DAISEY
connecting the first five years to a lifetime of success

KS MIECHV Caregiver Activities Form

Directions: Fill this form out once per quarter for each caregiver. Answers on this form should reflect the entire quarter. Home visit counts should include the entire quarter and other answers should reflect most updated information gathered this quarter.

- Quarter 1: October 1st – December 31st
- Quarter 2: January 1st – March 31st
- Quarter 3: April 1st – June 30th
- Quarter 4: July 1st – September 30th

The PDF version of this form is only provided for your convenience. The form may be filled out directly in DAISEY without printing and filling out a paper version.

Note: Mandatory DAISEY questions are preceded by an asterisk (*). This form cannot be saved in DAISEY without the answers to these questions.

Basic Information

*Which caregiver was involved? _____

*Date of activity: _____
Note: This is the date the data on this form was entered into the DAISEY system

Service

*Total number of home visits this quarter: _____

*Number of postnatal home visits this quarter: _____

*Number of postnatal home visits where the caregiver was asked if they have any concerns for their child's development, behavior or learning this quarter: _____

*Retention status (select one)

☐ Currently receiving services ☐ Stopped services before completion
☐ Completed program ☐ Other

If client has left from the program, fill out the next two questions. If not, leave the next two questions blank.

Date of discharge (if applicable) _____

Reason for client discharge (select one, if applicable)

- ☐ Achieved case goals
- ☐ Age out
- ☐ Dissatisfied
- ☐ Lack of interest
- ☐ Too busy
- ☐ Declined
- ☐ Unable to contact or locate
- ☐ Inactivity
- ☐ Failure to follow guidelines
- ☐ Family no longer eligible
- ☐ Switched home visiting programs
- ☐ Family moved away
- ☐ Child removed from custody
- ☐ Child adopted
- ☐ Institutionalized
- ☐ Needs exceed program
- ☐ Program full
- ☐ Program lost funding
- ☐ Miscarriage or stillbirth
- ☐ Death of Parent or child

Demographics

*Highest level of education completed (select one)

- ☐ Less than HS diploma
- ☐ HS diploma / GED
- ☐ Some college / training
- ☐ Technical training or certification
- ☐ Associate's degree
- ☐ Bachelor's degree or higher
- ☐ Other

If caregiver has less than a HS diploma:
Is the caregiver currently enrolled in high school or a GED program? (select one) ☐ Yes ☐ No

*Employment status (select one) ☐ Employed full-time ☐ Employed part-time ☐ Not employed

*Total people living in household: _____

*Annual household income: _____

*Housing status (select one, then answer the matching follow-up question below)

- ☐ Owns or shares own home or condominium or apartment
- ☐ Rents or shares own home or apartment
- ☐ Lives in public housing
- ☐ Lives with parent or family member
- ☐ Not homeless, but some other arrangement
- ☐ Homeless and sharing housing
- ☐ Homeless and living in an emergency or transitional shelter
- ☐ Homeless with some other arrangement

Health

*Current pregnancy status (select one) ☐ Pregnant ☐ Not pregnant

Current health insurance (select one)

- ☐ No insurance coverage
- ☐ Medicaid or CHIP
- ☐ Tri Care
- ☐ Private or Other

*Has this caregiver has continuous health insurance coverage for the past 6 months? (select one)

☐ Yes ☐ No

Date of postpartum medical visit: _____
Note: Postpartum medical visit should occur within 8 weeks (56 days) of delivery.

*Was the caregiver using tobacco or cigarettes at enrollment? (select one) ☐ Yes ☐ No
Note: This includes all forms of tobacco or cigarette use, including: cigars, pipes, hookahs, chew, dip, snuff, and electronic nicotine delivery systems (e.g. e-cigs).

If yes: Date of referral for tobacco cessation: _____

Edinburgh Postnatal Depression Screen

Date of Edinburgh Postnatal Depression Screening completed: _____
Note: Depression screening should occur at least once per client. For prenatal enrollees: within 3 months of delivery. For postnatal enrollees: within 3 months of enrollment.

Edinburgh Postnatal Depression Screening score: _____
Note: Any score greater than or equal to 10 indicates a referral for depression services is needed.

Date of referral made for depression (if applicable): _____

Date of referral completed for depression (if applicable): _____

Relationship Screen

Date of Relationship Screen (Abuse Assessment Screen): _____
Note: Screener should be completed within 6 months of enrollment.

Relationship Screen (Abuse Assessment Screen) Score: _____
Note: A score of 1 or more indicates a referral is needed.

Date of referral made for Intimate Partner Violence (if applicable): _____

Date of safety plan made for Intimate Partner Violence (if applicable): _____

UNCOPE/ASSIST Substance Abuse Screen

Date of UNCOPE/ASSIST screening: _____ UNCOPE Screening Score: _____

Assist Scores:

Tobacco score: _____	Alcohol score: _____	Cannabis score: _____
Cocaine score: _____	Amphetamine score: _____	Inhalants score: _____
Sedatives score: _____	Hallucinogens score: _____	Opioids score: _____
Other drugs score: _____		

Priority Populations

*Household has a history of child abuse or neglect or has had interactions with child welfare services (select one) ☐ Yes ☐ No
Note: Based on self-report, an enrollee who has a history of abuse or neglect and has had involvement with child welfare services either as a child or as an adult.

*Someone in the household has a history of substance abuse or needs substance abuse treatment (select one)
☐ Yes ☐ No
Note: Based on self-report, an enrollee who has a history of substance abuse or who has been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.

*Someone in the household uses tobacco products in the home (select one) ☐ Yes ☐ No
Note: Based on self-report, enrollees who use tobacco products in the home or who have been identified as using tobacco through a substance abuse screening administered during intake. Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and electronic nicotine delivery systems (ENDS).

*Someone in the household has attained low student achievement or has a child with low student achievement (select one) ☐ Yes ☐ No
Note: This is based on self-report from the caregiver. Do they perceive themselves or their children as having low student achievement?

*Someone in the household is currently serving or formerly served in the US Armed Forces? (select one) ☐ Yes ☐ No
Note: Based on self-report, families that include individuals who are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States. For this criterion, definition includes a military member's dependent acquired through marriage, adoption, or other action during the course of a member's current tour of assigned duty.

*Household has a child with developmental delays or disabilities (select one) ☐ Yes ☐ No
Note: This should be based on both parent report and home visitor observation. Do you suspect any children in the household have a developmental delay or disability?