EARLY HEAD START

HSFIS APPLICATION / ENROLLMENT FORMS

SECTION 1 : APPLICATION INFORMATION
APPLICANT DEMOGRAPHICS

Complete this section for the parent or other person (hereafter referred to as Applicant)with primary responsibility for care of applying child(ren). This section should also be completed if the applicant is a pregnant woman. This section provides demographic information about the applicant, including: race, language skills, education, and employment. Skip to question 1.8 if Preface has been completed for this applicant.

1.1 **Applicant's name:** _____
Last name *First name* *MI*

1.2 Date of birth: ___/___/___ MM DD YY
computed: HA1-age (top and bottom-coded)

1.3 Social security number: ___-___-___

1.4 Gender: ☐ Male ☐ Female

1.5 Address:
(Mark all that apply)
☐ Living Here
☐ Mailing Address
☐ Pick-up Address
Street _____ Phone
Town/City _____ State _____ Zip Code

1.6 Other Address:
(Mark all that apply)
☐ Living Here
☐ Mailing Address
☐ Pick-up Address
Street _____ Phone
Town/City _____ State _____ Zip Code

1.7 Is there another adult who has major responsibility for the care of the applying children?

☐ No
☐ Yes-->Who? _____
Last name *First name* *MI*

1.8 What race/ethnicity do you consider yourself to be? *(Mark only one)*
HA1-8

100 ☐ White (non-Hispanic)
200 ☐ Black (non-Hispanic)
500 ☐ American Indian : Tribal affiliation _____
☐ Eskimo
☐ Aleut
600 ☐ Other, specify: _____

☐ Biracial/multiracial
Specify races: _____

300 *Hispanic (specify):*
301 ☐ Mexican/Chicano ☐ Cuban
304 ☐ Central American 305 ☐ Other: _____
302 ☐ Puerto Rican

400 *Asian or Pacific Islander (specify):*
☐ Chinese ☐ Guamanian
☐ Filipino ☐ Japanese
☐ Korean ☐ Asian Indian
☐ Samoan ☐ Hawaiian
☐ Vietnamese ☐ Other: _____

~~1.9~~ Do you speak a language other than English at home?

☐ No ☐ Yes, Spanish ☐ Yes, other: Specify _____

1.9 What language(s) do you speak at home?
HA1-9-1 Primary ← HA1-9-2 Secondary
1 ☐ English
2 ☐ Spanish
99 ☐ Other

1.10 *HSFIS INTERVIEWER: How well does the applicant speak English?*
HA1-10
1 ☐ Very well 2 ☐ Well 3 ☐ Not Well 4 ☐ Not at all

SECTION 1: APPLICATION INFORMATION
APPLICANT DEMOGRAPHICS

1.11 Have you previously been enrolled in Head Start or other childhood development program? Please specify which program(s) and date(s) of attendance.

HA1-11 (Any? 0/1) HA1-11-n (count of types)

- ☐ No
- ☐ Yes, Early Head Start — from __/__/__ to __/__/__
- ☐ Yes, Parent and Child Center (PCC) — from __/__/__ to __/__/__
- ☐ Yes, Comprehensive Child Development Program (CCDP) — from __/__/__ to __/__/__
- ☐ Yes, Head Start Family Child Care Program — from __/__/__ to __/__/__
- ☐ Yes, Head Start Migrant Program — from __/__/__ to __/__/__
- ☐ Yes, Head Start Home-based / Homevisit for 3 - 5 yr olds — from __/__/__ to __/__/__
- ☐ Yes, Head Start Center-based for 3 - 5 yr olds — from __/__/__ to __/__/__
- ☐ Yes, other : Specify _____ — from __/__/__ to __/__/__

1.12 What is your marital status?

HA1-12

- 1 ☐ Single
- 2 ☐ Married
- 3 ☐ Separated
- 4 ☐ Divorced / ☐ Widowed
- 6 ☐ Cohabiting

1.13 What is the highest level of education you have completed? *(Mark only one)*

HA1-13

- ☐ No school completed
- 04 ☐ Less than 4th grade
- 05 ☐ 5th-8th grade
- 06 ☐ 9th grade
- 07 ☐ 10th grade
- 08 ☐ 11th grade
- 09 ☐ 12th grade (no diploma)
- 10 ☐ High school graduate (high school diploma or equivalent, e.g., GED)
- 11 ☐ Some college (but no degree)
- 12 ☐ Associate degree in college
- 13 ☐ Bachelor's degree / ☐ Master's degree / ☐ Doctorate degree

1.14 What is your primary occupational status? *(Mark only one)*

HA1-14-1, HA1-14-2 HA1-14MO (topcoded)

- 1 ☐ Paying job
  - 11 ☐ Full-time (more than 34 hours weekly)
  - 12 ☐ Part-time
  - 13 ☐ Seasonal
  - 19 (unspecified)
- 2 ☐ In school
  - 21 ☐ Towards high school diploma/GED
  - 22 ☐ Towards trade/business qualification
  - 23 ☐ Towards college degree / ☐ Towards postgraduate degree
  - 25 ☐ Other: Specify _____
  - 29 (unspecified)
- 3 ☐ In job training program
  - ☐ Training program with salary
  - ☐ Training program without salary
  - 31 (all)
- 4 ☐ Unemployed
  - 41 ☐ With past employment experience; time since last job: _____ months
  - 42 ☐ With no previous job experience
  - 49 (unspecified)
- 5 ☐ Other
  - 51 ☐ Homemaker
  - ☐ Retired
  - 53 ☐ Unable to work due to disability
  - 97 (other/unspecified)

1.15 Have you ever attended vocational training or a trade or business school? ☐ Yes ☐ No (skip to 1.17)

HA1-15

1.16 *If Yes*, did you receive a certificate or license? ☐ Yes ☐ No

HA1-16

1.17 Have you ever participated in a government training program? ☐ Yes ☐ No (skip to 1.19)

HA1-17

1.18 *If Yes,* what training program(s) have you attended?

HA1-18-1 ☐ JOBS HA1-18-2 ☐ JTPA
HA1-18-3 ☐ Job Corps HA1-18-4 ☐ Other : Specify _____

Answer questions 1.19–1.24 only if applicant is age 19 years or younger. If not, continue with Section 2, question 2.1.

