Bureau of Family Health

Using DAISEY for improved family services coordination & measurement

Technical Assistance Brief

DAISEY, which stands for Data Application and Integration Solutions for the Early Years, is a shared measurement system. DAISEY was designed by social scientists to help communities see the difference they are making in the lives of at-risk children, youth and families. Implementation of a shared measurement system will allow the Bureau of Family Health at the Kansas Department of Health and Environment (KDHE) and their grantees to improve data quality, track progress toward shared goals, and enhance communication and collaboration.

Data Dictionary

This tool provides information on the data elements collected in DAISEY. Each section of this document represents a from. Each form section has information about the data elements in that form, including a definitions/descriptions, possible responses, and the purpose of each element.

This document will not provide all information necessary for preparing data for Import into DAISEY. For detailed information on Import requirements, see the Data Crosswalk.

Last Updated: July 1, 2021

July 1, 2021 form changes are indicated in red font.

Contents

*denotes forms that were added or have new changes for July 1, 2021

Form Overview

Forms	Information Collected
Profile Forms	
Caregiver (Adult) Profile	Demographic information that is 'static', not likely to change
Child Profile	Demographic information that is 'static', not likely to change
Encounter Forms	
KDHE Program Visit Form Adult	Demographic information that should be verified/updated at each contact
KDHE Program Visit Form Child	Demographic information that should be verified/updated at each contact
KDHE Program Referral Form	Information about referrals made and appropriate follow-up
Service Forms	
Becoming a Mom Service Form	Information about services delivered during the BaM session
Family Planning Service Form	Information about services delivered during the Family Planning visit
MCH Service Form*	Information about services delivered during the MCH visit
PMI Service Form*	Information about services delivered during the PMI visit
TPTCM Service Form*	Information about services delivered during the TPTCM visit
Additional Forms	
Becoming a Mom Birth Outcome Card	Birth outcome data for women completing Becoming a Mom
Becoming a Mom Completion Survey	Survey data for Becoming a Mom participants at program completion
Becoming a Mom Initial Survey	Survey data for Becoming a Mom participants at program initiation
Edinburgh*	Depression screening tool for prgenant and postpartum women
Tobacco Use Survey	Smoking history information for all program participants
PMI Birth Outcome Card	Birth outcome data for women in PMI program collected out of program visits
TPTCM Birth Outcome Card	Birth outcome data for women in TPTCM program collected out of program visits
KDHE One Key Question Form	Pregnancy Intentions
ASQ: 3	Ages and Stages Questionnaire
ASQ-SE: 2	Ages and Stages Questionnaire
Client Contact Form	Document contacts and notes
Parental Screener	Initial screening for parents
ASSIST	Substance Use Screener
KDHE Case Notes	Optional case notes form
KDHE Goal Tracking Form	Optional goal tracking form
CRAFFT+N Interview*	Optional screening tool

GAD-7*	Optional screening tool
PHQ-9*	Optional screening tool
PHQ-A*	Optional screening tool
PSC-17 Caregiver*	Optional screening tool
PSC-17 Child*	Optional screening tool

*denotes forms that were added or have new changes for July 1, 2020

Instructions

This Data Dictionary is organized into sections by Form. Each Form section provides information for the categories below with each row representing one data element.

Form Name

Question Label	Description / Definition	Data Type	Response Format	Response Options	Sysetm Required?	Purpose of Question/Element
The data element or question as it appears in DAISEY	A definition or description of the data element or question	The format of response options in DAISEY. May include: Drop-down list (single choice), Drop-down list (multiple choice), Date, Text, Narrative, and System Generated.	Format of response options/field in DAISEY. May include: Alphanumeric, Numeric, Text, Date (mm/dd/yyyy), Phone (555-555-5555), Dynamic.	If the data element or question includes a menu of possible responses, the possible responses are listed here.	Whether the field is required to be completed before the user can save the form.	Specific report that the data element will inform, or other purpose for including the data element or question.

