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FAMILY DATA FORM

ORIGINAL

Family Advocate: Amanda [redacted]

First Hug # 3073 **ASO Family #** _____

UNITY# 180404

Open Date: 11/26/18

Referral Source

	Self		Child Care
	Inter-Agency (Dept.)		Agency (Name)
✓	Hillsborough County School System		Faith Based Partnership

HOUSEHOLD INFORMATION

Street Address: [redacted]

Apt. #: _____ City: Tampa Zip Code: 33604

Phone #: [redacted]

E-Mail: [redacted]

 # Of Adults in Household: 2 **# Of Minor Children in Household:** 2

Household Structure

	Male (Single) Head of Household		Female (Single) Head of Household
	Other Relative – Kinship – Head of Household	✓	Dual 2 Parent Household
	Dual 2 Other Relative Kinship Head of Household		Other – Foster Parent, Neighbor or Friend

Highest Level of Education Attained in Household

	Some or no high school	✓	High school graduate or GED
	Technical Certificate		Some College
	Associates Degree		Bachelor's Degree
	Advanced Degree – Master's or Doctoral Degree		Refused

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS
• *Has anyone in your family ever received any help with their mental wellness?* • *Do you feel that every member in your family is getting all the help they need for their mental health or stress?* • *Has a doctor ever prescribed anyone in your family pills for nerves, anxiety, depression or anything like that?* • *Has anyone in your family ever gone to an emergency room or stayed in a hospital because they weren't feeling 100% emotionally?* • *Does anyone in your family have trouble learning or paying attention, or been tested for learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby? What about when you were pregnant?* • *Has anyone in your family ever hurt their brain or head?* • *Do you have any documents or papers about your family's mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your family's mental health?*

CLIENT SCORE:	0

NOTES
No reported mental health or feelings of anxiety or depression.

SCORING	
4	**Any** of the following among any family member: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following among any family member: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about the family's safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for any member of the family to be screened by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ All members of the family are in a heightened state of recovery, have a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** are engaged with mental health supports as necessary.
0	☑ No mental health or cognitive functioning issues disclosed, suspected or observed.

C. Medication

PROMPTS	CLIENT SCORE: 0
• *Has anyone in your family recently been prescribed any medications by a health care professional?* • *Does anyone in your family take any medication, prescribed to them by a doctor?* • *Has anyone in your family ever had a doctor prescribe them a medication that wasn't filled or they didn't take?* • *Were any of your family's medications changed in the last month? Whose? How did that make them feel?* • *Do other people ever steal your family's medications?* • *Does anyone in your family ever sell or share their medications with other people it wasn't prescribed to?* • *How does your family store their medication and make sure they take the right medication at the right time each day?* • *What do you do if you realize someone has forgotten to take their medications?* • *Do you have any papers or documents about the medications your family takes?*	**NOTES** Son takes albuterol and breathing treatments as needed

	SCORING
4	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason.
3	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following for any family member: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following is true for **every** family member: ☐ No medication prescribed to them ☑ Successfully self-managing medication for 181+ consecutive days

E. Experience of Abuse & Trauma of Parents

PROMPTS	CLIENT SCORE: 1
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. ***Because this section is self-reported, if there are more than one parent present, they should each be asked individually.*** • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES** Past history of domestic violence however does not affect client

	SCORING
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☑ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE: 0
• *[Observe, don't ask] Any abcesses or track marks from injection substance use?* • *Does anybody force or trick people in your family to do things that they don't want to do?* • *Do you or anyone in your family ever do stuff that could be considered dangerous like drinking until they pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Does anyone in your family ever find themselves in situations that may be considered at a high risk for violence?* • *Does your family ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES** No exposure to risky or exploitive situations

SCORING	
4	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 10+ higher risk and/or exploitive events ☐ In the past 90 days, any member of the family left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 4-9 higher risk and/or exploitive events ☐ In the past 180 days, any member of the family left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 1-3 higher risk and/or exploitive events ☐ 181+ days ago, any member of the family left an abusive situation
1	☐ Any involvement in higher risk and/or exploitive situations by any member of the family occurred more than 180 days ago but less than 365 days ago
0	☑ In the past 365 days, no involvement by any family member in higher risk and/or exploitive events