1.19 Are you currently an elementary, middle or high school student?
HA1-19
☐ Yes ☐ No (skip to 1.24)

1.20 *If Yes,* what level of school are you currently in?
HA1-20
1 ☐ Elementary
2 ☐ Middle or junior high
3 ☐ High school

1.21 What is the name of your school? _____

1.22 Is there a teen parent program in your school? ☐ Yes ☐ No (skip to 2.1)
HA1-22
1.23 *If Yes,* are you enrolled in that program? ☐ Yes (skip to 2.1) ☐ No (skip to 2.1)
HA1-23
1.24 ***For female applicants only:*** *If No,* did you drop out of school?
HA1-24
0 ☐ No, completed high school
1 ☐ Yes, before I became pregnant
2 ☐ Yes, due to school policy related to pregnancy
3 ☐ Yes, by my own choice, despite school policy that would allow me to remain in school
9 yes, details missing

SECTION 3: APPLICATION INFORMATION
OTHER FAMILY MEMBERS (FATHER)

Fill out Section 3 for the person listed in P.7 or 1.7 (i.e., other parent or person with major responsibility for care of the applying children) and any family members not listed in Section 2. The box below provides a working definition of family, family member and focal adult which should be used for purposes of completing this section.

FAMILY: A family is composed of: (1) a pregnant woman or (2) 2 or more people who: (a) reside in the same household; and (b) are related either by blood, marriage, adoption, or commitment. A child's biological or adoptive parent or other focal adult who resides outside of the household may also be included.

FAMILY MEMBER: A family member is anyone who is: (1) an adult (person over age 18) who resides in the same household who is related by either blood, marriage, adoption or commitment; (2) the focus child's biological or adoptive parent whether they reside within the household or not; or (3) a child (under age 18) who resides in the same household as the focus child.

FOCAL ADULT: An individual is considered to be a focal adult if he/she (1) is over age 18 or the biological parent of an Early Head Start child; and (2) provides either financial and/or emotional support to the child. Financial support includes, but is not limited to, shelter, food, and clothing.

3.1 Person 1 name: _____
Last name *First name* *MI*

3.2 Date of birth: ___/___/___ (MM DD YY) 3.3 Social security number: ___-___-___

(computed HA3-Age - bottom and top-coded)

3.4 Gender: ☐ Male ☐ Female

3.5 Address:
(Mark all that apply)
☐ Living Here
☐ Mailing Address
☐ Pick-up Address

Street _____ Phone _____
Town/City _____ State _____ Zip Code _____

3.6 Other Address:
(Mark all that apply)
☐ Living Here
☐ Mailing Address
☐ Pick-up Address

Street _____ Phone _____
Town/City _____ State _____ Zip Code _____

3.7 What is this person's primary relationship to you *(i.e., the person with primary responsibility for care of applying children)*? *(Mark one)*

HA3-7

01 ☐ Husband/Wife	☐ Biological parent	☐ Sibling
02 ☐ Significant Other	☐ Adoptive parent	☐ Step/half sibling
☐ Biological Child	☐ Step parent	☐ Other relative
☐ Adoptive Child	☐ Foster parent	☐ Godparent
☐ Foster Child	☐ Grandparent	☐ Legal guardian
☐ Step Child	☐ Aunt/Uncle	19 ☐ No biological/legal relationship

SECTION 3: APPLICATION INFORMATION
OTHER FAMILY MEMBERS (FATHER)

3.8 What is this person's relationship to your child(ren) who are eligible for Early Head Start *listed in Section 2*? *(Mark one)*

Focus Child 1: (Name:_____ Birthdate: __/__/__)

HA3_8

07 ☐ Biological parent	☐ Sibling	☐ Other relative
08 ☐ Adoptive parent	☐ Step/half sibling	☐ Godparent
08 ☐ Step parent	☐ Grandparent	☐ Legal guardian
08 ☐ Foster parent	☐ Aunt/Uncle	19 ☐ No biological/legal relationship

Child 2: (Name:_____ Birth date: __/__/__)

☐ Biological parent	☐ Sibling	☐ Other relative
☐ Adoptive parent	☐ Step/half sibling	☐ Godparent
☐ Step parent	☐ Grandparent	☐ Legal guardian
☐ Foster parent	☐ Aunt/Uncle	☐ No biological/legal relationship

Child 3: (Name:_____ Birth date: __/__/__)

☐ Biological parent	☐ Sibling	☐ Other relative
☐ Adoptive parent	☐ Step/half sibling	☐ Godparent
☐ Step parent	☐ Grandparent	☐ Legal guardian
☐ Foster parent	☐ Aunt/Uncle	☐ No biological/legal relationship

3.9 Is this person a focal adult in your child's life?

HA3_9

☐ Yes ☐ No

3.10 Does this person reside in the same household with you *(i.e., adult person with primary responsibility for care of applying children)*?

HA3_10

1 ☐ Yes, all the time
2 ☐ Yes, some of the time
3 ☐ No, never: Specify distance from home _____ miles → HA3_10mi

1 = <=5 miles
2 = 6-10 miles
3 = 11-25 miles
4 = >25 miles

3.11 Is this person employed or in school? *(Mark all that apply)*

HA3_11A ☐ Is employed
HA3_11B ☐ Is in school
HA3_11C ☐ Neither employed nor in school

3.12 Has this person ever been enrolled in Head Start or other child development program? Please specify which program(s) and date(s) of attendance.

☐ No	
☐ Yes, Early Head Start	from __/__ to __/__
☐ Yes, Parent and Child Center (PCC)	from __/__ to __/__
☐ Yes, Comprehensive Child Development Program (CCDP)	from __/__ to __/__
☐ Yes, Head Start Family Child Care Program	from __/__ to __/__
☐ Yes, Head Start Migrant Program	from __/__ to __/__
☐ Yes, Head Start Home-based / Home visit for 3 - 5 yr olds	from __/__ to __/__
☐ Yes, Head Start Center-based for 3 - 5 yr olds	from __/__ to __/__
☐ Yes, other : Specify _____	from __/__ to __/__

SECTION 2: ENROLLMENT INFORMATION
OTHER FAMILY MEMBERS (FATHER)

Fill out one copy of Section 2 for all other family members. Section 2 provides additional information related to other members in the enrolling family. Information in this section will be used to guide provision of services to the family.

