

CFCOC Supplemental HMIS Enrollment Form

Client Name / ID: _____

CFCOC ID: _____

Name/Identification and Contact Information:

Legal First Name: _____

Middle Name: _____

Legal Last Name: _____

Suffix: _____

Mother's Maiden Name: _____

Date Client Started Receiving Services Funded from CFCOC: _____

Child's Place of Birth

If born in Orange County, please select which hospital in Orange County ([X] one):

<input type="checkbox"/>	AHMC Anaheim Regional Medical Center (formerly Anaheim Memorial Medical Center)	<input type="checkbox"/>	Placentia Linda Hospital
<input type="checkbox"/>	Anaheim General Hospital	<input type="checkbox"/>	Saddleback Memorial Medical Center
<input type="checkbox"/>	Anaheim Memorial Medical Center West	<input type="checkbox"/>	San Clemente Hospital & Medical Center
<input type="checkbox"/>	Chapman Medical Center	<input type="checkbox"/>	Santa Ana Hospital Medical Center
<input type="checkbox"/>	Coastal Communities Hospital	<input type="checkbox"/>	South Coast Medical Center
<input type="checkbox"/>	Fountain Valley Regional Hospital & Medical Center	<input type="checkbox"/>	St. Joseph Hospital – Orange
<input type="checkbox"/>	Garden Grove Hospital and Medical Center	<input type="checkbox"/>	St. Jude Medical Center
<input type="checkbox"/>	Hoag Memorial Hospital Presbyterian	<input type="checkbox"/>	University of California Irvine Healthcare
<input type="checkbox"/>	Irvine Regional Hospital and Medical Center	<input type="checkbox"/>	West Anaheim Medical Center
<input type="checkbox"/>	Kaiser Foundation Hospital – Irvine	<input type="checkbox"/>	Western Medical Center – Santa Ana
<input type="checkbox"/>	Kaiser Foundation Hospital – Anaheim	<input type="checkbox"/>	Western Medical Center – Anaheim
<input type="checkbox"/>	La Palma Intercommunity Hospital	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	Los Alamitos Medical Center	<input type="checkbox"/>	Home/Birthing Center
<input type="checkbox"/>	Mission Hospital	<input type="checkbox"/>	Do not know / Decline to Answer
<input type="checkbox"/>	Orange Coast Memorial Medical Center		

If child was not born in Orange County, select one option and complete the information to the right:

<input type="checkbox"/>	In California	County:	_____
<input type="checkbox"/>	In U.S.	State:	_____
<input type="checkbox"/>	Outside U.S.	Country:	_____

Demographics

What is the marital status of the adults with whom the child lives most or all of the time?

<input type="checkbox"/>	Married or legal domestic partnership	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	Single parent household	<input type="checkbox"/>	Don't Know
<input type="checkbox"/>	Cohabiting-living with partner	<input type="checkbox"/>	Decline to Answer

What type of primary health insurance is this child currently covered by?

<input type="checkbox"/>	Public insurance (e.g. Medi-Cal, CalOptima, Healthy Families)	<input type="checkbox"/>	No coverage
<input type="checkbox"/>	Public insurance – infant covered temporarily under the mother's insurance	<input type="checkbox"/>	Do not know
<input type="checkbox"/>	Private insurance (through employer or self)	<input type="checkbox"/>	Decline to answer

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Income

What is the current status of the parent's income?

- No income
- Inadequate income
- Can meet basic needs with subsidy (e.g., WIC, Food Stamps, etc)
- Can meet basic needs and manage debt without assistance
- Income is sufficient, well managed; has discretionary income and is able to save
- Don't know

Please mark the most appropriate range below for the total household income of this child's family.

- | | |
|--|---|
| <input type="checkbox"/> Less than \$10,000 (less than \$833/month) | <input type="checkbox"/> \$40,000 - \$49,999 (\$3334 - \$4167/month) |
| <input type="checkbox"/> \$10,000 - \$14,999 (\$834 - \$1250/month) | <input type="checkbox"/> \$50,000 - \$74,999 (\$4168 - \$6250/month) |
| <input type="checkbox"/> \$15,000 - \$19,999 (\$1251 - \$1667/month) | <input type="checkbox"/> \$75,000 - \$99,999 (\$6251 - \$8333/month \$) |
| <input type="checkbox"/> \$20,000 - \$24,999 (\$1668 - \$2083/month) | <input type="checkbox"/> \$100,000 or more (\$8334/month or more) |
| <input type="checkbox"/> \$25,000 - \$29,999 (\$2084 - \$2500/month) | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> \$30,000 - \$39,999 (\$2501 - \$3333/month) | <input type="checkbox"/> Decline to answer |

Employment

What is the parent's current employment status?