Caregiver (Adult) Profile

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Caregiver ID	DAISEY generated client identifier	Text	Alphanumeric		No	Client Identification
Caregiver System ID	DAISEY generated client identifier	Auto-generated	Alphanumeric		No	Client Identification
Alternate ID	Organizational client identifier	Text	Alphanumeric		No	Organizational reference
First Name	Client First Name	Text	Alphanumeric		Yes	Deduplication for reporting
Last Name	Client Last Name	Text	Alphanumeric		Yes	Deduplication for reporting
Enrollment Date	Date Client Profile created in DAISEY	Date	Date (mm/dd/yyyy)		No	BG forms and narrative, FPAR, PMI & TPTCM reporting
Date of Birth	Client Date of Birth	Date	Date (mm/dd/yyyy)		Yes	System tracking
Sex - Select one	Client Sex	Drop-down list (single choice)	Text	Female|Male	Yes	FPAR, MCHBG
Race - Select all that apply	Client Race	Drop-down list (multiple choice)	Text	White|Black or African American|American Indian or Alaska Native|Asian|Native Hawaiian or Other Pacific Islander|Unknown/Not Reported	Yes	MCHBG, FPAR, PMI & TPTCM reporting
Ethnicity - Select one	Client Ethnicity	Drop-down list (single choice)	Text	Hispanic or Latino|Not Hispanic or Latino|Not Reported	Yes	MCHBG, FPAR, PMI & TPTCM reporting

Caregiver (Adult) Profile

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Primary Language	Client's primary language (self-report)	Drop-down list (single choice)	Text	English|Spanish|Other	Yes	MCHBG and FP narrative
Specify:	Client's primary language if Other selected in previous question	Text	Text		No	Tied to question above
Limited English Proficiency?	Whether the client has a limited ability to read, write, speak or understand English (client does not understand services and information provided in English)	Drop-down list (single choice)	Text	Yes|No|Unknown/Not Reported	Yes	FPAR
Is this the primary caregiver of the child?	Designates the 'primary' adult client involved in services. Defaults to 'yes' on new profiles.	Drop-down list (single choice)	Text	Yes|No	Yes	Creates link to family members
If No, Select Primary Caregiver		Hidden	Text		No	

FPAR	Family Planning Annual Report (Required to maintain FP funding) (Federal)
MCHBG	MCH Block Grant (Title V Annual Application and Report required for annual funding) (Federal)
PMI	Pregnancy Maintenance Initiative (Report to Legislature Pursuant to KSA 65-1, 159a) (State)
TPTCM	Teen Pregnancy Targeted Case Management Report to the Legislature & Medicaid (State)
FP	Family Planning (Title X Annual Application and Report required for annual funding) (Federal)

KDHE Program Visit Form - Adult

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Agency / Clinic	Agency or clinic where client received services documented on this form	Narrative	Text		No	
Client Address:	Client's current street address	Narrative	Text		No	client tracking
City	Client's current city of residence	Text	Alphanumeric		No	client tracking
Zip code	Client's current zip code	Text	Alphanumeric		Yes	target populations and poor outcomes/surveillance and tracking
County of Residence	Client's current county of residence	Drop-down list (single choice)	Text	*List of Kansas Counties plus an option for Out of State*	Yes	target populations and poor outcomes/surveillance and tracking
Phone Number	Client's current phone number	Text	Phone (555-555-5555)		No	client tracking
Email:	Client's current email address	Text	Text		No	client tracking
Preferred Method of Contact	Client's preferred method(s) of contact	Drop-down list (multiple choice)	Text	Phone Call|Text|Email|Mail|Do Not Contact	No	client tracking

KDHE Program Visit Form - Adult

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Program	Program client participated in	Drop-down list (single choice)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)	Yes	BG forms & narrative, FPAR & FP narrative, PMI & TPTCM reporting
Primary Healthcare Coverage	Client's primary type of healthcare coverage	Drop-down list (single choice)	Text	None/Self Pay|Private Insurance|TRICARE| KanCare/Medicaid|CHIP (Formerly HealthWave)|Medicare (client is on disability)|Unknown/Not Reported	Yes	BG form and narrative, FPAR, PMI & TPTCM reporting
Secondary Healthcare Coverage	Client's secondary type of healthcare coverage, if applicable	Drop-down list (single choice)	Text	None|Private Insurance|TRICARE| KanCare/Medicaid|CHIP (Formerly HealthWave)|Medicare (client is on disability)|Unknown/Not Reported	Yes	BG form and narrative, FPAR, PMI & TPTCM reporting
Has the client had a well visit during the last 12 months?	Indicates whether the client had a well visit within the last 12 months with any provider, not just with this program	Drop-down list (single choice)	Text	Yes|No|Client is unsure	Yes	MCHBG Measure