2.1 Person's name: _____
Last name *First name* *MI*

2.2 Social security number: ___ - ___ - ____

2.3 Address: _____
(If different from enrollee) *Street* *Apt.#*

_____
Town/City *State* *Zip*

2.4 Phone numbers: _____ _____ _____
Home *Work* *Message*

2.5 What race/ethnicity does this person consider herself/himself to be? *(Mark only one)*

HE 2-5

100 ☐ White (non-Hispanic)

200 ☐ Black (non-Hispanic)

800 ☐ American Indian : Tribal affiliation _____
☐ Eskimo
☐ Aleut
☐ Other, specify: _____

☐ Biracial/multiracial
Specify races _____

Hispanic (specify):
301 ☐ Mexican/Chicano ☐ Cuban
304 ☐ Central American 305 ☐ Other/unspecified
302 ☐ Puerto Rican

400 *Asian or Pacific Islander (specify):*
☐ Chinese ☐ Guamanian
☐ Filipino ☐ Japanese
☐ Korean ☐ Asian Indian
☐ Samoan ☐ Hawaiian
☐ Vietnamese ☐ Other: _____

~~2.6~~ Does this person speak a language other than English at home?

☐ No ☐ Yes, Spanish ☐ Yes, other: Specify _____

2.6 What Language(s) does this person speak at home?
HE 2-6-1 Primary ← HE2-6.2 Secondary
1 ☐ English
2 ☐ Spanish
99 ☐ Other

2.7 How well does this person speak English?

HE 2-7

1 ☐ Very well 2 ☐ Well 3 ☐ Not Well 4 ☐ Not at all

2.8 What is this person's highest level of education completed? *(Mark only one)*

HE 2-8

☐ No school completed
04 ☐ Less than 4th grade
05 ☐ 5th-8th grade
06 ☐ 9th grade
07 ☐ 10th grade
08 ☐ 11th grade
09 ☐ 12th grade (no diploma)
10 ☐ High school graduate/GED
11 ☐ Some college (but no degree)
12 ☐ Associate degree in college
13 ☐ Bachelor's degree
☐ Master's degree
☐ Doctorate degree

☐ Not applicable

2.9 What is this person's primary occupational status? *(Mark only one)*

HE2-9-1

1 ☐ Paying job
- ☐ Full-time (more than 34 hours weekly)
- ☐ Part-time
- ☐ Seasonal

2 ☐ In school
- ☐ Towards high school diploma/GED
- ☐ Towards trade/business qualification
- ☐ Towards college degree
- ☐ Towards postgraduate degree
- ☐ Other: Specify _____

3 ☐ In job training program
- ☐ Job training with salary
- ☐ Job training without salary

4 ☐ Unemployed
- ☐ With past employment experience; time since last job: _____ months
- ☐ With no previous job experience

5 ☐ Other
- ☐ Homemaker
- ☐ Retired
- ☐ Unable to work due to disability

9 ☐ Not applicable

2.10 Has this person ever attended vocational training or a trade or business school?

HE2-10

☐ Yes ☐ No (skip to 2.12) ☐ Not applicable (skip to 2.12)

2.11 *If Yes,* did this person receive a certificate or license?

HE2-11

☐ Yes ☐ No ☐ Not applicable

2.12 Has this person ever participated in a government training program?

HE2-12

☐ Yes ☐ No (skip to 2.1 for next person) ☐ Not applicable (skip to 2.1 for next person)

2.13 *If Yes,* what government training program(s) did this person attend? *(Check all that apply)*

HE2-13-1 ☐ JOBS HE2-13-2 ☐ JTPA
HE2-13-3 ☐ Job Corps HE2-13-4 ☐ Other : Specify _____

SECTION 4: APPLICATION INFORMATION
FAMILY COMPOSITION AND RESOURCES

Each family submitting an application should complete Section 4. Section 4 provides additional information related to the applying family including: family type, financial status and social supports. The box below provides a working definition of family which should be used for purposes of completing this section.

FAMILY: A family is composed of: (1) a pregnant woman or (2) 2 or more people who: (a) reside in the same household; and (b) are related either by blood, marriage, adoption or commitment. A child's biological or adoptive parent or other focal adult who resides outside of the household may also be included.

4.1 Please tell me which of the following descriptions best fits your family: *(Read list and check only one)*

HA4-1

01 ☐ Two parent family (married or common law)
02 ☐ Single parent family (mother figure only)
04 ☐ Single parent family (mother figure only) living with partner
03 ☐ Single parent family (father figure only)
05 ☐ Single parent family (father figure only) living with partner
06 ☐ Other relative(s)
07 ☐ Foster family
99 ☐ Other: Specify _____

4.2 How many adults are there in your family? _____ adults

HA4-2 (topcoded)

4.3 How many children are there in your family? _____ children

HA4-3 (topcoded)

4.4 What is your family's yearly gross income? $ _____

HA4-4

1 = less than $3,000
2 = $3,000 - < $6,000
3 = $6,000 - < $12,000
4 = $12,000 - < $18,000
5 = $18,000 - < $24,000
6 = $24,000 - < $30,000
7 = $30,000 or more

4.5 What time period is this income based on? *(Mark only one)*

HA4-5

1 ☐ Previous 12 months
2 ☐ Last calendar year

4.6 How many adults contributed to this income? ____ adults

HA4-6 (topcoded)

4.7 Many families receive services or financial assistance from one or more programs or agencies. Does your family receive any of the following types of services or financial assistance? *(Read list and mark all that apply)*

HA4-7-01 ☐ Medical financial assistance (i.e. Medicaid/Medicare)
HA4-7-02 ☐ AFDC
HA4-7-03 ☐ Food Stamps
HA4-7-04 ☐ WIC
HA4-7-05 ☐ Supplemental Security Income (SSI)
~~HA4-7-06~~ ☐ Foster care/Adoption subsidy
☐ Unemployment insurance HA4-7-07
☐ Public housing assistance HA4-7-08
☐ Energy program assistance HA4-7-09
☐ EPSDT HA4-7-10
☐ Child support/alimony HA4-7-11
☐ Other: Specify ~~HA4-7-12~~ HA4-7-12

HA4-7-NO ☐ None of the above

HA4-7-N number of types of financial assist/services received

4.8 Has your family applied to receive Supplemental Security Income (SSI)?

HA4-8

☐ Yes ☐ No

SECTION 3: ENROLLMENT INFORMATION
~~OTHER FAMILY MEMBERS~~ FAMILY CIRCUMSTANCES

Fill out Section 3 for each family to be enrolled. Section 3 provides additional information about the enrolling family's current circumstances, including family strengths and needs. This information will form the basis upon which a family needs assessment and case plan will be completed. The box below provides a working definition of family which should be used in filling out this section.

