Health Insurance
11. Healthy Pregnancy
12. Home Safety
13. Illicit Drug Use
14. Immunizations
15. Oral Health
16. Parenting
17. Postpartum Care
18. Prenatal Care
19. Preterm Birth
20. Preventive Care / Primary Care
21. Safe Sex or STD
22. Safe Sleep
23. Self-Sufficiency
24. Smoking
25. Postpartum Plan
26. Other (Specify)
27. Program Activity

Meeting Details

Meeting Frequency: *

Specify:

Meeting Date

Meeting Date

Participating Community Members

Member

Total Number of Community Members on the Board:	Total Number of Board Members:	Percentage of Community Members on the Board:

Participating Community Partners

Partner Name*	Organization Type*	Specify

* Records missing required fields will not be saved.

Traditional Organization Type Codes:

1. Prenatal Care Provider
2. Primary Care Physician
3. Dental Provider
4. Pediatrician
5. Birthing Hospital
6. Family Planning Provider
7. Domestic Violence Provider
8. Substance Use Provider
9. Health Home
10. Mental Health / Behavioral Health
11. Social Service Agency
12. Immigration Services
13. Financial Services
14. Legal Services
15. WIC
16. Public Health Nurse / LHD
17. Education Provider
18. Insurance Navigator
19. Managed Care Plan
20. Community-Based Organization
21. Other PICHC Program
22. Other Health Care Provider
23. Other Traditional (Specify)

Non-Traditional Organization Type Codes:

24. Advocacy Agencies
25. Breast / Chest Feeding Providers
26. Community Centers
27. Grassroots Organizations
28. Faith-Based Organizations
29. Minority-Focused Organizations
30. Other Non-Traditional (Specify)

Social Determinants and Community Needs

Addresses social determinants of health and community needs?

Total number of collaborations with community partners addressing social determinants of health and community needs.

Social Determinants	Specify

Social Determinant Type Codes:

1. Economic Stability
2. Education Access and Quality
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context
6. Other (Specify)

Community Need

Community Need

If Coordinated Outreach and Referrals

Please describe the Coordinated Outreach Activity: *

Developed any new formal or informal written agreements with partners?

Type of Coordinated Outreach Activity: *

Specify:

If yes, describe the agreement and the organization involved and nature of agreement:

Is Agreement Formal or Informal?

If Formal Written Agreement, What Type?

Agreement Date: *

Participating Community Referral Partners

Partner Name*	Organization Type*	Specify

Partner Name*	Organization Type*	Specify

* Records missing required fields will not be saved.

Traditional Organization Type Codes:

1. Prenatal Care Provider
2. Primary Care Physician
3. Dental Provider
4. Pediatrician
5. Birthing Hospital
6. Family Planning Provider
7. Domestic Violence Provider
8. Substance Use Provider
9. Health Home
10. Mental Health / Behavioral Health
11. Social Service Agency
12. Immigration Services
13. Financial Services
14. Legal Services
15. WIC
16. Public Health Nurse / LHD
17. Education Provider
18. Insurance Navigator
19. Managed Care Plan
20. Community-Based Organization
21. Other PICHC Program
22. Other Health Care Provider
23. Other Traditional (Specify)

Non-Traditional Organization Type Codes:

24. Advocacy Agencies
25. Breast / Chest Feeding Providers
26. Community Centers
27. Grassroots Organizations
28. Faith-Based Organizations
29. Minority-Focused Organizations
30. Other Non-Traditional (Specify)

Social Determinants and Community Needs

Addresses social determinants of health and community needs?

Total number of collaborations with community partners addressing social determinants of health and community needs.

Social Determinants	Specify

Social Determinant Type Codes:

1. Economic Stability
2. Education Access and Quality
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context
6. Other (Specify)

Community Need

Community Need

Contacts

Last Name	First Name	Age (in years)	May Contact?	Preferred Contact
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	

Referrals

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	
Specify:			○ Yes ○ No	

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
			○ Yes ○ No	

Specify:

* Records missing required fields will not be saved.

Service Codes:

Health Care

1. Adult primary care
2. Child primary care
3. Dental services
4. Early Intervention
5. Family Planning
6. Immunization
7. Lead Testing
8. Mental Health Services
9. Postpartum Care
10. Prenatal Care
11. Other, Specify

Family & Social Support Referrals

12. Breastfeeding
13. Car Seat
14. Childcare
15. Child Development
16. Child Support
17. Clothing / Baby Care Items
18. Domestic Violence
19. Educational Attainment
20. Employment / Vocational Services
21. Environmental Health / Safety
22. English as a Second Langauge (ESL)
23. Family Resource Center
24. Food Pantry
25. Furniture
26. Health Insurance
27. HEAP
52. Doula

Home Visiting

28. Early Head Start
29. Head Start
30. Healthy Families New York
31. Healthy Start
32. Home Instruction for Parents of Preschool Youngsters
33. Nurse-Family Partnership
34. Parent Child Home Program
35. Parents as Teachers
36. Public Health Nurse / LHD
37. Other Home Visiting Program, Specify

Other Services

38. Housing
39. Immigration Services
40. Legal Services
41. Nutrition, General
42. Safe Sleep
43. Smoking Cessation
44. SNAP (Food Stamps)
45. Substance Use
46. Support Groups
47. TANF/DSS Cash Assistance
48. Translation
49. Transportation
50. WIC
51. Other, Specify

Family Member Codes:

1. Client
2. Client's partner
3. Other biological parent of enrolled child (non-partner)
4. Enrolled child
5. Other child
6. Other relative
7. Non-relative

Information

Would like more information about...? (Check all that apply)

- [ ] Family planning/contraception
- [ ] Pregnancy testing
- [ ] Safe sex
- [ ] Exercise, opportunities to exercise
- [ ] Nutrition, access to healthy foods
- [ ] HIV testing
- [ ] STD testing
- [ ] Job search/placement assistance
- [ ] Adult basic education or GED preparation
- [ ] ESL (English as a Second Language)
- [ ] Vocational or job skills training
- [ ] Alcohol
- [ ] Basic needs (housing, food, etc)
- [ ] Depression
- [ ] Domestic Violence
- [ ] Health Insurance
- [ ] Illicit Drug Use
- [ ] Preventative Care / Primary Care
- [ ] Smoking

Pregnant or Parenting

- [ ] Child care programs
- [ ] Parenting skills
- [ ] Lead assessment/testing
- [ ] Child development
- [ ] Safe sleep
- [ ] Environmental health/safety
- [ ] Car seat use
- [ ] Healthy pregnancy
- [ ] Feeding with breast milk and child nutrition
- [ ] Immunizations
- [ ] Accessing dental care
- [ ] Birth Plan / Preterm Birth
- [ ] Infant / New Born Care
- [ ] Postpartum Care
- [ ] Prenatal Care

CHSR

PICHC

DMIS User Manual

Version 2.0

April 2026



CENTER FOR HUMAN SERVICES RESEARCH
UNIVERSITY AT ALBANY State University of New York

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1. Getting Started

Getting a User ID

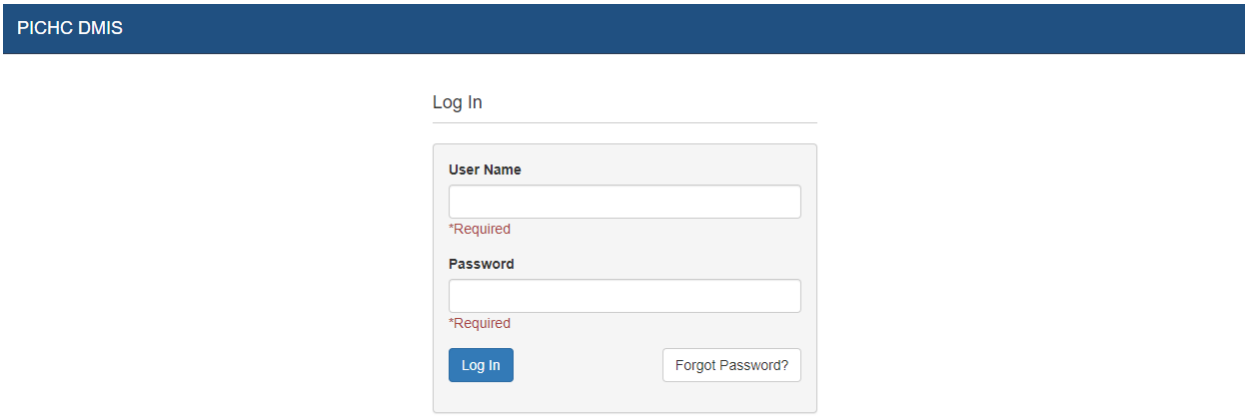
1. New users must be created by site administrators (CHSR). A request to create a user can be made by filling out and emailing the User Request Form.

2. Only site administrators (CHSR) can activate/deactivate user accounts. To request account activation/deactivation, please submit a Help Desk Ticket.

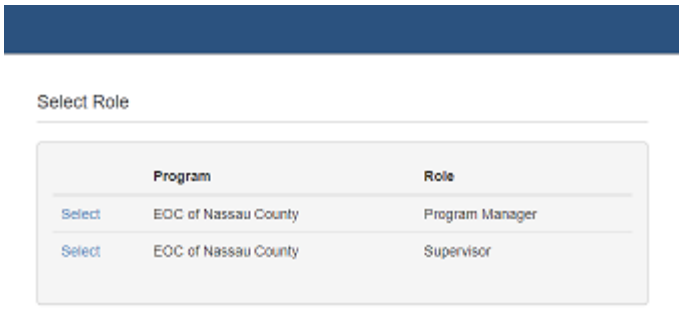
Logging In

1. In a web browser, preferably Chrome, navigate to http://pichc.azurewebsites.net

2. To log in for the first time, you must reset your password. See below, item 1B5.
3. For all subsequent log ins, enter your username and password in the appropriate boxes and click "Submit."



User Role: An account can be associated with one or many roles. If you have multiple roles associated with your account, you will be prompted to choose a role after logging in.

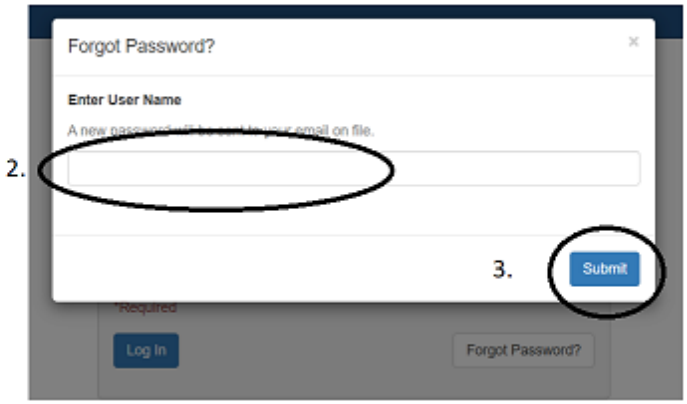


Password Reset: Passwords can be reset via the login page.