- No job
- Temporary, part-time or seasonal; inadequate pay, no benefits
- Employed full time; inadequate pay; few or no benefits
- Employed full time with adequate pay and benefits
- Maintains permanent employment with adequate income and benefits
- Don't know

Children's Education

(If child is 3-5), what is the current status of the early education of this child?

- Child is not enrolled in school
- Child is enrolled in school, but not attending classes
- Enrolled in school, but child only occasionally attending classes
- Enrolled in school and attending classes most of the time
- Enrolled and attending on a regular basis
- Don't know
- Client is under the age of 3

Child Specific Questions

(If 0-2) Does parent currently have any kind of regular childcare arrangements for 10 or more hours per week for this child?

- | | |
|---|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Does not have regular childcare arrangement and does not need |
| <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> NA- over age 2 | |

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If yes, what type of childcare does the child attend? (Select all that apply and leave blank if over age 2)

- | | |
|---|--|
| <input type="checkbox"/> Grandparent or family member | <input type="checkbox"/> Child's own home - Non-family member |
| <input type="checkbox"/> Head Start/ state program | <input type="checkbox"/> Non-family member in his/her own home |
| <input type="checkbox"/> Preschool or nursery school | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Childcare center | <input type="checkbox"/> Don't know |

In a typical week, how often does a family member read to or show picture books to this child?

- | | |
|---|--|
| <input type="checkbox"/> Every day | <input type="checkbox"/> Not at all |
| <input type="checkbox"/> 3-6 times a week | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Once or twice a week | <input type="checkbox"/> Decline to answer |

Think back to the last week. On a given day, how many children's books were available in your home to read to this child? Please include books you own or borrowed.

- | | |
|-------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> More than 10 |
| <input type="checkbox"/> 1-2 | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> 3-5 | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> 6-10 | |

In general, what is the primary location where you take this child for routine medical care like well-child check-ups?

Well-child check-up means a general check-up.

- | | |
|---|--|
| <input type="checkbox"/> A doctor's office, private clinic or HMO | <input type="checkbox"/> Have never taken child for routine medical care |
| <input type="checkbox"/> Public health department or community health center/clinic | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> The emergency room at a hospital | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> Other _____ | |

Have you ever been asked to fill out a checklist of activities that this child can do, such as certain physical tasks, whether this child can draw certain objects, or ways this child can communicate with you?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Unsure, maybe |
| <input type="checkbox"/> No | <input type="checkbox"/> Decline to Answer |

At what age did this child first visit the dentist or dental hygienist?

- | | |
|--|--|
| <input type="checkbox"/> Child has never been to the dentist | <input type="checkbox"/> 4 years old |
| <input type="checkbox"/> Less than 1 year old | <input type="checkbox"/> 5 years old |
| <input type="checkbox"/> 1 year old | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> 2 years old | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> 3 years old | |

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When did this child last see a dentist or dental hygienist for dental care?

- | | |
|--|--|
| <input type="checkbox"/> Less than 6 months ago | <input type="checkbox"/> 2 years ago or more |
| <input type="checkbox"/> Between 6 months and a year ago | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Between 1 to 2 years ago | <input type="checkbox"/> Decline to answer |

Do you believe this child has a medical, developmental and/or behavioral condition that may affect his/her performance ins school?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Unsure, maybe |
| <input type="checkbox"/> No | <input type="checkbox"/> Decline to Answer |

General

How did you learn about this program?

- | | |
|--|---|
| <input type="checkbox"/> Friend or family member (word of mouth) | <input type="checkbox"/> Orange County Fair |
| <input type="checkbox"/> Childcare provider | <input type="checkbox"/> Outreach worker |
| <input type="checkbox"/> Flyer | <input type="checkbox"/> School district |
| <input type="checkbox"/> Professional referral | <input type="checkbox"/> 211 Phone line |
| <input type="checkbox"/> Family Resource Center | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Community Organization | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Regional Center | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Newspaper, radio, television | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> Health fair or community event | |

Staff Name (verifying completion of Data Entry): _____