KDHE Program Visit Form - Adult

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Does the client have a special health care need or disability?	Indicates whether the client has a medical diagnosis or requires care beyond general preventive care	Drop-down list (single choice)	Text	Yes|No	Yes	Client tracking, Caregiver health project, SHCN program referral
Does the client care for any children who have special health care needs?	Indicates whether the client cares for a child who has a medical diagnosis or requires care beyond general preventive care	Drop-down list (single choice)	Text	Yes|No	Yes	Client tracking, Caregiver health project, SHCN program referral
Household Size (number of people living in the household)	Total number of individuals living in the client's household	Text	Numeric		Yes	BG forms & narrative, FPAR (poverty level requirements)
Annual Household Income	Client's reported or estimated annual income for all individuals living in the household, from all income sources. *Note: if the client has no information about income or refuses to provide their income information, enter '999999'*	Text	Numeric		Yes	BG forms & narrative, FPAR (poverty level requirements)

KDHE Program Visit Form - Adult

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Annual Household Income	Client's reported or estimated annual income for all individuals living in the household, from all income sources.	Drop-down list (single choice)	Text	Less than $10000|$10000 to $14999|$15000 to $19999|$20000 to $24999|$25000 to $34999|$35000 to 49999|$50000 or more|Don't Know|Refused	Yes	BG forms & narrative, FPAR (poverty level requirements)
Education Level	Highest level of education obtained by client	Drop-down list (single choice)	Text	<12 Years|High School Diploma or GED|Vocational Certification/License| College-No Degree|Associates Degree|Bachelor Degree or higher|Client refused to answer	Yes	PMI & TPTCM reporting
Current Student	Indicates whether the client is a current student	Drop-down list (single choice)	Text	Yes|No|Client refused to answer	Yes	PMI & TPTCM reporting
Employment	Client's current employment status	Drop-down list (single choice)	Text	Unemployed|Occasional/Seasonal Employment|Part-Time|Full-Time|Client refused to answer	Yes	PMI & TPTCM reporting
Marital Status	Client's current marital status	Drop-down list (single choice)	Text	Single|Married|Separated|Divorced|Widowed|Client refused to answer	Yes	PMI & TPTCM reporting
Health Care Enrollment Assistance - ACA	Marketplace	Drop-down list (single choice)	Text	On-site assistance|Off-site assistance|Did not provide assistance	Yes	

KDHE Program Visit Form - Adult

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Health Care Enrollment Assistance - Medicaid	KanCare/Medicaid	Drop-down list (single choice)	Text	On-site assistance|Off-site assistance|Did not provide assistance	Yes	
Health Care Enrollment Assistance - Third party	Private Insurance	Drop-down list (single choice)	Text	On-site assistance|Off-site assistance|Did not provide assistance	Yes	
Visit In-Person or Virtual?	Determines whether visit occurred in person or remotely.	Drop-down list (single choice)	Text	1,In person|2,Virtual, phone call only|3,Virtual, video chat (Skype, Zoom, FaceTime, etc.)	No	KDHE will use this to assess data trends and comparisons between in-person client encounters and remote client encounters for the duration of the COVID-19 pandemic and possibly beyond
If this is a Family Planning Visit is the visit confidential? *Note: This question appears in the form of an overlay when a user clicks 'save' or 'submit'*	Denotes whether this program visit is confidential. *Note: This applies to Family Planning visits ONLY all other programs including BaM, MCH, TPTCM, and PMI should click Not Confidential.*	Text	Text	Confidential (Restricted)/Not Confidential (Unrestricted)	Yes	FP requires based on client request