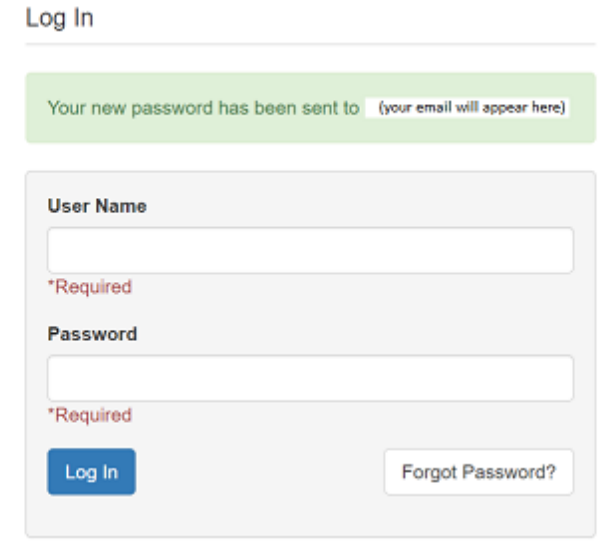
1. Click "Forgot Password?"



2. Enter your User Name in the box
3. Click "Submit"



You will see a message in a green box if you are successful.



2. Using the System

Menu

Home

Technical Support - For help resolving technical issues of any sort, a help desk ticket can be submitted using the “Submit a Ticket” link.

Quick Links

User Manual: A copy of this document.

Program Q&A: An FAQ with some commonly asked questions received from programs.

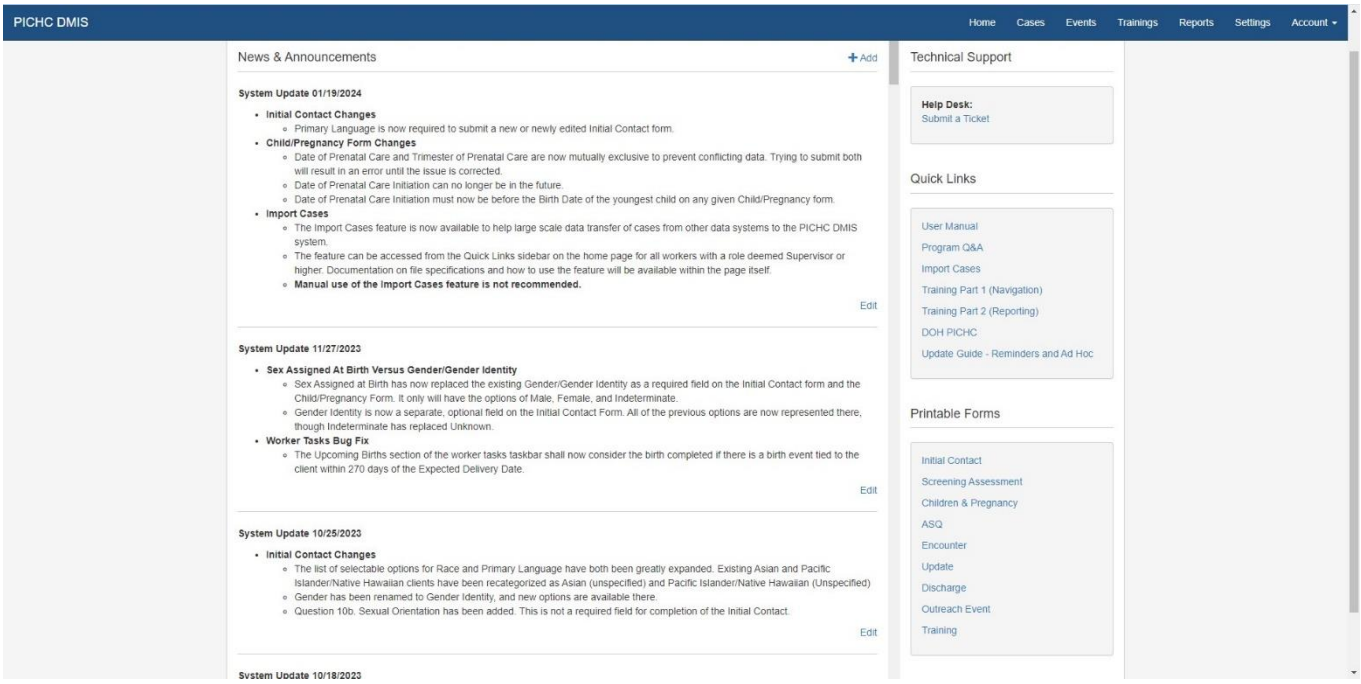
Import Cases: A feature added to the DMIS allowing for mass import of cases from an external database. Requires external vendor support to transfer the cases properly through the intake and screening forms.

Training Parts 1 and 2: Instructional videos on how to use the DMIS for navigation and reporting purposes.

DOH PICHC: An external link to the NYS DOH web site.

User Manual - Reminders and Ad Hoc: A guide to Reminder and Ad Hoc Reporting features.

Printable Forms - These are available to users who would prefer to fill out a paper form which will then be transcribed into the system. These forms cannot be used to input data directly.

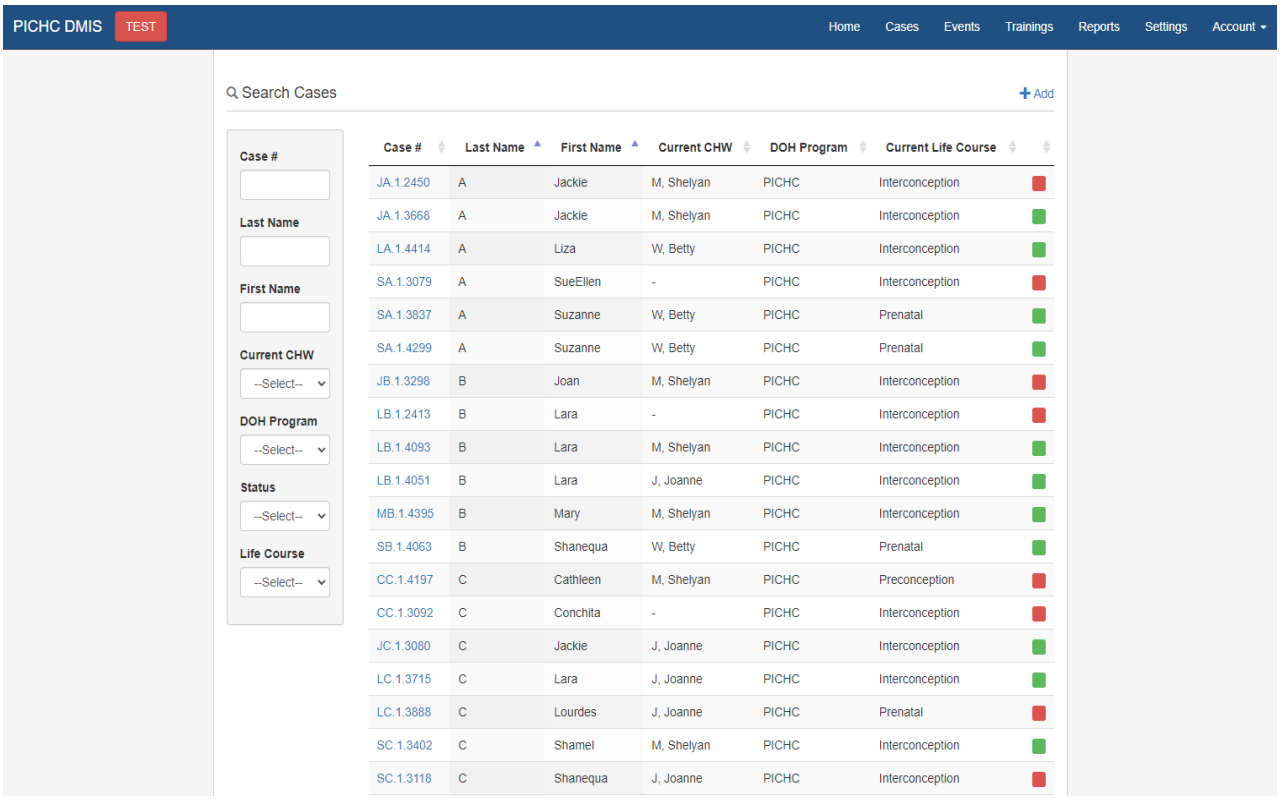


Cases

The “Cases” page displays all clients in the user’s program for Supervisor, CHW and Data Entry roles. For Contract Admin users, this page displays all clients in the system.

The list can be sorted by any column by clicking on the arrows in the appropriate column header.

The list can also be searched by entering text into one or more of the boxes on the left-hand side.

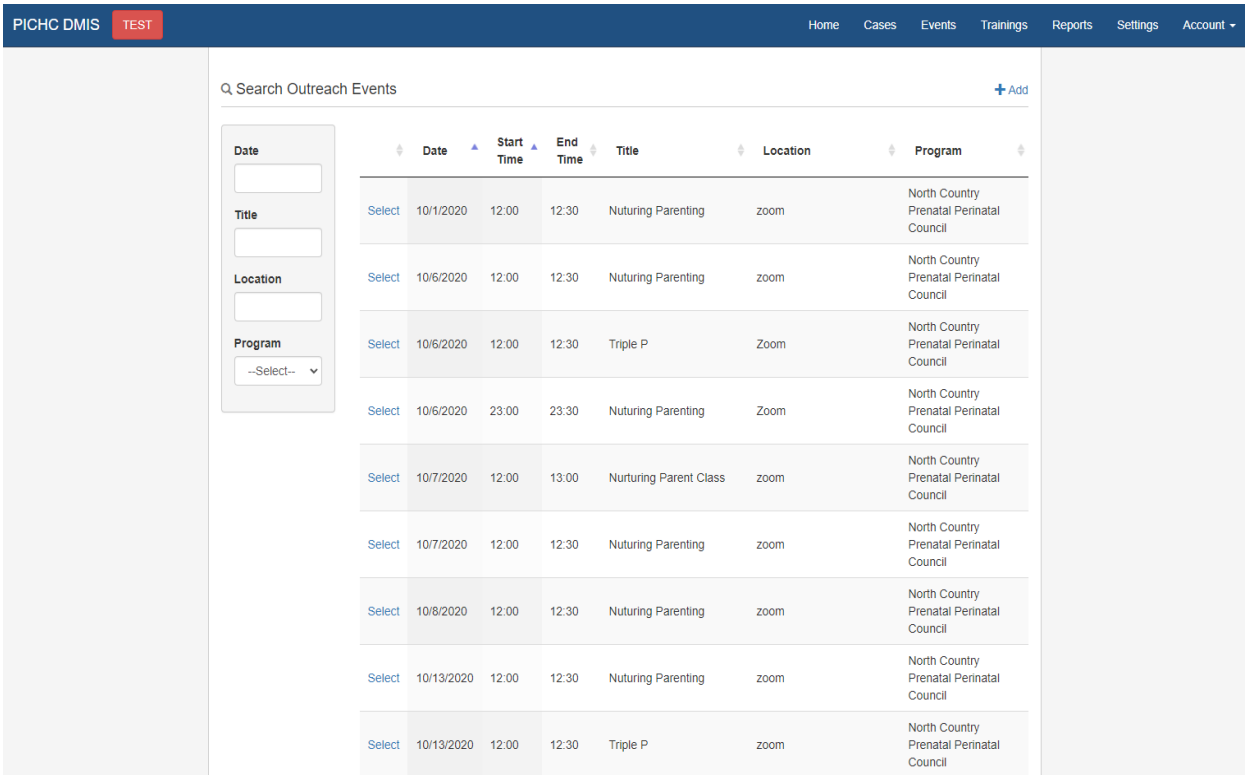


Events

The Outreach and Group Session form can be used to record outreach events.