I. Legal

PROMPTS
• *Does your family have any "legal stuff" going on?* • *Has anyone in your family had a lawyer assigned to them by a court?* • *Does anyone in your family have any upcoming court dates? Do you think there's a chance someone in your family will do time?* • *Any outstanding fines?* • *Has anyone in your family paid any fines in the last 12 months for anything?* • *Has anyone in your family done any community service in the last 12 months?* • *Is anybody expecting someone in your family to do community service for anything right now?* • *Did your family have any legal stuff in the last year that got dismissed?* • *Is your family's housing at risk in any way right now because of legal issues?*

CLIENT SCORE:	0

NOTES
No legal issues

	SCORING
4	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following among any family member: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues among family members, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☑ No family member has had any legal issues within the past 365 days, **and** currently no conditions of release

K. Personal Administration & Money Management

PROMPTS
• *How are you and your family with taking care of money?* • *How are you and your family with paying bills on time and taking care of other financial stuff?* • *Does anyone in your family have any street debts or drug or gambling debts?* • *Is there anybody that thinks anyone in your family owes them money?* • *Do you budget every single month for every single thing your family needs? Including cigarettes? Booze? Drugs?* • *Does your family try to pay your rent before paying for anything else?* • *Is anyone in your family behind in any payments like child support or student loans or anything like that?*

CLIENT SCORE:	4

NOTES
Landlord debt totaling $4k (current: $2k, past due: $2k) No current budget plan Boyfriend donates plasma 2x/wk

	SCORING
4	**Any** of the following: ☐ No family income (including formal and informal sources) ☑ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments **Or**, for the person who normally handles the household's finances, **any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Not aware of the full amount spent on substances, if the household includes a substance user
3	☐ Real or perceived debts of $999 or less, past due or requiring monthly payments, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if the household includes a substance user
2	☐ In the past 365 days, source of family income has changed 2+ times, **or** For the person who normally handles the household's finances, **any** of the following: ☑ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

M. Self Care & Daily Living Skills of Family Head

PROMPTS
• *Do you have any worries about taking care of yourself or your family?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Does anyone in your family ever need reminders to do things like shower or clean up?* • *Describe your family's last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your family's clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*

CLIENT SCORE: 2

NOTES

Visits laundromat weekly
Food stamps covers household for the month
Children help clean the room and have other household chores
No bugs/mice
Boyfriend's mother assisting with electric bill monthly

	SCORING
4	**Any** of the following for head(s) of household: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following for head(s) of household: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following for head(s) of household: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☑ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, family accessed community resources 4 or fewer times, **and** head of household is fully taking care of all the family's daily needs
0	☑ For the past 365+ days, fully taking care of all the family's daily needs independently

O. History of Homelessness & Housing

PROMPTS	CLIENT SCORE: 2
• *How long has your family been homeless?* • *How many times has your family experienced homelessness other than this most recent time?* • *Has your family spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your family's permanent address?* • *Has your family ever spent time sleeping in a car, alleyway, garage, barn, bus shelter, or anything like that?* • *Has your family ever spent time sleeping in an abandoned building?* • *Was anyone in your family ever been in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?*	**NOTES** Stayed at Metropolitan Ministries Uplift U transitional housing in 2014 for 10 months.

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of family homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of family homelessness
2	☑ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of family homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of family homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of family homelessness

Q. Stability/Resiliency of the Family Unit

PROMPTS	CLIENT SCORE: 0
• *Over the past year have there been any different adults staying with the family like a family friend, grandparent, aunt or that sort of thing? If so, can you tell me when and for how long and the changes that have occurred?* • *Other than kids being taken into care, have there been any instances where any child has gone to stay with another family member or family friend for any length of time? Can you tell me how many times, when and for how long that happened?*	**NOTES** No changes in household

	SCORING
4	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relative within the family have changed 4+ times ☐ Children have left or returned to the family 4+ times
3	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 3 times ☐ Children have left or returned to the family 3 times
2	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 2 times ☐ Children have left or returned to the family 2 times
1	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 1 time ☐ Children have left or returned to the family 1 time
0	In the past 365 days, **any** of the following have occurred: ☑ No change in parental arrangements and/or other adult relatives within the family ☑ Children have not left or returned to the family

