CFCOC Supplemental HMIS Exit Form

Client Name / ID: _____

CFCOC ID: _____

Name/Identification and Contact Information:

Legal First Name: _____ Middle Name: _____

Legal Last Name: _____ Suffix: _____

Mother's Maiden Name: _____

Demographics

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

- ☐ Public insurance (e.g. Medi-Cal, CalOptima, Healthy Families)
- ☐ Public insurance – infant covered temporarily under the mother's insurance
- ☐ Private insurance (through employer or self)
- ☐ Other_____
- ☐ No coverage
- ☐ Do not know
- ☐ Decline to answer

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

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

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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?

- ☐ Yes
- ☐ No
- ☐ NA- over age 2
- ☐ Does not have regular childcare arrangement and does not need
- ☐ Don't know

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

- ☐ Grandparent or family member
- ☐ Head Start/ state program
- ☐ Preschool or nursery school
- ☐ Childcare center
- ☐ Child's own home - Non-family member
- ☐ Non-family member in his/her own home
- ☐ Other _____
- ☐ Don't know

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

- ☐ Every day
- ☐ 3-6 times a week
- ☐ Once or twice a week
- ☐ Not at all
- ☐ Don't Know
- ☐ 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.

- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ More than 10
- ☐ Don't Know
- ☐ Decline to answer

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.

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

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?

- ☐ Yes
- ☐ No
- ☐ Unsure, maybe
- ☐ Decline to Answer

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

- ☐ Child has never been to the dentist
- ☐ Less than 1 year old
- ☐ 1 year old
- ☐ 2 years old
- ☐ 3 years old
- ☐ 4 years old
- ☐ 5 years old
- ☐ Don't Know
- ☐ Decline to answer

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

- ☐ Less than 6 months ago
- ☐ Between 6 months and a year ago
- ☐ Between 1 to 2 years ago
- ☐ 2 years ago or more
- ☐ Don't Know
- ☐ Decline to answer

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

- ☐ Yes
- ☐ No
- ☐ Unsure, maybe
- ☐ Decline to Answer

Family-Specific Questions

From the lists below, check all the services your program provided to this child and/or family. (Select all that apply)

1. Information and Referral (Select all that apply)

- ☐ 1.1 Provided information
- ☐ 1.2 Made referral(s)
- ☐ 1.3 Followed up on referral(s)

2. Health Access (Select all that apply)

- ☐ 2.1 Health Insurance status check
- ☐ 2.2 Enrollment assistance - Health Insurance
- ☐ 2.3 Medical Home status check
- ☐ 2.4 Assistance with connecting to Medical Home
- ☐ 2.5 Status check - Dental Insurance
- ☐ 2.6 Dental Insurance enrollment assistance
- ☐ 2.7 Dental Home status check
- ☐ 2.8 Assistance connecting to Dental Home

3. Case Management/Home Visitation/Prenatal Care (Select all that apply)

- ☐ 3.1 Case Management
- ☐ 3.2 Prenatal Care Management
- ☐ 3.3 Home Visits
- ☐ 3.4 Home Safety Inspection

4. Early Care and Education (ECE)/School Readiness/Literacy (Select all that apply)

- ☐ 4.1 Preschool Classes for Children
- ☐ 4.2 Child Care
- ☐ 4.3 Literacy Service(s)
- ☐ 4.4 Transition to Kindergarten
- ☐ 4.5 Nutrition/Fitness – Child Education
- ☐ 4.6 Oral Health – Child Education
- ☐ 4.7 Safety – Child Education
- ☐ 4.8 Hygiene – Child Education
- ☐ 4.9 Other Health Topic(s) – Child Education
- ☐ 4.10 Kindergarten Support & Academics
- ☐ 4.11 Other ECE Service(s) _____

5. Housing /Shelter/Food/Transportation (Select all that apply)

- ☐ 5.1 Food Assistance
- ☐ 5.2 Housing/Shelter
- ☐ 5.3 Transportation Services
- ☐ 5.4 Car Seat Distribution

6. Medical/Dental/Behavioral Services (Select all that apply)

- ☐ 6.1 Dental Restorative Treatment
- ☐ 6.2 Dental Preventive Treatment (e.g. Sealant, Fluoride, Cleaning)
- ☐ 6.3 Immunization(s) Provided
- ☐ 6.4 Mental Health/Behavioral Treatment
- ☐ 6.5 Sick Visit
- ☐ 6.6 Specialty Care
- ☐ 6.7 Well Child Check Up
- ☐ 6.8 Prenatal Medical Visits

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7. Parent Assistance (Select all that apply)