FAMILY: A family is composed of: (1) a pregnant woman, or (2) 2 or more people who: (a) reside in the same household; and (b) are related either by blood, marriage, adoption or commitment. A child's biological or adoptive parent or other focal adult who resides outside of the household may also be included.

3.1 Many families have areas in which their resources or circumstances are strong, and other areas in which they may need assistance. To what extent are your resources or circumstances in the following areas adequate? For each of the resources I mention, please tell me how well your family's needs are met on a consistent basis, month-in and month-out, by indicating whether the way the need is met is adequate, somewhat adequate, or inadequate.

	2 Adequate	3 Somewhat Adequate	4 Inadequate	-4/.0 Not Applicable	
HE3-1-01	☐	☐	☐	☐	Food
HE3-1-02	☐	☐	☐	☐	Housing
HE3-1-03	☐	☐	☐	☐	Money to buy necessities
HE3-1-04	☐	☐	☐	☐	Clothes for your family
HE3-1-05	☐	☐	☐	☐	Heat and Water/Plumbing
HE3-1-06	☐	☐	☐	☐	Money to pay monthly bills
HE3-1-07	☐	☐	☐	☐	Job for yourself or spouse/partner
HE3-1-08	☐	☐	☐	☐	Medical care for your family
HE3-1-09	☐	☐	☐	☐	Public Assistance (SSI, AFDC, Medicaid, etc.)
HE3-1-10	☐	☐	☐	☐	Dependable transportation
HE3-1-11	☐	☐	☐	☐	Time to be with family members
HE3-1-12	☐	☐	☐	☐	Telephone or access to a phone
HE3-1-13	☐	☐	☐	☐	Babysitting or Child Care for your child(ren)
HE3-1-14	☐	☐	☐	☐	Money to buy special equipment/supplies for child(ren)
HE3-1-15	☐	☐	☐	☐	Dental care for your family
HE3-1-16	☐	☐	☐	☐	Someone to talk to
HE3-1-17	☐	☐	☐	☐	Toys for your child(ren)
HE3-1-18	☐	☐	☐	☐	English speaking and reading skills
HE3-1-19	☐	☐	☐	☐	Information or access to information about parenting
HE3-1-20	☐	☐	☐	☐	Opportunities to participate in community groups (ie. religious, social, school)
HE3-1-21	☐	☐	☐	☐	Friends or family to help you when needed (ie. money, shelter, transportation)

3.2 *HSFIS INTERVIEWER: Please note any areas in which the enrollee indicated resources or circumstances that are particularly strong or suggested a challenge requiring immediate attention (i.e., an urgent need).*

(included in 3.1 variables)

code 1
Special strengths: _____

code 5
Urgent needs: _____

☐ No special strengths or urgent needs

3.3 Do you own or rent your housing, receive subsidized housing, or receive your housing free or in exchange for services? *(Mark only one)*

HE3-3
01 ☐ Own housing
02 ☐ Rent housing
03 ☐ Exchange services for housing
04 ☐ Make no payment for housing
05 ☐ Receive subsidized housing
99 ☐ Other, specify: _____
12 emergency shelter
13 with friends/relatives
14 with parents

3.4 What type of housing does your family currently live in?

HE3-4
1 ☐ House
2 ☐ Apartment
3 ☐ Mobile home/trailer
99 4 ☐ Community shelter
99 5 ☐ Hotel/motel room
99 6 ☐ Homeless/no housing
99 other

3.5 How long has your family lived at your present address?

HE3-5
1 ☐ Less than 6 months
2 ☐ 6 - 12 months
3 ☐ 1 - 2 years
4 ☐ More than 2 years

3.6 How many times has your family moved during the last 12 months?

HE3-6
0 ☐ Family has not moved
1 ☐ Once
2 ☐ Twice
3 ☐ Three times
4 ☐ Four or more times

3.7 Has your family ever been homeless during the last 12 months? *(Including currently homeless)*

HE3-7
☐ Yes ☐ No (skip to 3.9)

3.8 *If Yes*, for how much time was your family homeless during the last 12 months?

HE3-8
1 ☐ Less than 1 month
2 ☐ 1 - 3 months
3 ☐ 3 - 6 months
4 ☐ More than 6 months

3.9 Does your family currently have a means of transportation?

HE3-9
☐ Yes ☐ No (skip to 3.12)

3.10 *If Yes*, what means of transportation does your family use? *(Mark all that apply)*

HE3-10-1 ☐ Private vehicle (car, truck, van)
HE3-10-2 ☐ Friend's or relative's vehicle
HE3-10-3 ☐ Public transportation (bus, subway, taxi)
☐ Other: _____
HE3-10-4

3.11 Does your family have alternative transportation if your usual mode or means of transportation is not available?

HE3-11
☐ Yes ☐ No

3.12 Are you currently pregnant?

HE3-12 (more recently entered cases only)
☐ Yes *(Please complete Supplement A)* ☐ No

(ver: June 17, 1996)

Early Head Start: *Enrollment Information (Pregnant Woman)*

SUPPLEMENT A: ENROLLMENT INFORMATION HEALTH AND PREGNANCY HISTORY

Assurance of Confidentiality: The information on this form is being requested on a voluntary basis. The information you provide will help us to deliver or direct services most appropriate for your family's needs. Some of the information may be used to help plan national program initiatives. If you prefer not to provide some of the information, it will not affect the services we try to deliver. However, some information is required for eligibility determination. All information will be held in strict confidence.

Complete Supplement A if the enrollee is a pregnant woman. Supplement A provides information related to the enrollee's health and pregnancy history. These questions are being asked to determine risk factors that may effect the enrollee's current pregnancy.