Outreach events are not linked to cases.

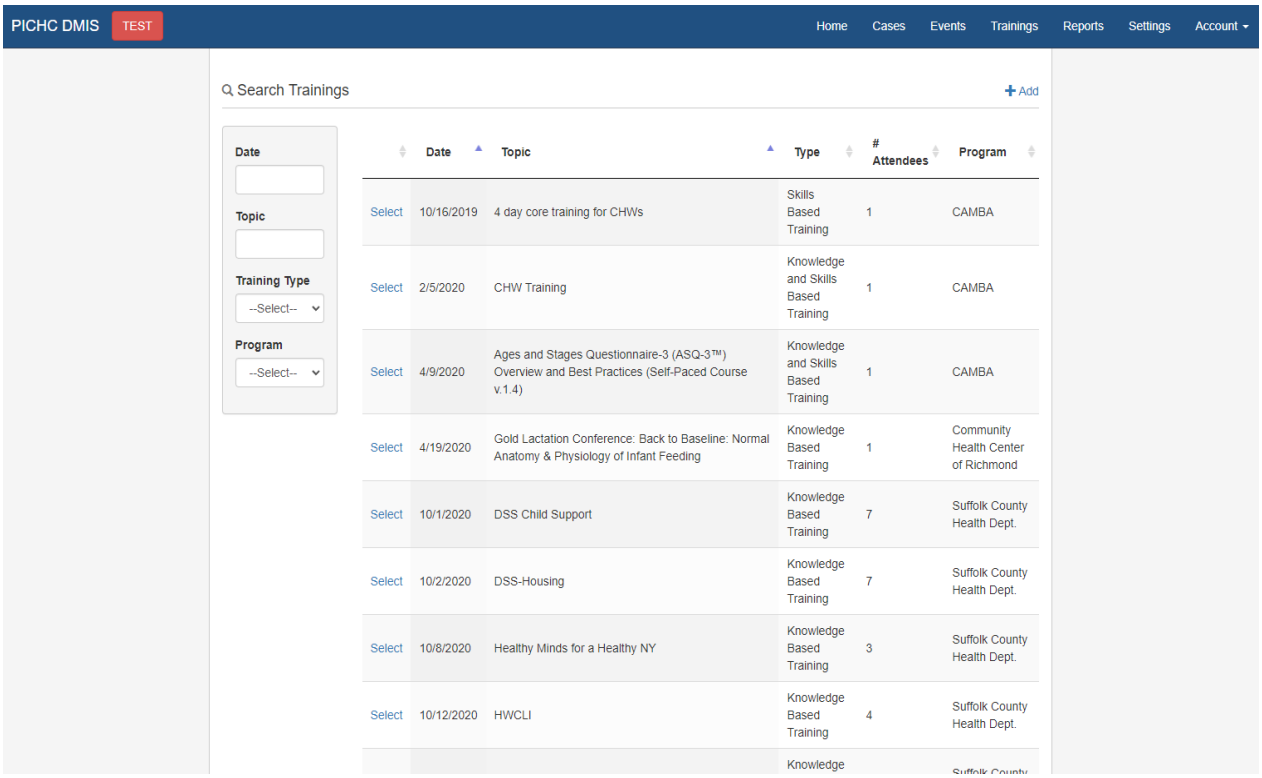
Click “New” to add a new event or click “select” next to an existing event to edit that event.



Trainings

The Training form is used to record workers' training sessions.

Click "New" to add a new training or click "select" next to an existing training to edit that training.



Reports

This section contains a multitude of reports that summarize information across various forms.

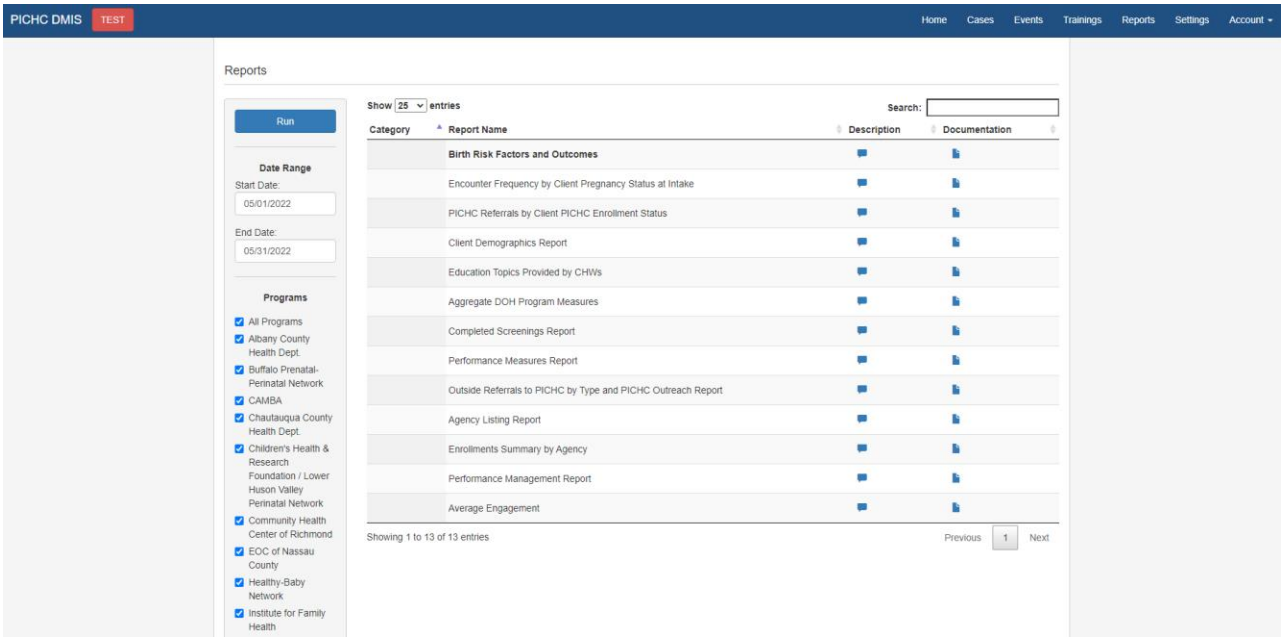
Documentation for each report describing how each item is calculated can be viewed by clicking the file icon.

Reports are run against a specific date window. Dates can be entered after a report is selected.

Reports are calculated based on defined business rules, including client eligibility and selected date ranges.

Postpartum visit measures exclude early discharges, non-live births, and visits occurring within the first week of delivery.

Some reports include detailed client-level breakdowns for auditing and analysis purposes.



Settings

Program Detail

Roles required: Program Manager, Data Entry

Use this form to add or update program specific information such as the program name, manager, address, phone number, etc.

Worker Detail Form: In 'Worker Administration' section, click 'Select' to edit an existing worker or '+ Add' to add a new worker.

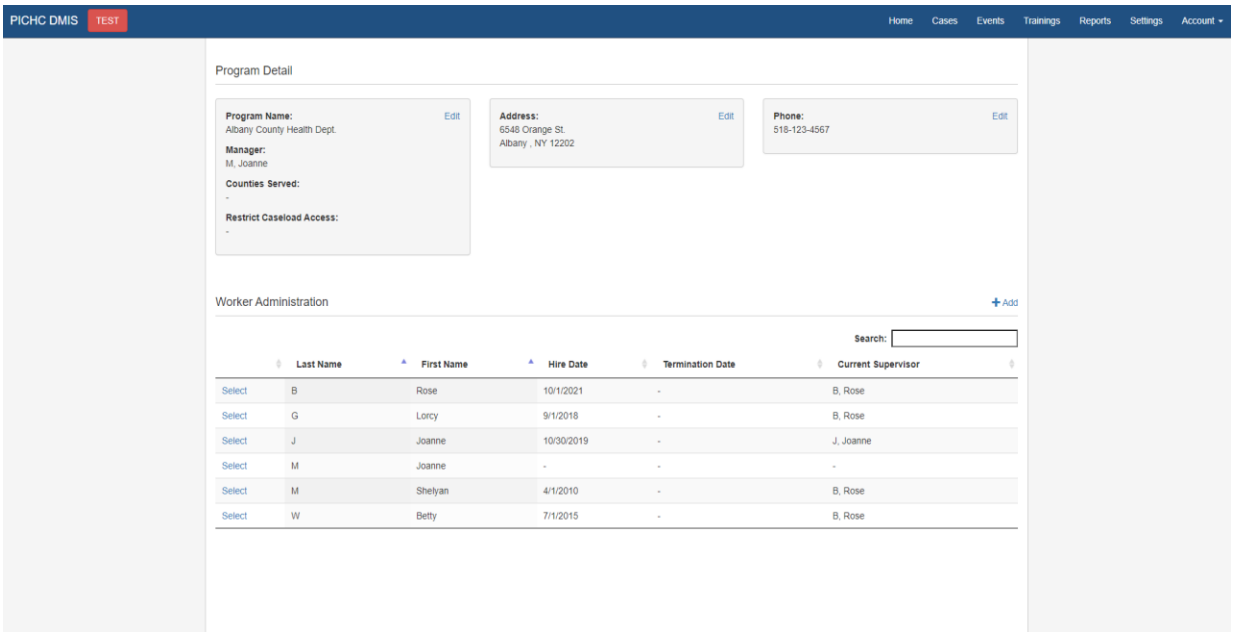
Worker Detail: Update name, hire date, termination date, username, assigned supervisor.

Supervisor History: Add, edit, or delete a supervisor assigned to the worker.

Caseload: Transfer cases to another worker.

Supervisees: Assign supervisees (other workers) to worker.

Link users to worker records by selecting their username in the worker detail section.



User Request Form

Roles required: Contract Admin, Program Manager, Data Entry

Use this form to request new user accounts.

Change Password – Use this form to change your password.
User Manual – A link to this document

Account

User Info – Information about your current log in session is displayed here.

Username

Program

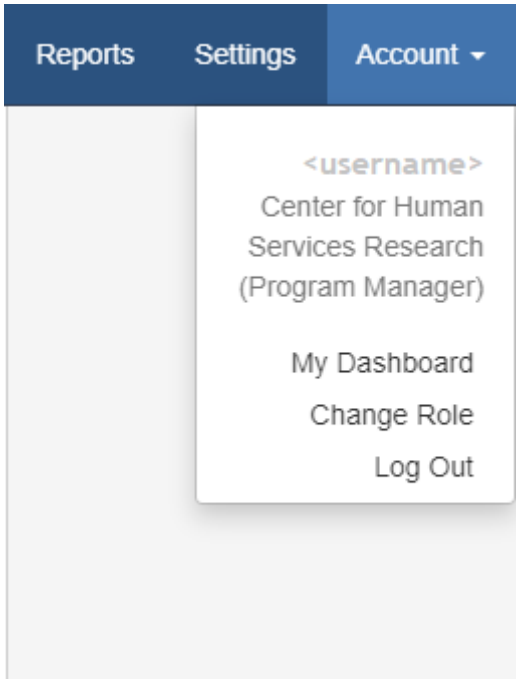
Current Role

My Dashboard - Informational screens that provide summary information tailored to user roles.