S. Size of Family Unit

PROMPTS	CLIENT SCORE: 4
• *I just want to make sure I understand how many kids there are, the gender of each and their age. Can you take me through that again?* • *Is anyone in the family currently pregnant?*	**NOTES** 2 parent household 32 weeks pregnant 7yo girl and 5yo boy

	SCORING	
	FOR ONE-PARENT FAMILIES:	**FOR TWO-PARENT FAMILIES:**
4	**Any** of the following: ☐ A pregnancy in the family ☐ At least one child aged 0-6 ☐ Three or more children of any age	**Any** of the following: ☑ A pregnancy in the family ☐ Four or more children of any age
3	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age	**Any** of the following: ☑ At least one child aged 0-6 ☐ Three children of any age
2	☐ At least one child aged 12–15.	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age
1	☐ At least one child aged 16 or older.	☐ At least one child aged 12 or older
0	☐ Children have been permanently removed from the family and the household is transitioning to services for singles or couples without children	

FAMILY SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (F-SPDAT)

FAMILIES

VERSION 2.01

Client: [redacted]	Worker: Amanda Lopez	Version:	Date: 11/19/18

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING	0	No reported mental health or feelings of anxiety or depression.
PHYSICAL HEALTH & WELLNESS	2	Client is 32 weeks pregnant and sees OBGYN every 2 weeks. Children are UTD on shots and physical. Son has asthma that flares up with weather changes, in which he receives medication and breathing treatments
MEDICATION	0	Son takes albuterol and breathing treatments as needed
SUBSTANCE USE	1	Boyfriend drinks on occasions. No other substance use with self or boyfriend
EXPERIENCE OF ABUSE AND/ OR TRAUMA	1	Past history of domestic violence however does not affect client
RISK OF HARM TO SELF OR OTHERS	0	No risk to self or others
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS	0	No exposure to risky or exploitive situations
INTERACTION WITH EMERGENCY SERVICES	1	Visits emergency room 1-2x/yr No police involvement

FAMILY SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (F-SPDAT)

FAMILIES

VERSION 2.01

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
PARENTAL ENGAGEMENT	2	Evenings consist of reading/homework, playing outside, eat dinner together, bathe, and bedtime by 830p. Children have good relationship with each other and parents.
STABILITY/RESILIENCY OF THE FAMILY UNIT	0	No changes in household
NEEDS OF CHILDREN	0	No concerns with Neveah
SIZE OF FAMILY	4	2 parent household 32 weeks pregnant 7yo girl and 5yo boy
INTERACTION WITH CHILD PROTECTIVE SERVICES AND/ OR FAMILY COURT	3	CPI involvement in August for false allegations of an illegal daycare. Case has been closed.
TOTAL	27	Rapid Re-Housing

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

Name Sonia [redacted] Date 11/26/18

Age _____ Gender (*Circle*): M (F) Other _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	(2)	3	4	2
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	(1)	2	3	4	1
3. In the last month, how often have you felt nervous and "stressed"?	0	1	(2)	3	4	2
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	(3)	4	1
5. In the last month, how often have you felt that things were going your way?	0	1	2	(3)	4	1
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	(2)	3	4	2
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	(4)	0
8. In the last month, how often have you felt that you were on top of things?	0	1	2	(3)	4	1
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	(2)	3	4	2
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	(2)	3	4	2

Please feel free to use the *Perceived Stress Scale* for your research. The PSS Manual is in the process of development, please let us know if you are interested in contributing.

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Mind Garden, Inc.
1690 Woodside Road, Suite #202
Redwood City, CA 94061 USA
Phone: (650) 261-3500 Fax: (650) 261-3505
e-mail: mindgarden@msn.com
www.mindgarden.com

References

The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24,* 386-396.

A Parent's Checklist · evised* Short Form

Pretest

Parent's/Caregiver's Name: Sonia [redacted] **Date:** 11/26/18

Child's Name: Neveah [redacted] **Child's School:** Kimbell ES

Please complete each question by circling the one answer that matches how much you have done each of these since the beginning of the **school** year (***first 2 grading periods of this school year***).