1. Enrollee's name: _____
   Last name *First name* *MI*

2. Social security number: ___ - ___ - _____

3. Do you have any medical coverage or health insurance? ☐ Yes ☐ No (skip to 8)
HES_3

4. *If Yes*, what type of coverage or insurance?
HES-4
1 ☐ Medicaid, EPSDT or equivalent
2 ☐ Other third party (e.g., private insurance company)

5. What is the insurance provider's name? _____ 6. What is the ID or policy number? _____

7. Is dental coverage included in this policy? ☐ Yes ☐ No
HES-7

8. How long have you been pregnant?
HES-8
1 ☐ Less than 12 weeks 2 ☐ 12-24 weeks 3 ☐ More than 24 weeks

9. What is your expected delivery date? ___/___/___
~~HES-9~~ omitted MM DD YY

10. Have you received any prenatal care? ☐ Yes ☐ No (skip to 12)
HES_10

11. *If Yes*, where did you receive prenatal care? *(Check all that apply)*

HES.11-1 ☐ Health clinic HES.11-2 ☐ Hospital ~~HES.11-4~~ ☐ In enrollee's home
HES.11-3 ☐ Private physician ~~HES.11-5~~ ☐ School-based health facility HES 11-6 ☐ Other, specify: _____

HES_11_N number of places received prenatal care

12. Who is your primary health care provider?

Name: _____
Last name *First name*

Address: _____
Street *Suite* *City* *State* *Zip Code*

☐ No primary health care provider

13. Who is your primary prenatal care provider?

Name: _____ (Last name) _____ (First name)

Address: _____ (Street) _____ (Suite) _____ (City) _____ (State) _____ (Zip Code)

☐ No primary prenatal care provider
☐ Same as primary health care provider

14. In which month of pregnancy did you first see a physician or attend a clinic for prenatal care?

HE5_14

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th

15. What is the date of your most recent prenatal care visit? ___/___/___ (MM DD YY) ☐ No prenatal care visits

~~HE5_15~~

16. What is the date of your next scheduled prenatal care visit? ___/___/___ (MM DD YY) ☐ None scheduled

~~HE5_16~~

17. How many prenatal care visits have you had since the first visit (not counting the first visit)?

HE5_17

01 ☐ No visits beyond the 1st 04 ☐ Three 07 ☐ Six 10 ☐ Nine or More
02 ☐ One 05 ☐ Four 08 ☐ Seven -1/.a ☐ Don't remember
03 ☐ Two 06 ☐ Five 09 ☐ Eight

18. What complications have you experienced during this and any previous pregnancies? *(Read list and check all that apply)*

(note: HSFIS data entry screen very different from paper form)

Previous Pregnancies	Current Pregnancy		
☐ (HE5_18A)	☐	Pain	Codes: 0 = none
☐ (HE5_18B)	☐	Headaches	1 = current
☐ HE5_18C	☐	Hypertension	2 = previous
☐ HE5_18D	☐	Irritability	3 = both
☐ HE5_18E	☐	Anxiety	4 = had problem, not specified which time
☐ HE5_18F	☐	Stress	
☐ HE5_18G	☐	Swelling	
☐ HE5_18H	☐	Fatigue	
☐ HE5_18I	☐	Bleeding	
☐ (HE5_18A)	☐	Anemia (Hgb < 10 or Hct < 30)	
☐ (HE5_18B)	☐	Sickle cell anemia	
☐ (HE5_18D)	☐	Diabetes (insulin dependent)	
☐ HE5_18J	☐	Pregnancy-induced hypertension	
☐ HE5_18K	☐	Low birth weight birth, specify weight: _____	
☐ HE5_18L	☐	Pre-term labor	
☐ (HE5_18O)	☐	Neonatal death (<28 days)	
☐ HE5_18M	☐	C-section	
☐ HE5_18O	☐	Other, specify: ~~HE5_18OT~~ _____	
☐ HE5_18NO	☐	**No complications experienced**	

HE5_18NP HE5_18NC count of complications (previous, current)

19. Did any of these complications require bedrest or hospitalization?

HE5_19

☐ Yes ☐ No (skip to 22)

20. *If Yes,* which complications? ~~(see list)~~

21. For how many days? _____
HE5_21, HE5-21-C, HE5-21-P (topcoded)

22. How many times have you been pregnant prior to this pregnancy? _____
HE5-22 (topcoded)

23. How many children have you given birth to? _____
HE5-23 (topcoded)

24. *If there is a discrepancy between number of pregnancies and number of births, ask:* What was the outcome of those other pregnancies? *(Check all that apply)*

~~HE5-24-1~~ ☐ Multiple birth ☐ Stillborn ~~HE5-24-3~~ ☐ Other, Specify: _____ ~~HE5-24-5~~
HE5-24-2 ☐ Miscarriage ☐ Abortion HE5-24-4 ☐ Refused (.C/-3 in others)

25. How many of your children were born prematurely *(i.e. < 5 lbs or < 7 mos)*? _____
HE5-25 (topcoded)

26. How long has it been since your last pregnancy?
HE5-26
0 ☐ Never been pregnant before
1 ☐ Less than 18 months
2 ☐ More than 18 months

27. What medical or health services are you currently receiving? *Read list and check all that apply. For each service currently received, ask:* When did you first start receiving this service?

HE5-27-1 ☐ Medical assistance / PWC since ___/___/___ ~~HE5-27D1~~
HE5-27-2 ☐ WIC / other nutritional services since ___/___/___ ~~HE5-27D2~~
HE5-27-0 { 03 ☐ Substance abuse treatment since ___/___/___
04 ☐ Mental health counseling/treatment since ___/___/___ } ~~HE5-27D3~~
99 ☐ Other services, specify: _____ since ___/___/___

HE5-27N0 ☐ **No services currently being received**

HE5-27-N number of services received (topcoded)

28. Have you participated in any support or educational groups for pregnancy, child birth or parenting during your current pregnancy?
HE5-28
☐ Yes ☐ No (skip to 31)

29. *If Yes,* what kinds of groups have you participated in? *(Check all that apply)*

HE5-29-1 ☐ Prenatal exercise HE5-29-5 ☐ Preparing for baby care
HE5-29-2 ☐ Prenatal general discussion HE5-29-6 ☐ Personal development
HE5-29-3 ☐ Birth education (i.e. Lamaze) HE5-29-7 ☐ Parenting education
HE5-29-4 ☐ Breast feeding preparation HE5-29-8 ☐ Other

HE5-29-N count of groups (topcoded)

30. How many sessions of these pregnancy, birth or parenting groups have you attended?
HE5-30
1 ☐ 1-5 3 ☐ 11-20 5 ☐ More than 30
2 ☐ 6-10 4 ☐ 21-30

31. Have you been visited regularly by any nurse, social worker, school support person, or similar person during your current pregnancy?
HE5-31
☐ Yes ☐ No (skip to 34)

32. *If Yes*, who has visited you? _____

33. What agency was the visitor from? _____ ☐ Don't know

34. Have you used any of the following during your pregnancy? *Read list and mark all that apply. For each substance used, ask:* When did you last use this? *and* How often do/did you use it?

a. Caffeine
HE5-34A1
00 ☐ No (skip to next substance) 07 ☐ Yes--> 10 ☐ Currently, within the past week
04 ☐ Formerly, time since last use: _____ ~~HE5-34A2~~