For Workers, the dashboard may include a Postpartum Visits section showing upcoming 8-week and 12-week postpartum due dates.

Change Role – Users with multiple roles associated with their account can use this link to change their currently logged in role without having to log out and in again.

Log Out – Click this link to log out of the application.



Creating a New Case

Cases are added to the system via the Cases page accessible from the menu.

Click “+ Add” on the Cases page to create a case by entering an Initial Contact form.

Case Home Page

Case Detail

The name and birth date of the client can be edited by clicking ‘Edit’ on the left side.

To delete a case, click the “X Delete Case” link on the right side. The link is only visible to program manager and data entry users.

On the right side, there will be one of four colored items.

a. Yellow – “Pending” – The case has an Initial Contact form, but no Screening Assessment.

b. Green – “Enrolled” – The case has a completed Screening Assessment.

c. Grey – “Expired” – The case was discharged before the Screening Assessment was entered. I.e., there is an Initial Contact and a Discharge form, but no Screening Assessment.

d. Red – “Discharged” – The case was discharged after a Screening Assessment is entered. I.e., the Initial Contact, Screening Assessment and Discharge forms have been entered.

Additional information such as postpartum plan completion status and language spoken may also be displayed on the Case Detail page.

Contact Info

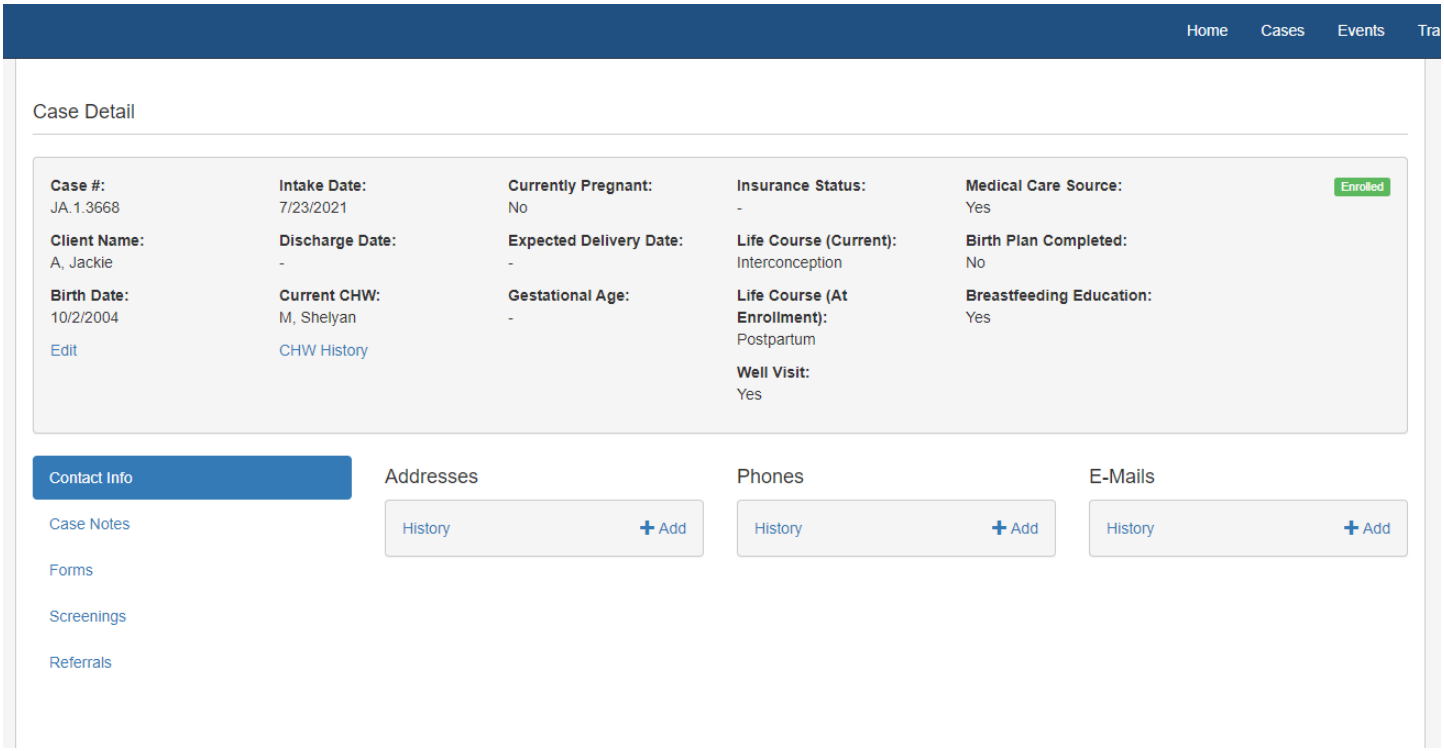
Multiple addresses, phone numbers and email addresses can be stored for each client.

To add, click the “+Add” link in the appropriate section.

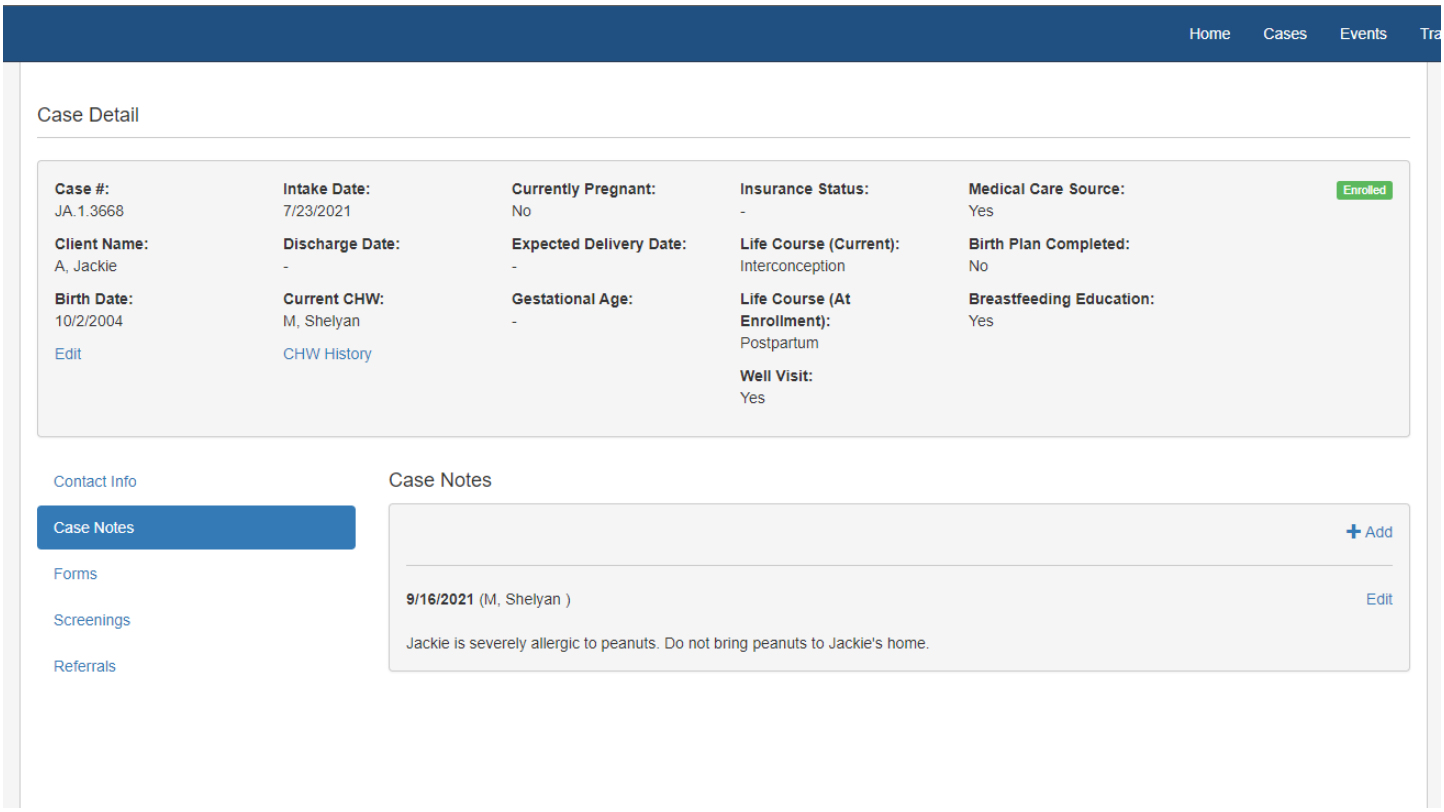
Individual entries can be deactivated so that they do not display on the home page. Click “Edit” next to the appropriate entry and click “Deactivate” to remove the entry from the home page.

Deactivated entries can be viewed by clicking the “History” link.

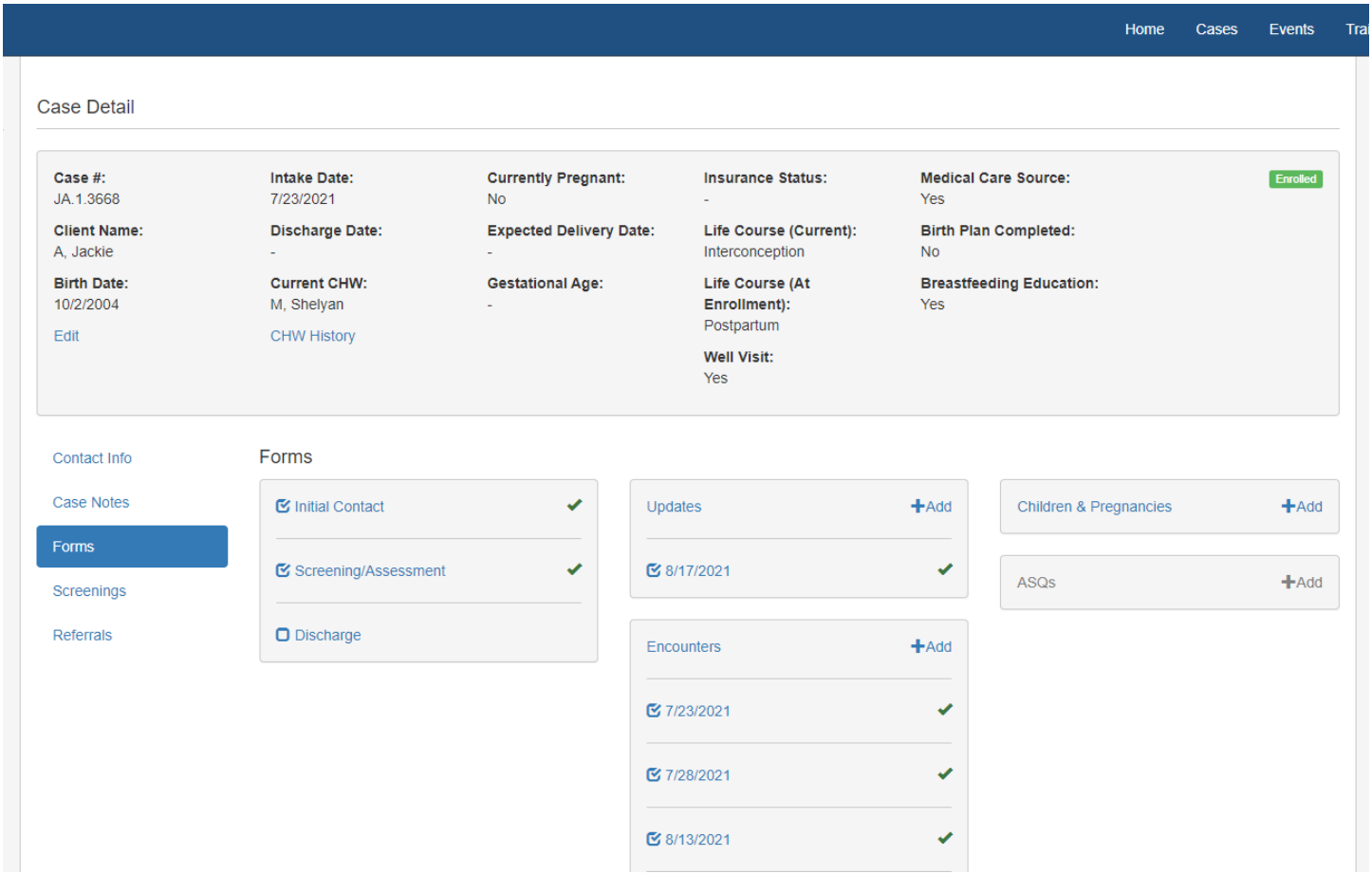
To reactivate an entry, open the history and click “Activate” next to the desired entry.