In the first half of this school year (first 2 grading periods), how often have I...?	Never 1	Rarely 2	Sometimes 3	Often 4	Almost Always 5
1. I made sure my child was in school and on time.	1	2	3	4	(5)
2. I communicated regularly with my child's teacher.	1	2	(3)	4	5
3. I have known how to help my child do well in school.	1	2	3	4	(5)
4. I set a bedtime for my child.	1	2	3	4	(5)
5. I set family routines including meals, study time and other activities together.	1	2	3	4	(5)
6. I made time each day for my child to share what he/she did in school.	1	2	3	4	(5)
7. I read with my child or made sure he/she was reading daily.	1	2	3	4	(5)
8. I helped at my child's school and/or attended school activities.	1	(2)	3	4	5
9. I displayed my child's schoolwork at home.	1	2	3	4	(5)
10. I helped my child with homework assignments.	1	2	3	4	(5)

(45)

*Revised with permission from Hillsborough County Public Schools, January 2013.

2 3 40

Goals:

Enroll in aftercare program

Parent-Student-Teacher Compact

NAME OF SCHOOL CHILD ATTENDS: Kimball Elem

SCHOOL AGREEMENT

The entire school staff will share the responsibility for improved student achievement, therefore we will do the following:

- Hold parent/teacher conferences.
- Send frequent reports to parents on their child's progress.
- Provide opportunities for parents to volunteer and participate in their child's class.
- Provide an environment that supports learning.
- Respect the student, their parents and the diverse culture of the school.

School/Teacher Signature _____ Date _____

PARENT/CAREGIVER AGREEMENT

I want my child to reach his/her full academic potential, therefore I will do the following to support my child's learning:

- Regularly communicate with my child's school; including attending parent-teacher conferences and volunteering in the classroom.
- Make sure that my child attends school daily and arrives on time.
- Support the school staff and respect cultural differences of others.
- Establish a time and place for homework and check it daily.
- Monitor television and movie viewing.
- Help to make positive use of out of school time.

Parent/Caregiver Signature Soneel [redacted] Date 11/26/18

STUDENT AGREEMENT

It is important that I do the best that I can, therefore I will do the following:

- Come to school each day on time with my homework completed and with the supplies that I need.
- Always try to work to the best of my ability.
- Believe that I can learn and I will learn.
- Follow the rules of conduct at my school.
- Respect my school, myself, other students, and accept cultural differences.

Student Signature _____ Date _____

ASQ-3 Ages & Stages Questionnaires®

57 months 0 days through 66 months 0 days

60 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: 12/3/18.

Child's information

Child's first name: Messiah. Middle initial: Child's last name: [redacted]

Child's gender: (X) Male ( ) Female

Child's date of birth: 10/29/13.

Person filling out questionnaire

First name: Sonia Middle initial: Last name: [redacted]

Relationship to child: (X) Parent ( ) Guardian ( ) Teacher ( ) Child care provider ( ) Grandparent or other relative ( ) Foster parent ( ) Other:

Street address: [redacted]

City: Tampa State/ Province: FL. ZIP/ Postal code: 33604

Country: USA Home telephone number: [redacted] Other telephone number:

E-mail address: [redacted]

Names of people assisting in questionnaire completion: Amanda Lopez

Program Information

Child ID #:

Program ID #:

Program name:

P101600101

COMMUNICATION (continued)

	YES	SOMETIMES	NOT YET	
5. Does your child answer the following questions? *(Mark "sometimes" if your child answers only one question.)*	●	○	○	10

"What do you do when you are hungry?" *(Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.")* Please write your child's response:

Eat

"What do you do when you are tired?" *(Acceptable answers include: "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.")* Please write your child's response:

Sleep

6. Does your child repeat the sentences shown below back to you, without any mistakes? *(Read the sentences one at a time. You may repeat each sentence one time. Mark "yes" if your child repeats both sentences without mistakes or "sometimes" if your child repeats one sentence without mistakes.)*	○	●	○	5

Jane hides her shoes for Maria to find.