HE5-34A3 How often?
1 ☐ Daily 3 ☐ Monthly 2 ☐ Weekly 4 ☐ Less than monthly

b. Cigarettes/tobacco
HE5-34B1
00 ☐ No (skip to next substance) 07 ☐ Yes--> 10 ☐ Currently, within the past week
04 ☐ Formerly, time since last use: _____ ~~HE5-34B2~~

HE5-34B3 How often?
1 ☐ Daily 2 3 ☐ Monthly 2 ☐ Weekly 2 4 ☐ Less than monthly

c. Non-prescription drugs, specify: _____
HE5-34C1
00 ☐ No (skip to next substance) 07 ☐ Yes--> 10 ☐ Currently, within the past week
04 ☐ Formerly, time since last use: _____ ~~HE5-34C2~~

HE5-34C3 How often?
1 ☐ Daily 3 ☐ Monthly 2 ☐ Weekly 4 ☐ Less than monthly

d. Prescription drugs, specify: _____
HE5-34D1
00 ☐ No (skip to next substance) 07 ☐ Yes--> 10 ☐ Currently, within the past week
04 ☐ Formerly, time since last use: _____ ~~HE5-34D2~~

HE5-34D3 How often?
1 ☐ Daily 2 3 ☐ Monthly 2 ☐ Weekly 2 4 ☐ Less than monthly

e. Alcohol
~~HE5-34E1~~
00 ☐ No (skip to next substance) 07 ☐ Yes--> 10 ☐ Currently, within the past week
04 ☐ Formerly, time since last use: _____ ~~HE5-34E2~~

~~HE5-34E3~~ How often?
1 ☐ Daily 3 ☐ Monthly 2 ☐ Weekly 4 ☐ Less than monthly

f. Other drug, specify _____
~~HE5-34F1~~
00 ☐ No 07 ☐ Yes--> 10 ☐ Currently, within the past week
04 ☐ Formerly, time since last use: _____ ~~HE5-34F2~~

~~HE5-34F3~~ How often?
1 ☐ Daily 3 ☐ Monthly 2 ☐ Weekly 4 ☐ Less than monthly

HE5-34-N number of substances used (top coded)

SECTION 2: APPLICATION INFORMATION
EARLY HEAD START ELIGIBLE CHILDREN FOCUS CHILD

Fill out Section 2 for each child in the family eligible to receive direct services through Early Head Start. Section 2 provides specific information about each eligible child in the applying family. If the applicant is currently pregnant, please fill out this section for her new baby as soon as possible after the baby is born. If the applicant is currently pregnant and has no eligible children, check the box below and skip to Section 3.

☐ Applicant is currently pregnant and has no eligible children (skip to 3.1)

2.1 **Child 1 name:** _____
Last name *First name* *MI*

2.2 Date of birth: ___/___/___ (MM DD YY) 2.3 Social security number: ___-___-___

(Computed: HA2-mths -top-coded)

2.4 Gender: 1 ☐ Male 2 ☐ Female also HA2-sex : M,F
HA2-4

2.5 Other Address:
(Mark all that apply)
☐ Living Here
☐ Mailing Address
☐ Pick-up Address

Street _____ Phone _____

Town/City _____ State _____ Zip Code _____

2.6 What is this child's relationship to you *(i.e., the applicant, who is the primary care provider)*? *(Mark one)*
HA2-6
03 ☐ Biological Child ☐ Adoptive Child 04 ☐ Foster Child ☐ Step Child
☐ Relative: Specify _____ ☐ Other: Specify _____

2.7 What race/ethnicity do you consider this child to be? *(Mark only one)*
HA2-7
100 ☐ White (non-Hispanic)
200 ☐ Black (non-Hispanic)
500 ☐ American Indian : Tribal affiliation _____
☐ Eskimo
☐ Aleut
800 ☐ Other, specify: _____

☐ Biracial/multiracial
Specify races: _____

300 *Hispanic (specify):*
301 ☐ Mexican/Chicano ☐ Cuban
304 ☐ Central American 305 ☐ Other: _____
302 ☐ Puerto Rican

400 *Asian or Pacific Islander (specify):*
☐ Chinese ☐ Guamanian
☐ Filipino ☐ Japanese
☐ Korean ☐ Asian Indian
☐ Samoan ☐ Hawaiian
☐ Vietnamese ☐ Other: _____

~~2.8~~ Does this child speak a language other than English at home?

☐ No ☐ Yes, Spanish ☐ Yes, other: Specify _____ ☐ Not applicable

2.8 What language(s) does the child speak at home?
HA2-8_1 Primary language: 1 ☐ English 2 ☐ Spanish 99 ☐ other

2.9 How well does this child speak English?
HA2-9
1 ☐ Very well 2 ☐ Well 3 ☐ Not Well 4 ☐ Not at all 5 ☐ Not applicable

2.10 Has this child previously been enrolled in Head Start or other childhood development program? Please specify which program(s) this child has attended and the date(s) of attendance.

- ☐ No
- ☐ Yes, Early Head Start — from __/__/__ to __/__/__
- ☐ Yes, Parent and Child Center (PCC) — from __/__/__ to __/__/__
- ☐ Yes, Comprehensive Child Development Program (CCDP) — from __/__/__ to __/__/__
- ☐ Yes, other : Specify _____ — from __/__/__ to __/__/__

2.11 Do you or anyone else have any concerns about this child's overall health and development?

HA2-11

☐ No ☐ Yes: Describe _____ ☐ Don't know

2.12 Is this child suspected to be experiencing developmental delay?

HA2-12

0 ☐ No
1 ☐ Yes, by primary care provider
5 ☐ Yes, by EHS program staff
3 ☐ Yes, by medical provider
5 { ☐ Yes, by social service agency
{ ☐ Yes, by other person or agency: Specify_____
.A/-1 ☐ Don't know

2.13 Has this child received an evaluation because of concerns about the child's overall health and development or because of suspected developmental delay?