Case Notes - The case notes section can be used to store any information pertaining to the case that should be recorded but does not have a place in one of the existing forms.



Forms - The forms section contains all the case related forms. This is where all case related data entry can be accomplished.



a. Initial Contact - This form serves as the starting point for a case. New cases are created by adding initial contact forms.

b. Screening/Assessment

c. Update

d. Discharge

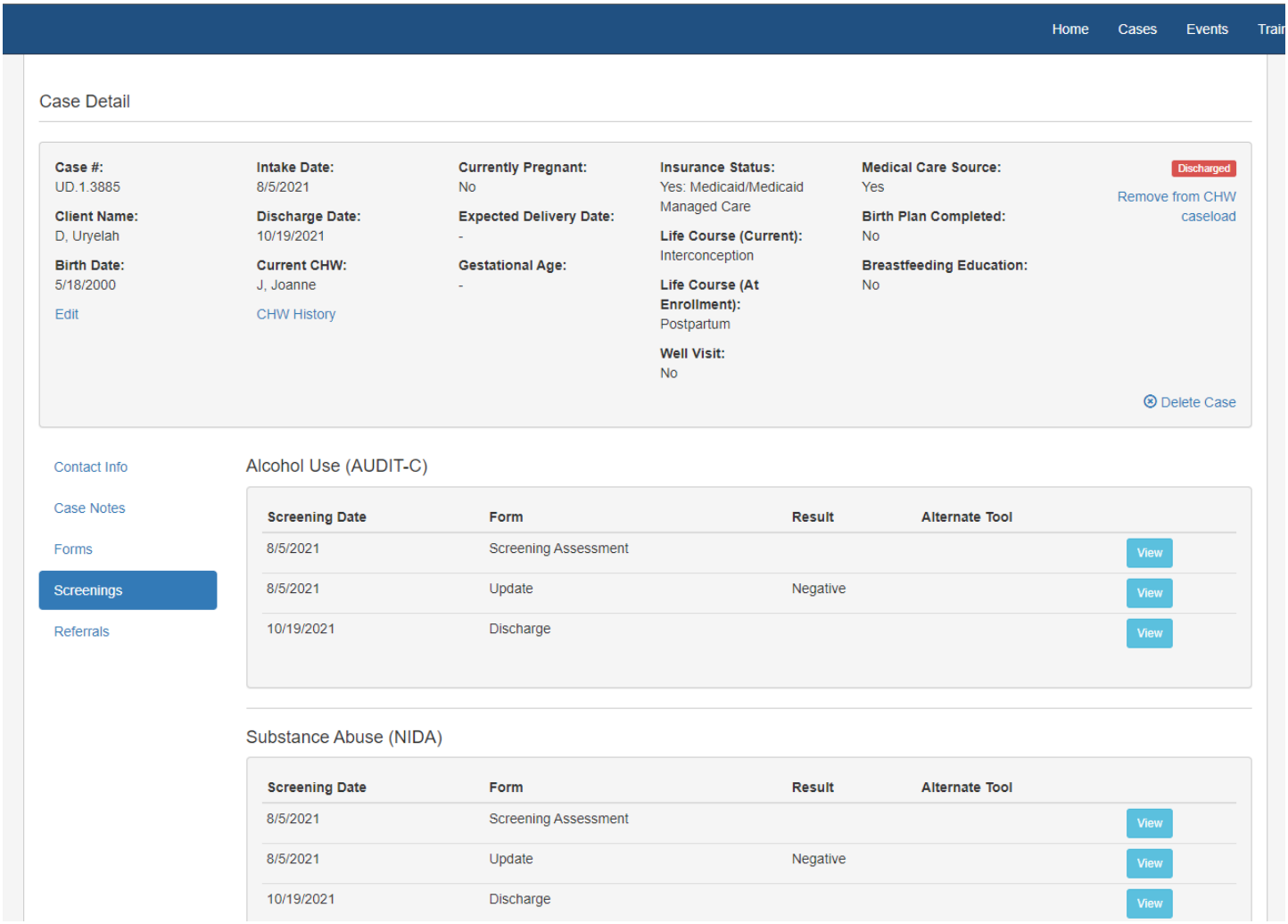
e. Encounter

f. Child Information & Pregnancy Outcomes

g. ASQ

Some forms include additional questions related to postpartum visits and pregnancy outcomes, which are used in reporting and performance measures.

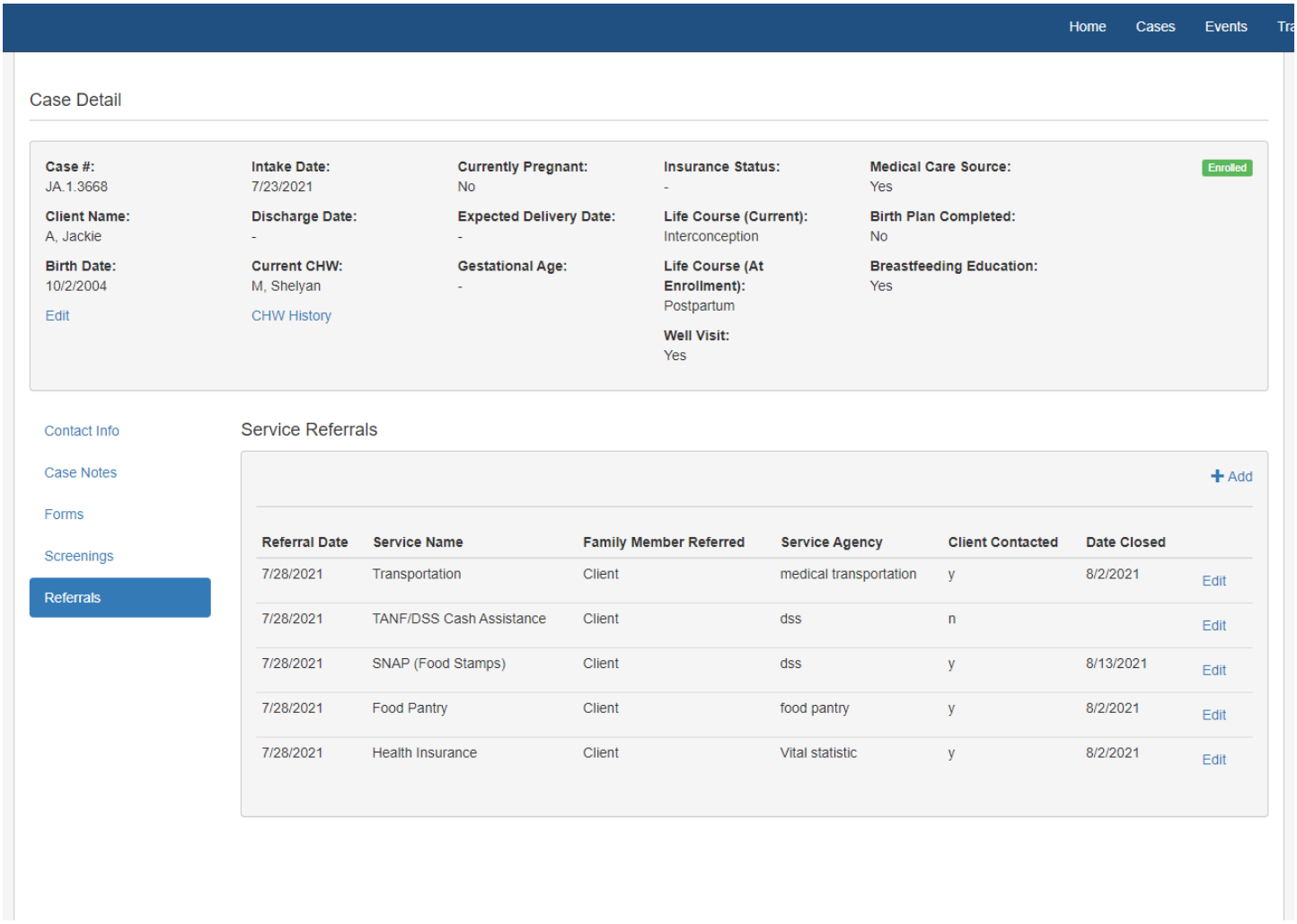
Screenings – The screenings section shows



Referrals – The referrals section shows referrals entered for the case.

Referrals entered in the system are used in reporting and performance measures.

Certain referral types, such as Doula services, are included in reporting categories and may be used for program evaluation.