Al read the blue book under his bed.

COMMUNICATION TOTAL 55

GROSS MOTOR

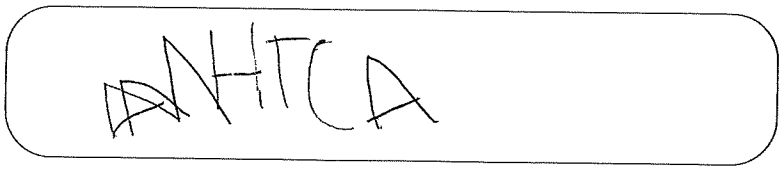
	YES	SOMETIMES	NOT YET	
1. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")* 	●	○	○	10
2. Does your child catch a large ball with both hands? *(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)* 	●	○	○	10
3. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? *(You may give your child two or three tries before you mark the answer.)* 	○	●	○	5

FINE MOTOR (continued)

	YES	SOMETIMES	NOT YET	
5. Using the letters below to look at, does your child copy the letters without tracing? Cover up all of the letters except the letter being copied. *(Mark "yes" if your child copies four of the letters and you can read them. Mark "sometimes" if your child copies two or three letters and you can read them.)*	●	○	○	10

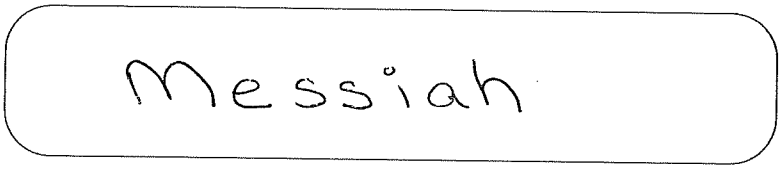
V H T C A

(Space for child's letters)

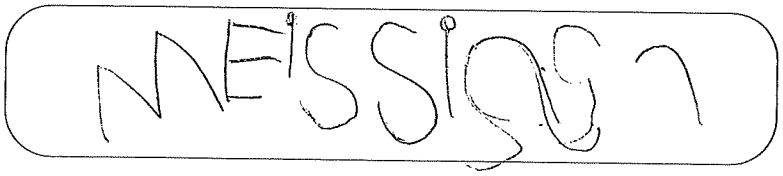


6. Print your child's first name. Can your child copy the letters? The letters may be large, backward, or reversed. *(Mark "sometimes" if your child copies about half of the letters.)*	○	●	○	5

(Space for adult's printing)



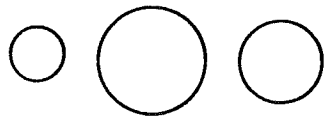
(Space for child's printing)



FINE MOTOR TOTAL 55

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When asked, "Which circle is smallest?" does your child point to the smallest circle? *(Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)*	●	○	○	10



2. When shown objects and asked, "What color is this?" does your child name five different colors like red, blue, yellow, orange, black, white, or pink? *(Mark "yes" only if your child answers the question correctly using five colors.)*	●	○	○	10

PERSONAL-SOCIAL *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your child dress and undress himself, including buttoning medium-size buttons and zipping front zippers?	◉	○	○	10
5. Does your child use the toilet by herself? *(She goes to the bathroom, sits on the toilet, wipes, and flushes.)* Mark "yes" even if she does this after you remind her.	◉	○	○	10
6. Does your child usually take turns and share with other children?	◉	○	○	10

PERSONAL-SOCIAL TOTAL 60

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ◉ YES ○ NO

2. Do you think your child talks like other children her age? If no, explain: ◉ YES ○ NO

3. Can you understand most of what your child says? If no, explain: ◉ YES ○ NO

4. Can other people understand most of what your child says? If no, explain: ◉ YES ○ NO

60 Month ASQ-3 Information Summary

57 months 0 days through 66 months 0 days

Child's name: Messiah [redacted] Date ASQ completed: 12/3/18.