HA2-13

0 ☐ No 1 ☐ Yes .A/-1 ☐ Don't know

2.14 Has this child received an evaluation for early intervention or special education and related services?

HA2-14no ☐ No (skip to 2.18)
☐ Yes, by Part H program
☐ Yes, by a medical physician
☐ Yes, by hospital staff
☐ Yes, by a multidisciplinary team
☐ Yes, by a health professional (i.e., OT, PT, speech therapist): Specify_____
☐ Yes, by an educator
☐ Yes, by a social worker
☐ Yes, by a psychologist
☐ Yes, by other person or agency: Specify_____
☐ Don't know

HA 2.14-N · number of evaluations (top coded)

2.15 Was this evaluation used to request early intervention services?

HA2-15

0 ☐ No 1 ☐ Yes .A/-1 ☐ Don't know

2.16 Did the evaluation result in eligibility for the child and family to receive early intervention services?

HA2-16

0 ☐ No (skip to 2.18) 1 ☐ Yes .A/-1 ☐ Don't know (skip to 2.18)

2.17 What are the reasons for eligibility for early intervention or special education and related services for this child?

- ☐ At risk for developmental disability
- ☐ Atypical development
- ☐ Diagnosed developmental disability
- ☐ Developmental delay in 1 or more areas: Specify which areas *(check all that apply)*:
  - ☐ Motor development ☐ Cognitive development ☐ Behavior
  - ☐ Social-emotional development ☐ Language/communication
- ☐ Don't know

HA2-17_N count of reasons (topcoded)

Questions 2.18 and 2.19 are asked so that we may assure that the program meets the requirements of the Head Start regulation that at least 10 percent of enrollment opportunities are made available to children with disabilities.

*2.18 *Three categories of risk are used by most states to identify young children at risk for adverse developmental outcomes. They are: (1) established risks; (2) biological/medical risks, and (3) environmental risks. Based on parent report, documented medical history, or other records, please specify all appropriate indicators of risk for this child.*

HA2-18 Any Established/ Biological/Medical/Environmental Risks { 0 = no, .S = ambiguous data, 1 = yes

Please tell me whether your child has the following conditions or characteristics. *Read list and check all that apply.*

Parent Report	*Records*	
		Established Risks HA2ES_N number of risks indicated (topcoded)
☐	☐	A chromosomal abnormality, such as Down Syndrome
☐	☐	A congenital birth defect, such as myelomeningocele
☐	☐	A congenital syndrome, such as Fetal Alcohol Syndrome
☐	☐	HIV positive/AIDS
☐	☐	A sensory impairment, such as a hearing or vision impairment
☐	☐	Is medically fragile, describe:_____
☐	☐	Other, specify:_____

HA2ES_no ☐ ***Parent report and records indicate no established risks***

HA2ES_DK ambiguous data

Biological/Medical Risks HA2BM_N number of risks indicated (topcoded)

☐	☐	An abnormal neurological finding, such as seizures, microcephaly, or macrocephaly
☐	☐	Asphyxia
☐	☐	A central nervous system infection/trauma
☐	☐	A major congenital anomaly, such as a craniofacial anomaly
☐	☐	Congenital heart disease
☐	☐	Sickle cell anemia
☐	☐	Diabetes
☐	☐	A sibling with documented disabilities
☐	☐	Evidence of prenatal exposure to drugs
☐	☐	Birth weight under 1500 grams or prematurity (less than 32 weeks)
☐	☐	Nutritional deficits, such as failure to thrive
☐	☐	Severe chronic illness, describe: _____
☐	☐	HIV positive child or mother
☐	☐	Other, specify:_____

HA2BM_no ☐ ***Parent report and records indicate no biological/medical risks***

HA2BM_DK ambiguous data

**Item may need to be filled out after enrollment based on medical or other records.*

HA2EBM_N number of combined Established and Biological/Medical Risks (topcoded)

2.18 *(continued)*

Parent Report: 1 | Records: 2 | Both: 3 | Not specified: 9

Environmental Risks

HA2En_N (number of risks indicated)

← HA2EnT01 (type code - 01, 02)

HA2En_01 ☐ 01 Parental substance abuse
☐ 02 Parental developmental disability, specify: _____

HA2En_03 ☐ 03 Biological mother less than 17 years old

HA2En_04 ☐ 04 Maternal education less than 8th grade level

HA2En_05 ☐ 2 = Documented child abuse or neglect
☐ 1 = Suspected child abuse or neglect
} HA2EnT05 (type) (1, 2)

HA2En_07 ☐ 07 Family social disorganization

☐ 08 Family is homeless

HA2En_09 ☐ 09 Poverty

☐ 99 Other, specify: _____

HA2En_04 ← HA2En_Ty (type code - 08, 99)

HA2En_no ☐ ***Parent report and records indicate no risks***

HA2En_DK ambiguous data

*2.19 Has this child been diagnosed with, or is this child suspected to have, any of the following that might require early intervention, special education, and/or related services? *(Read list and mark all that apply.) For each diagnosis marked, ask:* When was this diagnosis made, and who made it?

HA2-19_n (number of impairments indicated - suspected or diagnosed)

HA2-19_S (1) HA2-19_D (2) ← number of impairments suspected diagnosed

	Suspected	Diagnosed	Date:	Evaluated by:
Visual impairment including blindness	☐ HA2-19B1	☐	~~HA2-19C1~~ / /	
Hearing impairment including deafness	☐ HA2-19B2	☐	~~HA2-19C2~~ / /	
Orthopedic impairment	☐ HA2-19B3	☐	~~HA2-19C3~~ / /	
Speech or language impairment	☐ HA2-19B4	☐	~~HA2-19C4~~ / /	
Health impairment	☐ HA2-19B5	☐	~~HA2-19C5~~ / /	
Mental retardation	☐	☐	/ /	
Emotional/behavioral disorder	☐	☐	/ /	
Learning disability	☐	☐	/ /	
Autism	☐	☐	/ /	
Traumatic brain injury	☐	☐	/ /	
Other impairments: _____	☐	☐	/ /	

← HA2-19B

← HA2-19C

HA2-19no ☐ **None suspected or diagnosed**

HA2-19DK ambiguous data

**Item may need to be filled out after enrollment based on medical or other records.*

(ver: June 17, 1996)

Early Head Start: *Enrollment Information*

SECTION 1: ENROLLMENT INFORMATION
EARLY HEAD START ELIGIBLE CHILDREN FOCUS CHILD

Assurance of Confidentiality: The information on this form is being requested on a voluntary basis. The information you provide will help us to deliver or direct services most appropriate for your family's needs. Some of the information may be used to help plan national program initiatives. If you prefer not to provide some of the information, it will not affect the services we try to deliver. However, some information is required for eligibility determination. All information will be held in strict confidence.