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Child Profile

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Child ID	DAISEY generated client identifier	Text	Alphanumeric		No	Client Identification
Alternate ID	Organizational client identifier	Text	Alphanumeric		No	Organizational reference
First Name	Client First Name	Text	Alphanumeric		Yes	deduplication for reporting
Last Name	Client Last Name	Text	Alphanumeric		Yes	deduplication for reporting
Active Status	LEAVE BLANK. This field not used by KDHE Family Health Grantees.	Drop-down list (single choice)	Text	Active|Inactive	No	NOT Required. Leave blank.
Enrollment Date	Date Client Profile created in DAISEY	Date	Date (mm/dd/yyyy)		No	system tracking
Date of Birth	Client Date of Birth	Date	Date (mm/dd/yyyy)		Yes	BG forms and narrative, FPAR, PMI & TPTCM reporting
Sex - Select one	Client Sex	Drop-down list (single choice)	Text	Female|Male	Yes	BG narrative
Race - Select all that apply	Client Race	Drop-down list (multiple choice)	Text	White|Black or African American|American Indian or Alaska Native|Asian|Native Hawaiian or Other Pacific Islander|Unknown/Not Reported	Yes	BG forms, PMI & TPTCM reporting

Child Profile

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Ethnicity - Select one	Client Ethnicity	Drop-down list (single choice)	Text	Hispanic or Latino|Not Hispanic or Latino|Not Reported	Yes	BG forms, PMI & TPTCM reporting
Primary Language	Client's primary language (self-report)	Drop-down list (single choice)	Text	English|Spanish|Other	Yes	BG narrative
Specify:	Client's primary language if Other selected in previous question, or indicate if non-verbal	Text	Text		No	Tied to question above
Limited English Proficiency?	Whether the client has a limited ability to read, write, speak or understand English (client does not understand services and information provided in English)	Drop-down list (single choice)	Text	Yes|No|Unknown/Not Reported	Yes	BG narrative
Primary Caregiver ID	Name of primary adult client associated to this child client	Text	Alphanumeric		No	Identification of associated Primary Caregiver
Primary Caregiver System ID		Text	Numeric		No	Identification of associated Primary Caregiver

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KDHE Program Visit Form - Infant / Child / Adolescent

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which child was involved?	Name of the client receiving services documented in this form	Drop-down list (single choice)	Dynamic Child	*Options will include all associated children*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Agency / Clinic	Agency or clinic where client received services documented on this form	Narrative	Text		No	
Client Address:	Client's current street address	Narrative	Text		No	client tracking
City	Client's current city of residence	Text	Alphanumeric		No	client tracking
Zip code	Client's current zip code	Text	Alphanumeric		Yes	target populations and poor outcomes/surveillance and tracking
County of Residence	Client's current county of residence	Drop-down list (single choice)	Text	*List of Kansas Counties plus an option for Out of State*	Yes	target populations and poor outcomes/surveillance and tracking
Phone Number	Client's parent/caregiver's current phone number	Text	Phone (555-555-5555)		No	client tracking
E-Mail:	Client's parent/caregiver's current email address	Text	Text		No	client tracking
Preferred Method of Contact	Client's parent/caregiver's preferred method(s) of contact	Drop-down list (multiple choice)	Text	Phone Call|Text|Email|Mail|Do Not Contact	No	client tracking

KDHE Program Visit Form - Infant / Child / Adolescent

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Program	Program client participated in during current visit	Drop-down list (single choice)	Text	Maternal Child Health (MCH/M&I)	Yes	MCHBG forms & narrative, FPAR & FP narrative, PMI & TPTCM reporting
Primary Healthcare Coverage	Client's primary type of healthcare coverage	Drop-down list (single choice)	Text	None/Self Pay|Private Insurance|TRICARE| KanCare/Medicaid|CHIP (Formerly HealthWave)|Medicare (client is on disability)|Unknown/Not Reported	Yes	MCHBG form and narrative, FPAR, PMI & TPTCM reporting
Secondary Healthcare Coverage	Client's secondary type of healthcare coverage, if applicable	Drop-down list (single choice)	Text	None|Private Insurance|TRICARE| KanCare/Medicaid|CHIP (Formerly HealthWave)|Medicare (client is on disability)|Unknown/Not Reported	Yes	MCHBG form and narrative, FPAR, PMI & TPTCM reporting
Has the client had a well visit during the last 12 months?	Indicates whether the client had a well visit within the last 12 months with any provider, not just with this program	Drop-down list (single choice)	Text	Yes|No|Client is unsure	Yes	MCHBG Measure