Child's ID #: _____ Date of birth: 10/29/13

Administering program/provider: First Hug

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	33.19		●	●	●	●	●	●	●	○	○	○	○	◉	○
Gross Motor	31.28		●	●	●	●	●	●	●	○	○	○	○	◉	○
Fine Motor	26.54		●	●	●	●	●	●	○	○	○	○	○	◉	○
Problem Solving	29.99		●	●	●	●	●	●	○	○	◉	◉	○	○	○
Personal-Social	39.07		●	●	●	●	●	●	●	●	○	○	○	○	◉

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? (Yes) NO
   Comments:
2. Talks like other children his age? (Yes) NO
   Comments:
3. Understand most of what your child says? (Yes) NO
   Comments:
4. Others understand most of what your child says? (Yes) NO
   Comments:
5. Walks, runs, and climbs like other children? (Yes) NO
   Comments:
6. Family history of hearing impairment? YES (No)
   Comments:
7. Concerns about vision? YES (No)
   Comments:
8. Any medical problems? YES (No)
   Comments:
9. Concerns about behavior? (YES) No
   Comments:
10. Other concerns? YES (No)
    Comments:

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ▬ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

_____ Provide activities and rescreen in _____ months.
_____ Share results with primary health care provider.
_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
_____ Refer to primary health care provider or other community agency (specify reason): _____.
_____ Refer to early intervention/early childhood special education.
✓ No further action taken at this time
_____ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101600901

[redacted] PARENT SIGNATURE

(Pre)/Post Test SIDS and Safe Infant Sleep

Name: Sonia [redacted] Date: 1/14/19

Babies can "catch" SIDS.	T	(F)
Babies automatically cough up or swallow fluid that they spit up or vomit—it's a reflex to keep the airway clear. Studies show no increase in the number of deaths from choking among babies who sleep on their backs. In fact, babies who sleep on their backs might clear these fluids better because of the way the body is built.	(T)	F
A baby cannot catch SIDS. SIDS is not caused by an infection, so it can't be caught or spread.	(T)	F
SBS Stand for Shaken Baby Syndrome	(T)	F
Cribs themselves do not cause SIDS. But features of the sleep environment—such as a soft sleep surface—can increase the risk of SIDS and other sleep-related causes of infant death. Find out more about what is a safe sleep environment for your baby.	(T)	F
SIDS can be prevented.	(T)	F X
When a baby is shaken the following may happen, Bleeding behind the eye, blindness, broken ribs, loss of memory and emotion, loss of speech and hearing, cerebral palsy from bleeding around the brain, broken long bones(arms and legs), learning disabilities, death.	(T)	F
Babies who sleep on their backs will choke if they spit up or vomit during sleep.	T	(F)
The following symptoms may indicate that a baby has been shaken. Rolling eye, difficulty breathing, vomiting, convulsions, no response to voice or touch ,unconsciousness.	(T)	F
Recent evidence suggests that shots for vaccines may have a protective effect against SIDS. All babies should see their health care providers regularly for well-baby checkups and should get their shots on time as recommended by their health care provider.	T	(F) X
There are some situation that makes it ok to shake a baby.	T	(F)
If parents sleep with their babies in the same bed, they will hear any problems and be able to prevent them from happening.	T	(F)
Babies are at risk of SIDS only until they are 1 year old. Most SIDS deaths occur when babies are between 1 month and 4 months of age. SIDS is not a health concern for babies older than 1 year of age.	(T)	F (12)
Because SIDS occurs with no warning or symptoms, it is unlikely that any adult will hear a problem and prevent SIDS from occurring. Sleeping with a baby in an adult bed increases the risk of suffocation and other sleep-related causes of infant death. Sleeping with a baby in an adult bed is even more dangerous when: •The adult smokes cigarettes or has consumed alcohol or medication that causes drowsiness. •The baby shares a bed with other children. •The sleep surface is a couch, sofa, waterbed, or armchair. •There are pillows or blankets in the bed •The baby is younger than 11 weeks to 14 weeks of age. •The baby shares a bed with more than one person, especially if sleeping between two adults. Instead of bed sharing, health care providers recommend room sharing—keeping your baby's sleep area in the same room where you sleep. Room sharing is known to reduce the risk of SIDS and other sleep-related causes of infant death.	(T)	F