Fill out one copy of Section 1 for each of the enrollee's children who are eligible for direct services by Early Head Start. Section 1 provides additional information related to the enrollee's Early Head Start children. Information in this section will be used to guide provision of services to the family. If the applicant is currently pregnant, please complete Supplement A and fill out this section for her new baby as soon as possible after the baby is born. If the applicant is currently pregnant and has no eligible children, check the box below and skip to Section 2.

☐ Applicant is currently pregnant and has no eligible children (skip to 2.1)

1.1 Enrollee's name: _____
Last name *First name* *MI*

1.2 Social security number: ___ - ___ - ____

1.3 Child's name: _____
Last name *First name* *MI*

1.4 Will this child be cared for by someone other than you, in addition to participating in Early Head Start?
HE1-4
☐ Yes ☐ No (skip to 1.6)

1.5 *If Yes*, who else will care for the child? *(Mark all that apply)*

HE1-5-1 ☐ Older sibling under age 12
HE1-5-2 ☐ Older sibling age 12 or older
HE1-5-3 ☐ Relative
HE1-5-4 ☐ Adult nonrelative in child's own home
☐ Adult nonrelative in nonrelative's home
☐ Child care center
☐ Other: Specify _____
☐ Not yet arranged
HE1-5-5
HE1-5-6
HE1-5-7
HE1-5-8

1.6 Is this child covered under any medical coverage or health insurance? ☐ Yes ☐ No (skip to 1.11)
HE1-6

1.7 *If Yes*, what type?
HE1-7
1 ☐ Medicaid, EPSDT or equivalent
2 ☐ Other third party (e.g., private insurance company)

1.8 Provider's name: _____ 1.9 ID or policy number: _____

1.10 Is dental coverage included on this policy? ☐ Yes ☐ No
HE1-10

1.11 What is the date of this child's most recent physical exam? ___/___/___ ☐ No physical exam
MM DD YY
~~HE1-11~~ HE1-11NC

SECTION 1: ENROLLMENT INFORMATION
EARLY HEAD START ELIGIBLE CHILDREN

FOCUS CHILD

1.12 Who is this child's regular primary care provider?

Doctor/Clinic name _____ *Phone #* _____

Street _____ *Suite #* _____

Town/City _____ *State* _____ *Zip* _____

☐ No regular primary care provider

~~HE1-13~~ HE1-13NC

1.13 What is the date of this child's most recent dental exam? ___/___/___ (MM DD YY) ☐ No dental exam

1.14 Who is this child's regular dentist?

Doctor/Clinic name _____ *Phone #* _____

Street _____ *Suite #* _____

Town/City _____ *State* _____ *Zip* _____

☐ No regular dentist

1.15 Is this child currently receiving services to address any special needs/disabilities?

HE1-15

☐ Yes ☐ No (skip to 1.18)

1.16 *If Yes*, what type of services? _____

1.17 *If Yes*, who provides these services?

Doctor/Clinic name _____ *Phone #* _____

Street _____ *Suite #* _____

Town/City _____ *State* _____ *Zip* _____

1.18 Is this child currently taking any prescription medications?

HE1-18

☐ Yes ☐ No (skip to 1.20)

1.19 *If Yes*, which medications? _____

~~HE1-19~~

1.20 At what time during pregnancy with this child did you (or the child's mother) first receive prenatal care?

HE1-20

1 ☐ During the first 3 months of pregnancy

2 ☐ During the middle 3 months of pregnancy

3 ☐ During the last 3 months of pregnancy

B/-2 ☐ No prenatal care received

A/-1 ☐ Don't remember/don't know

1.21 Did you (or the child's mother) experience any of the following medical problems during the pregnancy? *(Read lis and check all that apply)*

HE1-21...

☐ 01 Pain	☐ 07 Swelling	☐ 13 Pregnancy-induced hypertensio
☐ 02 Headaches	☐ 08 Fatigue	☐ 14 Low Birth Wt: Specify Wt_____
☐ 03 Hypertension	☐ 09 Bleeding	☐ 15 Pre-term labor
☐ 04 Irritability	☐ 10 Anemia (Hgb < 10 or Hct < 30)	☐ 16 C-section
☐ 05 Anxiety	☐ 11 Sickle cell anemia	☐ 17 Other, specify: _____
☐ 06 Stress	☐ 12 Diabetes (insulin dependent)	☐ 18 Don't know

1.22 Was this child born in a hospital or clinic?

HE1-22

☐ Yes ☐ No ☐ Don't know

1.23 What was this child's birth weight? *(or nearest estimate)*

HE1-23 (pounds + decimal) (bottom/top coded, rounded)

HE1-23-P HE1-23-O

___ Pounds ___ Ounces

*1.24 What was this child's APGAR Score?

HE1-24-1 HE1-24-5

1 min 5 min

1.25 Was this child born...

HE1-25

1 ☐ More than 2 months early?
2 ☐ 2 months to 3 weeks early?
3 ☐ About on time?
4 ☐ More than 3 weeks late?
-1/A ☐ Don't remember

1.26 As a newborn, did this child stay in the hospital because she/he had medical problems?

HE1-26

☐ Yes ☐ No (skip to 1.28) ☐ Don't know

1.27 *If Yes*, how long did the child stay in the hospital?

HE1-27

1 ☐ Less than 1 week
2 ☐ One week to 1 month
3 ☐ Over 1 month
-1/A ☐ Don't remember

1.28 Has this child ever experienced any of the following acute conditions? *Read list and for each condition that child has experienced, ask:* When did this child last experience this condition?

			Date of the most recent occurrence:
Asthma	HE1-28A1	☐	/ / ~~HE1-28B1~~
Anemia	HE1-28A2	☐	/ / ~~HE1-28B2~~
Meningitis	~~HE1-28A3~~	☐	/ /
Convulsions/seizures, without fever		☐	/ / ~~HE1-28B4~~
Ear infections	HE1-28A5	☐	/ / ~~HE1-28B5~~
Lead poisoning		☐	/ /
Intestinal parasites		☐	/ / ~~HE1-28B6~~
Head injury		☐	/ /
Inadequate diet		☐	/ /
Feeding/eating problem	~~HE1-28A6~~	☐	/ / ~~HE1-28B7~~
Allergy *(specify at right)*	HE1-28A7	☐	/ / ~~HE1-28B8~~ Specify: _____
None Experienced	HE1-28NC	☐	

HE1-28 DK (ambiguous data)

HE1-28-N (number of acute conditions indicated) (topcoded)

* *Item may need to be filled in after enrollment based on medical records.*