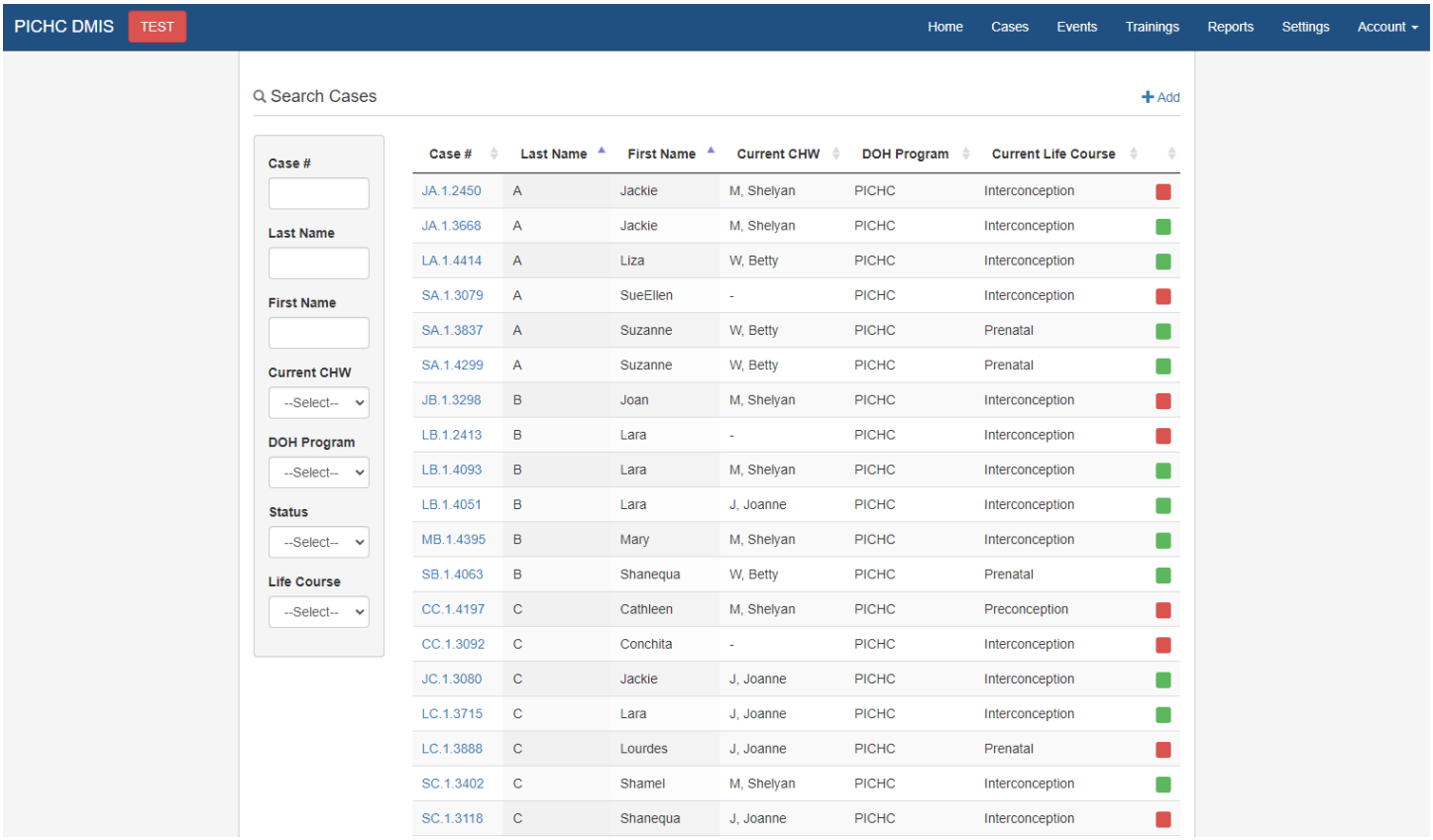
Finding your cases

A list of all cases in your program can be viewed by clicking the “Cases” link in the menu.

The list can be sorted by any column by clicking on the arrows in the appropriate column header.

The list can also be searched by entering text into one or more of the boxes on the left-hand side.

Click on a case number to view the case.



Other Functions

Transfer Cases

Role(s) required: Program Manager

Cases can be transferred between CHWs individually from the Case Details page or in batches on the Worker Detail form.

Case Access

Role(s) required: Program Manager, Data Entry

By default, CHWs can access every case in their program. To restrict case access, program managers should navigate to the Program Detail Form. In the top left panel, click 'edit' to display the 'Restrict caseload access' checkbox. When activated, CHWs will only be able to access cases to which they are assigned.

Supervisor Approval of Forms

Role(s) required: Supervisor

The forms on the case details page: Screening Assessment, Update, Discharge, etc. can be approved by users logged in with a Supervisor role.

There is an extra button next to the submit button visible only to Supervisors. If the form is not approved, the button is green and contains the text 'Approve.' If the form is approved, the button is red and contains the text 'Unapprove.'

Once a form is approved, it can't be edited. Therefore, if changes must be made to an approved form, it must be 'unapproved' first.

Approving a form does not save edits.

Supervisor and Worker Side Panels: Informational panels will appear on either side of the screen for Supervisors and Workers. These function much like dashboards, displaying summary information relevant to the user. For these to display, user accounts must be linked to worker records via the Worker Detail Form.

Worker Tasks Sidebar

Role(s) required: Worker

The "My Tasks" sidebar displays items requiring attention based on the user's role.

Session Timer

When you log in to the system a timer is set to twenty minutes. If you do not interact with the system after twenty minutes, you will be automatically logged out.

Interacting with the system includes clicking links, buttons, and entering data into form fields. Any interaction will reset the session timer.

If you are in the process of filling out a form when the timer expires, any data you've entered will be lost.

Before you are automatically logged out a message will appear with a countdown, prompting you to respond. If you respond before the countdown expires, the timer will be reset to twenty minutes.

3. Frequently asked questions

1. I receive an error message when I try to reset my password.

- A common mistake is to enter your email address when attempting to reset your password. Be sure to enter your username and not your email address.

2. I received a new password, but it does not work.

- If you try to copy and paste the new password, you may inadvertently copy an extra space character at the end of your password. When pasted, the extra space character will cause your password to fail. To avoid this, type your password into the password box.

3. Can we do a data download from our existing agency database (Captain) to avoid duplicate database entry?

- No, this function will not be available.

4. Can all CHWs see all cases and case data?

- By default, CHWs can access every case in their program. To restrict case access, see Function 2.E.2 Case Access.

5. Is there a place to include current file numbers or do all have to use the system's case numbers?

- There is no specific place for current file numbers. The case notes section on the case detail page can be used to store information that does not have a specific place.

6. Will the training presentation be sent to us to share with our CHWs so they can log on and watch?

- Below is the link to the recording of the PICHC monthly call (March 17, 2021) reviewing the soon-to-launch PICHC data system.

7. Is there a way to upload documents (i.e. consents, birth plans)?

- Currently, the system does not support uploading documents.

8. What browsers are supported? Are mobile browsers supported? Will the web page display in a mobile format, or as desktop version?

- Chrome and Edge are fully supported. We do not support Safari or mobile devices but in our rudimentary testing they work well. The web pages will display in mobile and desktop formats.

9. Are the case numbers that are created the same for all the programs using the system? Meaning if a client moved and had to transfer services would this client have the same case number?

- Case numbers are unique across programs. However, the current system cannot transfer cases.

10. Does a program manager who supervises CHWs need both manager and supervisor accounts, or can they see items needing attention in the program manager role?

- In this situation, the user would have two roles, Program Manager and Supervisor, associated with their account. They would need to select the Supervisor role when they log in to see items needing attention.

11. How often does the database refresh?

- The database refreshes in real time. Any data entered will be displayed immediately whether it be in reports, dashboards, etc.

12. Can 2 people be on the same case at the same time entering data or does the system have a safeguard for that?

- Two people can be on the same case at the same time entering data. This could lead to duplication issues.

13. Can supervisors make edits for ALL staff entries?

- Supervisors can make edits for ALL staff entries.

14. Is data entry time stamped?

- Every entry is time stamped. In addition, every time a form is edited or deleted, the entry is logged in a backup table.

15. As a supervisor, can I see the electronic footprint of staff in the system (like how long they were logged in and what they did while they were logged in)?

- The only 'footprint' visible to supervisors would be the entry of case related forms that have yet to be approved. These items appear on the supervisor's dashboard and side panels. The system does track the adding, editing and deleting of forms. This data can be analyzed by site administrators, but it is not readily available to supervisors.

16. It appears that in order for a client to be enrolled in program the Supervisor has to approve the initial contact form. Without that approval the client is listed as Pending and the CHW is not able to add Children and Pregnancies or Update Info. Can this be changed so that the supervisor does not need to approve the form before any of that happens? It will be very burdensome and inefficient for the supervisor to have to approve each one for each client, then the CHW have to go back and fill out the remainder of the info for the client.

- Approval of the Initial Contact form is not necessary for further data entry. However, the Screening Assessment is required to enter other forms. Due to the way the system is constructed, the Screening Assessment collects data that future forms use for calculations. Therefore, it must be entered before the other forms.

17. Is there a QA function where we can run a report to see what info is missing so we can make sure we haven't overlooked anything for each client?

- There is not such a report. Standard practices to ensure the quality of the client data entry will have to be used on the initial screening. This will allow the flexibility to complete screening as trust is built between the community health care worker and the client. An update form can be submitted at any time to allow the record of additional or updated screenings to address the client's needs.

18. We wanted to ask about the possibility of doing a bulk data entry. The way it is currently set up is that each individual encounter has to be input separately. Depending on the client, this could be quite time intensive to input this data each month, as sometimes we have many, many contacts with the same client. It would be much more efficient to be able to write the number of encounters, the number of each activities, referrals, etc. to that client each month, rather than a specific form for each encounter.

- Not all forms of contact with a client will be considered an encounter. Please only document encounters where there is an exchange of information, and when the following activities are completed, screenings, education, updating medical visits, and/or referrals. Check-ins, reminding clients of upcoming appointments, following up on referrals, via phone or text are not considered an encounter thus should not be documented.

19. What happens when you discharge a client by mistake and it is a client that is active, how can I put it back into enrolled status?

- Deleting the discharge form will change the status of a client back to active. Program Manager and Data Entry users have access to a delete button at the bottom of each form.

20. Why doesn't a CHW appear in the list of workers on forms?

    - A Program Manager needs to add this worker on the Program Detail Form.

21. Why is the pregnancy status information on the case detail page incorrect?

    - The system tries to determine the status of the client using three pieces of data. If they are entered erroneously, the case detail page may display incorrect information.

        1. The answer to "Currently Pregnant?" on the most recent entry (Screening Assessment, Update, Discharge).
        2. The "Expected Delivery Date" on the most recent entry (Screening Assessment, Update, Discharge).
        3. Pregnancy forms in system.

        If "Currently Pregnant?" is "yes" and there is an expected delivery date, then the system looks for a pregnancy form dated after the expected delivery date. If one is found, it is assumed to be the child that the client was pregnant with when "Currently Pregnant?" was answered "yes." Thus, the case detail page will display "No" for "Currently Pregnant?"

22. Why do I see postpartum due dates on the Dashboard or in My Tasks?

    - The system may display upcoming 8-week and 12-week postpartum due dates to help workers track timely follow-up activities. These items are shown based on the user's role.

PICHC DMIS
Reporting Issues

9/15/2021

Encounter Frequency by Client Pregnancy Status at Intake

- **Unknown cases**

- **Prenatal**: Screening Assessment item "Currently Pregnant?" = “Yes"

- If last delivery date is later than intake date, "Currently Pregnant?" = “No“
  - Pregnancy Status is reported as “Unknown”.
- Change “No” to “Yes” for the question “Currently Pregnant?"