Pre/Post Test SIDS and Safe Infant Sleep

Name: Sonia [redacted] Date: 1/14/19

Babies can "catch" SIDS.	T	(F)
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A baby cannot catch SIDS. SIDS is not caused by an infection, so it can't be caught or spread.	(T)	F
SBS Stand for Shaken Baby Syndrome	(T)	F
Cribs themselves do not cause SIDS. But features of the sleep environment—such as a soft sleep surface—can increase the risk of SIDS and other sleep-related causes of infant death. Find out more about what is a safe sleep environment for your baby.	(T)	F
SIDS can be prevented.	T	(F)
When a baby is shaken the following may happen, Bleeding behind the eye, blindness, broken ribs, loss of memory and emotion, loss of speech and hearing, cerebral palsy from bleeding around the brain, broken long bones(arms and legs), learning disabilities, death.	(T)	F
Babies who sleep on their backs will choke if they spit up or vomit during sleep.	T	(F)
The following symptoms may indicate that a baby has been shaken. Rolling eye, difficulty breathing, vomiting, convulsions, no response to voice or touch ,unconsciousness.	(T)	F
Recent evidence suggests that shots for vaccines may have a protective effect against SIDS. All babies should see their health care providers regularly for well-baby checkups and should get their shots on time as recommended by their health care provider.	(T)	F
There are some situation that makes it ok to shake a baby.	T	(F)
If parents sleep with their babies in the same bed, they will hear any problems and be able to prevent them from happening.	T	(F)
Babies are at risk of SIDS only until they are 1 year old. Most SIDS deaths occur when babies are between 1 month and 4 months of age. SIDS is not a health concern for babies older than 1 year of age.	(T)	F
Because SIDS occurs with no warning or symptoms, it is unlikely that any adult will hear a problem and prevent SIDS from occurring. Sleeping with a baby in an adult bed increases the risk of suffocation and other sleep-related causes of infant death. Sleeping with a baby in an adult bed is even more dangerous when: •The adult smokes cigarettes or has consumed alcohol or medication that causes drowsiness. •The baby shares a bed with other children. •The sleep surface is a couch, sofa, waterbed, or armchair. •There are pillows or blankets in the bed •The baby is younger than 11 weeks to 14 weeks of age. •The baby shares a bed with more than one person, especially if sleeping between two adults. Instead of bed sharing, health care providers recommend room sharing—keeping your baby's sleep area in the same room where you sleep. Room sharing is known to reduce the risk of SIDS and other sleep-related causes of infant death.	(T)	F

14

Home Safety Checklist (Children 0-5 years)

Circle any items of concern

FIRST YEAR OF LIFE:

- ✓ Do you put your baby on his or her back to sleep? In a safety-approved crib with sides up and no pillows, bumpers or soft bedding?
- ✓ Do you leave your baby alone on tables or beds or in or near a tub or sink, even for a moment?
- ✓ Do you leave your baby alone at home or in the car?
- ✓ Do you keep plastic bags and balloons away from your children?
- ✓ Does your child wear a pacifier or jewelry around his or her neck?
- ✓ Does your child play with small objects such as beads or nuts?
- ✓ Does anyone in your home ever smoke?
- ✓ Do you have a plan for escape from your home in the event of a fire?
- ✓ Do you use a car seat in the car at all times?

  Which direction does your child's car seat face? Rear

ONE TO FIVE YEARS OLD:

- ✓ Do you keep cleaning products, medicines and sharp objects out of the reach of your child and in locked cabinets?
- ✓ Do you keep the handles of pans on the stove out of the reach of your children?
- ✓ Do you have the number of the Poison Help Line posted? **1-800-222-1222**
- ✓ Do you keep appliances, cords, matches and lighters out of your child's reach?
- ✓ Do you place gates at the entrance to stairways (for children younger than 3 years)?
- ✓ Do you check your child's toys for safety hazards?
- ✓ Do you keep plastic bags and balloons away from your children?
- N/A Is there a gun in your home or the home where your child visits? **Locked, unloaded**
- ✓ Do you leave your child alone in the bathtub?
- ✓ Do you leave your child alone at home or in the car?
- ✓ Does anyone in your home ever smoke?
- ✓ Do you have a plan for escape from your home in the event of a fire?

Adapted from Framingham Safety Survey