- ☐ 7.1 Breast Feeding Assistance
- ☐ 7.2 Child Development
- ☐ 7.3 Childhood Injury Prevention
- ☐ 7.4 Child Passenger Safety
- ☐ 7.5 Health Related
- ☐ 7.6 Oral Health
- ☐ 7.7 Parenting Skills
- ☐ 7.8 School Readiness
- ☐ 7.9 Child Abuse Prevention
- ☐ 7.10 Children with Special Needs
- ☐ 7.11 Job skills, ESL, GED, parent literacy
- ☐ 7.12 Smoking Cessation
- ☐ 7.13 Alcohol/Substance Abuse Prevention
- ☐ 7.14 Nutrition/Fitness
- ☐ 7.15 Prenatal: Breastfeeding
- ☐ 7.16 Prenatal: Nutrition
- ☐ 7.17 Prenatal: Other_____
- ☐ 7.18 Breastfeeding Nutrition
- ☐ 7.19 Post Partum Depression
- ☐ 7.20 Parent/Child Classes
- ☐ 7.21 Other _____

8. Screening - Screening is the administration of a brief standardized tool that aids the identification of children at risk of a medical, mental, behavioral and/or developmental disorder and who should receive more intensive assessment or diagnosis for potential developmental delays. Screening does not result in either a diagnosis or treatment plan but rather identifies areas in which a child's development differs from same-age norms. (Select all that apply)

- ☐ 8.1 Screening - Immunization
- ☐ 8.2 Screening - Dental
- ☐ 8.3 Screening - Developmental
- ☐ 8.4 Screening - Cognitive
- ☐ 8.5 Screening - Mental Health/Behavioral
- ☐ 8.6 Screening - Physical Health
- ☐ 8.7 Screening - Psychosocial Risk Factors
- ☐ 8.8 Screening - Speech, Hearing, Vision
- ☐ 8.9 Screening - Fitness/Physical Activity

9. Assessment - An assessment is a thorough evaluation to establish the presence or absence of a diagnosable medical, mental, behavioral and/or developmental condition and to suggest the most appropriate type of treatment. Assessment tools are typically longer, more in depth, and require greater expertise to administer. (Select all that apply)

- ☐ 9.1 Dental
- ☐ 9.2 Developmental
- ☐ 9.3 Cognitive
- ☐ 9.4 Mental Health/Behavioral
- ☐ 9.5 Physical Health
- ☐ 9.6 Psychosocial Risk Factors
- ☐ 9.7 Speech, Hearing, Vision

Linkages

Problem	**Please indicate which of the following services you <u>referred</u> your client to. (*select all that apply)***	**Which of the following services <u>did you or your agency provide</u>? (*select all that apply)***	**Which of the following services did you <u>link</u> the client to? *(select all that apply)***	**Were any of the following services <u>unavailable</u>? *(select all that apply)***
Health/Dental Services				
Healthcare provider	☐	☐	☐	☐
Mental health provider	☐	☐	☐	☐
Dental care provider	☐	☐	☐	☐

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Vision provider	☐	☐	☐	☐
Insurance application assistance	☐	☐	☐	☐
Developmental services				
Developmental screening	☐	☐	☐	☐
Developmental assessment	☐	☐	☐	☐
211/Help Me Grow	☐	☐	☐	☐
Family Resource Center	☐	☐	☐	☐
CUIDAR/Child Behavioral Pathways	☐	☐	☐	☐
Speech and language services	☐	☐	☐	☐
Regional Center	☐	☐	☐	☐
Early Care and Education				
Preschool	☐	☐	☐	☐
School district	☐	☐	☐	☐
Child care	☐	☐	☐	☐
After school programs	☐	☐	☐	☐
Tutoring	☐	☐	☐	☐
Learning Link	☐	☐	☐	☐
Family Support Services				
Housing assistance (motel and hotel vouchers, rental assistance)	☐	☐	☐	☐
Food assistance	☐	☐	☐	☐
Clothing assistance	☐	☐	☐	☐
Utility assistance	☐	☐	☐	☐
Job training/Adult education/GED	☐	☐	☐	☐
Transportation	☐	☐	☐	☐

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Parenting Practices				
Parenting classes	☐	☐	☐	☐
Orange County Social Services Agency (OC SSA)	☐	☐	☐	☐
Domestic violence services	☐	☐	☐	☐
Intensive home visitation	☐	☐	☐	☐
Multidisciplinary case management team	☐	☐	☐	☐
Substance abuse services	☐	☐	☐	☐
Other, specify	☐	☐	☐	☐
Other, specify	☐	☐	☐	☐

Staff Name (verifying completion of Data Entry): _____