Encounter Frequency by Client Pregnancy Status At Intake

*INCLUDES CLIENTS HAVING ENCOUNTERS DATES WITHIN SPECIFIED DATE RANGE

Intake Date	Last Delivery Date	Previous Pregnancies	Pregnant at Screen	Encounter Date	Type of Contact	Contact Location	Pregnancy Status
9/15/2020	3/15/2021	1	n	6/16/2021	Phone		Unknown
9/15/2020	3/15/2021	1	n	7/20/2021	Text		Unknown

2

Encounter Frequency by Client Pregnancy Status at Intake

- **Unknown cases**

  - **Interconception**: Screening Assessment items "Last Delivery Date" is more than 8 weeks prior to Intake Date and "Currently Pregnant?" is not “Yes“.

  - Cases without last delivery date
    - Pregnancy Status is reported as “Unknown”.
  - Enter last delivery date when applicable.

Intake Date	Last Delivery Date	Previous Pregnancies	Pregnant at Screen	Encounter Date	Type of Contact	Contact Location	Pregnancy Status
9/15/2020	3/15/2021	1	n	6/16/2021	Phone		Unknown
9/15/2020	3/15/2021	1	n	7/20/2021	Text		Unknown
1/21/2021		2	n	1/21/2021	In-person	MICHC offic	Unknown
1/21/2021		2	n	2/5/2021	Phone		Unknown

Encounter Frequency by Client Pregnancy Status at Intake

- **Unknown cases**

  - **Preconception:** “Previous Pregnancies” are 0.

  - If “Previous Pregnancies” are greater than 0, “Last Delivery Date” must be filled out for clients to be categorized asinterconception.

Intake Date	Last Delivery Date	Previous Pregnancies	Pregnant at Screen	Encounter Date	Type of Contact	Contact Location	Pregnancy Status
7/30/2021			n	5/12/2021	E-mail		Unknown
7/30/2021			n	3/15/2021	Phone		Unknown
7/30/2021			n	4/26/2021	Phone		Unknown

  - **Please fill in all applicable fields!**

Encounter Frequency by Client Pregnancy Status at Intake

- **Other**
  - Client is found to be pregnant at later encounters
    - Go back and change “Currently Pregnant?” from “U” to “Y”
  - Do not enter a future date for “Last Delivery Date”.

Intake Date	Last Delivery Date	Previous Pregnancies	Pregnant at Screen	Encounter Date	Type of Contact	Contact Location	Pregnancy Status
1/13/2021			u	6/25/2021	Phone		Unknown
1/13/2021			u	7/28/2021	Phone		Unknown
1/13/2021			u	4/5/2021	In-person	Client home	Unknown
1/13/2021			u	3/9/2021	In-person	Client home	Unknown
1/13/2021			u	2/17/2021	In-person	Client home	Unknown
12/1/2020	11/19/2021		u	12/1/2020	Phone		Unknown

Encounter Frequency by Client Pregnancy Status at Intake

- Not all forms of contact with a client are considered an encounter
  - Document encounters only when:
    - there is an exchange of information and
    - the following activities are completed:
      - screenings,
      - education,
      - updating medical visits, and/or
      - referrals.
  - Do not document encounters for:
    - check-ins,
    - reminding clients of upcoming appointments,
    - following up on referrals, via phone or text.

Referrals Report

- Check the Detail Section of the report to make sure all completed referrals are accurately reflected on the report.
  - Issued: Count of Service Referrals entered into system.
  - Completed: Count of Issued Service Referrals
    - Client Contacted is “Y” and Date Closed is entered.
- Example:
  - When “Date Closed” or “Client Contacted” is not filled, or “Client Contacted” is showing “N”, the referrals are not showing as completed

MICHC Clients

Service Category	Service Type	Case Number	Form Date	Client Contacted	Date Closed
Health Care	Adult primary care	AS.1.3439	7/27/2021	y	
Health Care	Adult primary care	KM.1.3062	7/15/2021	y	
Health Care	Adult primary care	BW.2.2755	1/13/2021		1/13/2021
Health Care	Dental services	OB.2.2726	2/5/2021	n	2/5/2021

Birth Outcome Report

- **Birth History** section data pulls data from the Screening Assessment form.
- **Birth Outcome** section pulls data from the Child & Pregnancy Form.

Case Number	Previous preterm birth	Previous low birth weight	Child	Birth Date	Gestational Age	Lbs	Oz	First Birth	Receiving Prenatal Care	First Prenatal Medical Vist	Expected Delivery Date
	y	y	August	4/12/2021	34						

- Birth History:
  - Previous Low Birth Weight: Screening Assessment item "Any previous babies born below normal weight?" is "yes".
  - Previous Preterm Birth: Screening Assessment item "Any previous premature births?" is "yes".
  - Low Birth Weight: Child & Pregnancy Form item, "Birth Weight" less than 5lbs 8oz.
- Birth Outcome:
  - First Births: Child & Pregnancy Form item, "First Birth?" is "yes".
  - Preterm Births: Child & Pregnancy Form item, "Gestational Age" is less than 37 weeks.
  - Low Birth Weight: Child & Pregnancy Form item, "Birth Weight" is less than 5lbs 8oz.

Birth Outcome Report

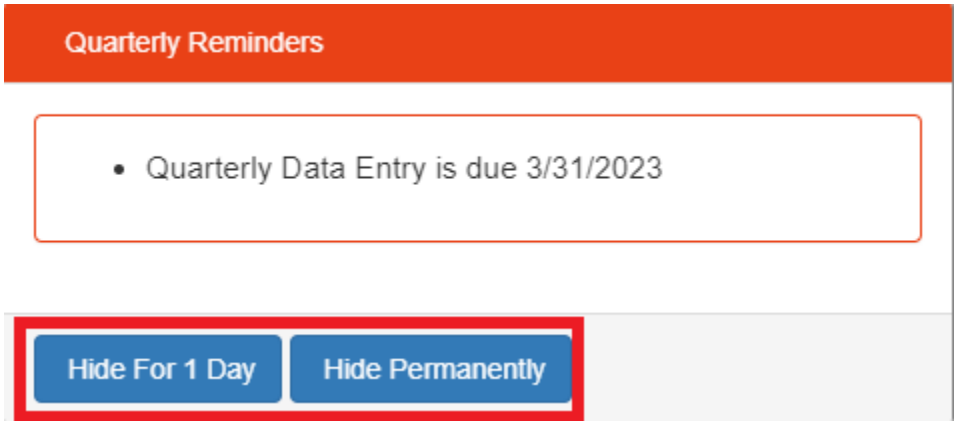
➢ Prenatal Care Initiation Form

- Fill in the following from the last Screening Assessment or Update prior to birth:
  - No Prenatal Care: if "Any prenatal visits?" is "no".
  - Unknown Trimester: if "Any prenatal visits?" is "yes", and "If yes, date of prenatal visit" is later than "If so, expected date of delivery", or either date is missing.
  - Unrecorded: if "Any prenatal visits?" is "unknown" or blank.

Prenatal Care Initiation	Clients	%
First Trimester	174	15.2
Second Trimester	35	3.0
Third Trimester	14	1.2
Unknown Trimester	280	24.4
No Prenatal Care	43	3.7
Unrecorded	602	52.4
Total	1148	

Reminder Overview

Reminders are a function that keeps track of data entry due dates, both Monthly and Quarterly. Reminders appear on your home page a set number of days before each due date in panels on the bottom left and bottom right of your screen. Each has two hide options, “Hide For 1 Day” and “Hide Permanently.”



Each hide option only applies to that category (Monthly or Quarterly) of Reminder, and can be reversed by clicking on the “Show (…) Reminders” button that will appear by the top of the page once you’ve manually hidden the Reminder. Hiding Reminders only applies to your current machine, not to your account; accessing the site from a different computer will show you the reminders like you haven’t hidden them. Additionally, please note that even hiding permanently only lasts for the duration of the current reminder. When the next monthly or quarterly window comes around, a new Reminder will come with it.

Reminder windows are:

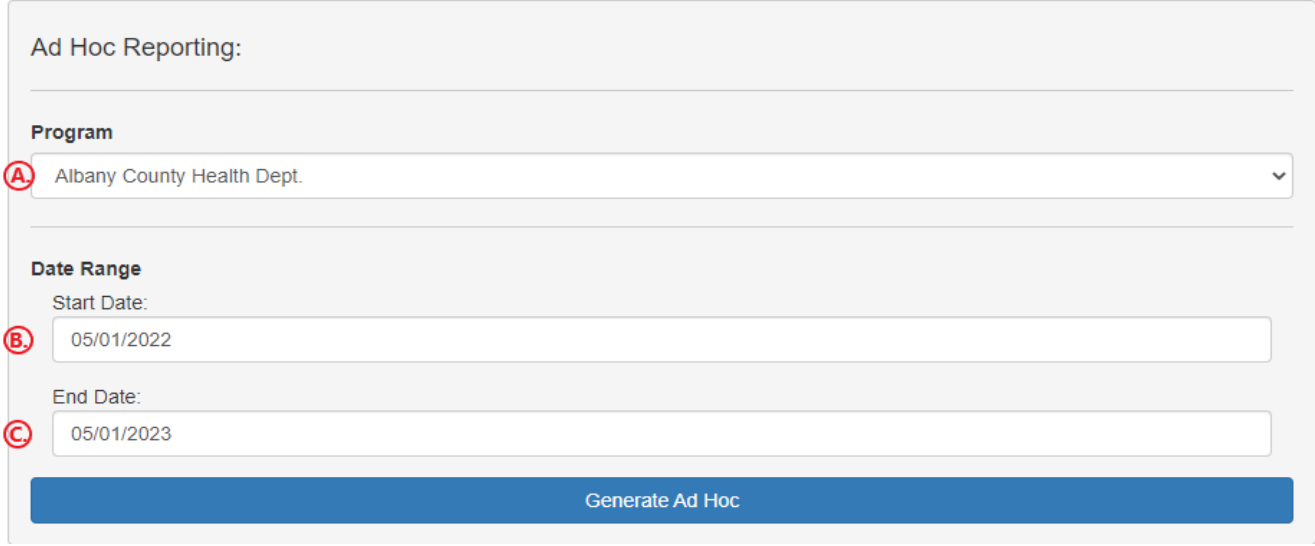
Reminder Type	Start Window	End Window
Monthly Reminder	7 Days Before Due Date	On Due Date
Quarterly Reminder	15 Days Before Due Date	End of Due Date Month

How To Use Ad-Hoc Reporting

The Ad-Hoc Report function allows data system users to review listings of clients active in their caseloads for a specifiable time period along with some of their key information.

1. **How to Create an Ad-Hoc Report:**

   To access Ad-Hoc Reporting, click on the "Reports" tab and scroll down to the bottom, where you will find three specifiable fields.



   a. Program. For all users at the level of Program Manager or below, this will have only one option, that being the program you're in. If you do have the ability to change this, note that the Ad Hoc report can only be run for one program at a time, due to the large amount of data it gathers.

   b. Start Date. By default, set to a year before the 1st of the current month, Start Date acts as a cutoff point for the report. **Any clients with a Discharge Date before the Start Date will not be included.**

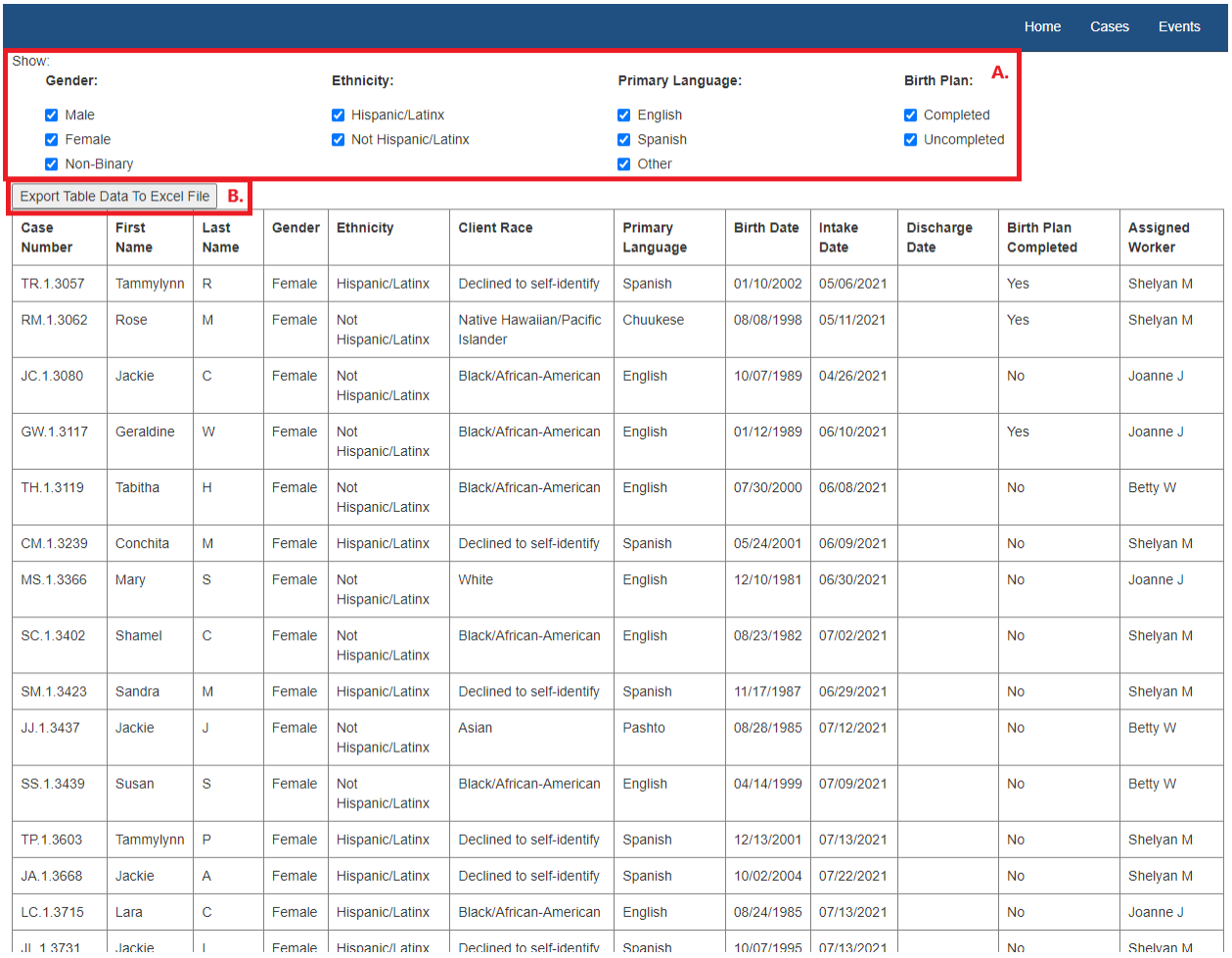
   c. End Date. By default, set to the 1st of the current month, End Date acts as a cutoff point for the report. **Any clients with an Intake Date after the End Date will not be included.**

   Once these three fields are specified, simply press the Generate Ad Hoc button and the report will be created.

2. Report Details

The report has 12 columns at present, among which Gender, Ethnicity, Primary Language and Birth Plan Completed have filters to show only certain values (*Figure A below*). By default, all filters are checked as selected; unchecking a checkbox will hide the rows matching the listed condition. By varying check box selections, you can do things like showing only males who identify as Hispanic/Latinx or English-speaking females with a completed birth plan.

Another option is to export this report to Excel, which will give you the ability to use additional filters and/or sorts. Click on the "Export Table Data To Excel File" button (*Figure B below*), and you will download a file called "rptAd-Hoc.xlsx." From this point on, this guide will cover some basic methods for manipulating the report with filtering in Excel.

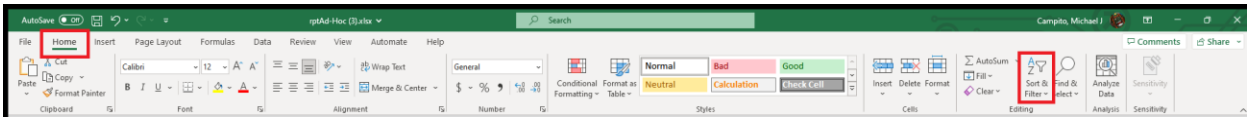


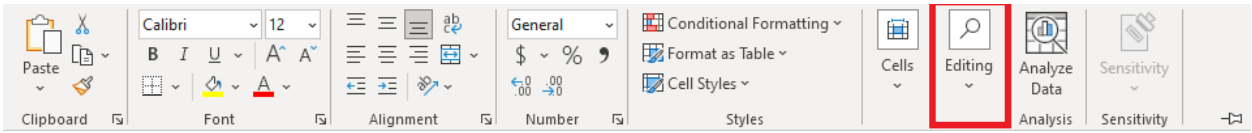
Case Number	First Name	Last Name	Gender	Ethnicity	Client Race	Primary Language	Birth Date	Intake Date	Discharge Date	Birth Plan Completed	Assigned Worker
TR.1.3057	Tammylynn	R	Female	Hispanic/Latinx	Declined to self-identify	Spanish	01/10/2002	05/06/2021		Yes	Shelyan M
RM.1.3062	Rose	M	Female	Not Hispanic/Latinx	Native Hawaiian/Pacific Islander	Chuukese	08/08/1998	05/11/2021		Yes	Shelyan M
JC.1.3080	Jackie	C	Female	Not Hispanic/Latinx	Black/African-American	English	10/07/1989	04/26/2021		No	Joanne J
GW.1.3117	Geraldine	W	Female	Not Hispanic/Latinx	Black/African-American	English	01/12/1989	06/10/2021		Yes	Joanne J
TH.1.3119	Tabitha	H	Female	Not Hispanic/Latinx	Black/African-American	English	07/30/2000	06/08/2021		No	Betty W
CM.1.3239	Conchita	M	Female	Hispanic/Latinx	Declined to self-identify	Spanish	05/24/2001	06/09/2021		No	Shelyan M
MS.1.3366	Mary	S	Female	Not Hispanic/Latinx	White	English	12/10/1981	06/30/2021		No	Joanne J
SC.1.3402	Shamel	C	Female	Not Hispanic/Latinx	Black/African-American	English	08/23/1982	07/02/2021		No	Shelyan M
SM.1.3423	Sandra	M	Female	Hispanic/Latinx	Declined to self-identify	Spanish	11/17/1987	06/29/2021		No	Shelyan M
JJ.1.3437	Jackie	J	Female	Not Hispanic/Latinx	Asian	Pashto	08/28/1985	07/12/2021		No	Betty W
SS.1.3439	Susan	S	Female	Not Hispanic/Latinx	Black/African-American	English	04/14/1999	07/09/2021		No	Betty W
TP.1.3603	Tammylynn	P	Female	Hispanic/Latinx	Declined to self-identify	Spanish	12/13/2001	07/13/2021		No	Shelyan M
JA.1.3668	Jackie	A	Female	Hispanic/Latinx	Declined to self-identify	Spanish	10/02/2004	07/22/2021		No	Shelyan M
LC.1.3715	Lara	C	Female	Hispanic/Latinx	Black/African-American	English	08/24/1985	07/13/2021		No	Joanne J
JL.1.3731	Jackie	L	Female	Hispanic/Latinx	Declined to self-identify	Spanish	10/07/1995	07/13/2021		No	Shelyan M

3. Intro to Filtering in Excel

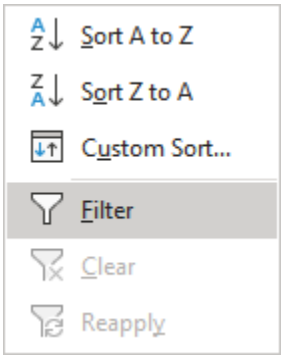
Excel has powerful built in functionality to allow for effective filtering of reports that we're going to take advantage of. First off, if editing is disabled for your new document (if so, it should have a yellow warning band at the top of the page), enable it. From there, we're going to try filtering a column.

a. In the Home menu at the top, look in the Editing section on the right for "Sort & Filter." If Excel is open fullscreen, this will be plainly visible on the toolbar (see first image below), while if you're at half or less it will be hidden in the dropdown indicated in the second image.

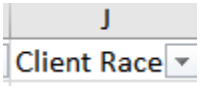




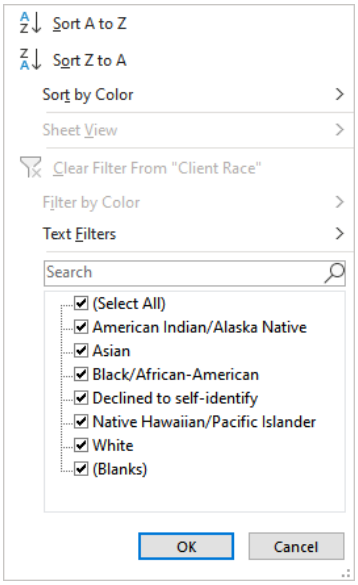
b. Click on the "Sort & Filter" option to open up a submenu, from which you want to select "Filter."



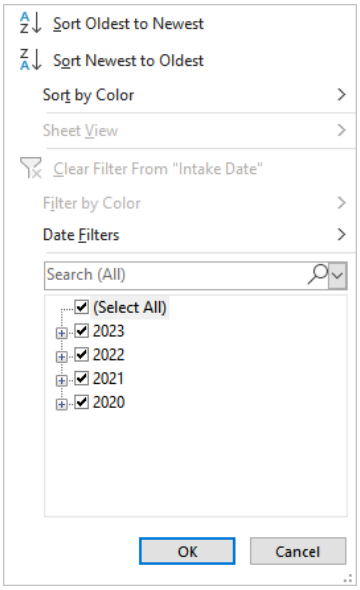
c. Doing this will add dropdown arrows to each of the column headings, which you can click on to sort and filter that column by the requested values.



For example, if you do this for client race, you can show or hide clients with each race by checking or unchecking each option.



Similarly, you can choose to hide all clients who don't have an intake date tied to a certain year.



All these filters will stack, allowing you to not just view only Native Hawaiian clients, but only Native Hawaiian clients with an intake date in 2021 and an uncompleted birth plan. You can also use the "Sort A to Z" option on any selected column to organize by case number, or "Sort Oldest to Newest" to organize by client birth date.

Excel has many options for displaying and sorting information, and you can find further tips on how to do more with your report here. However, the instructions already provided should be enough to cover your everyday needs and enable you to get the best use out of the new Ad-Hoc Report.