KDHE Program Visit Form - Infant / Child / Adolescent

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Medical Home	Indicates whether the client has a medical home: 1) a usual source of sick and well care, 2) a personal doctor or nurse, 3) effective cross-system care coordination, 4) patient and family-centered care, and 5) assistance in getting needed referrals.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG narrative
Provider / Clinic Name:	*BRANCHES FROM: "Medical Home"* Client's medical home provider name	Text	Text		No	Tied to question above
Does this child have special health care needs?	Indicates whether the child has a medical diagnosis or requires care beyond general preventive care	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG Forms
Household Size (number of people living in the household)	Total number of individuals living in the client's household	Text	Numeric		Yes	MCHBG forms & narrative, FPAR (poverty level requirements)
Annual Household Income	Client's reported or estimated annual income for all individuals living in the household, from all income sources. *Note: if the client has no information about income or refuses to provide their income information, enter '999999'*	Text	Numeric		Yes	MCHBG forms & narrative, FPAR (poverty level requirements)

KDHE Program Visit Form - Infant / Child / Adolescent

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Annual Household Income	Client's reported or estimated annual income for all individuals living in the household, from all income sources.	Drop-down list (single choice)	Text	Less than $10000|$10000 to $14999|$15000 to $19999|$20000 to $24999|$25000 to $34999|$35000 to 49999|$50000 or more|Don't Know|Refused	Yes	BG forms & narrative, FPAR (poverty level requirements)
Visit In-Person or Virtual?	Determines whether visit occurred in person or remotely.	Drop-down list (single choice)	Text	1,In person|2,Virtual, phone call only|3,Virtual, video chat (Skype, Zoom, FaceTime, etc.)	No	KDHE will use this to assess data trends and comparisons between in-person client encounters and remote client encounters for the duration of the COVID-19 pandemic and possibly beyond

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KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Referrals for Caregiver/Adult or Child?	Indicates whether an adult/caregiver client or a child client were referred for services documented on this form	Drop-down list (single choice)	Text	Caregiver/Adult|Child	Yes	Allows the option of indicating either an adult/caregiver or child for the referrals
Which caregiver was involved?	*BRANCHES FROM: "Referrals for Caregiver/Adult or Child?"* Name of the caregiver/adult client receiving services documented in this form if applicable. NOTE: you must either select the name of the adult/caregiver OR the child involved in the referral	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	No	Document which adult/caregiver in the family the referral was for
Which child was involved?	*BRANCHES FROM: "Referrals for Caregiver/Adult or Child?"* Name of the child client receiving services documented in this form if applicable. NOTE: you must either select the name of the adult/caregiver OR the child involved in the referral	Drop-down list (single choice)	Dynamic Child	*Options will include all associated children*	No	Document which child in the family the referral was for
Date of Activity	Date of referrals documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date referrals were made

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Program	Program originating the form	Drop-down list (single choice)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)	Yes	MCHBG & FP narrative, PMI and TPTCM state reporting
Child Protection referral	Indicates whether a child abuse/neglect report was made to DCF	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative, PMI state report
Child Protection Referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the referral for child protection	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Child Protective Services Case Not Opened|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative, PMI state report
Domestic Violence referral	Indicates whether a referral was made regarding domestic violence	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Domestic Violence Referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the referral for domestic violence	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Rape/Sexual Assault referral	Indicates whether a referral was made regarding rape/sexual assault	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Rape\Sexual Assault Referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the referral regarding rape/sexual assault.	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative
Suicide Prevention referral	Indicates whether a referral was made regarding suicide prevention	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Suicide Prevention Referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the suicide prevention referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative
Early Childhood Services (Headstart, PAT) referral	Indicates whether a referral was made to Early Childhood Services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
GED/High School Completion referral	*BRANCHES FROM: Preceding field* Indicates whether a referral was made regarding GED / High School Completion	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative, PMI & TPTCM state reporting
Parenting Education/Support referral	Indicates whether a referral was made for parenting education or support services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, PMI & TPTCM state reporting

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Pregnancy Education referral	*BRANCHES FROM: Preceding field* Indicates whether a referral was made for pregnancy education	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, PMI & TPTCM state reporting
Alcohol/Substance Abuse referral completed? *Moved from Support Services / Systems Section	Indicates whether a referral was made for alcohol or substance abuse services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Alcohol/Substance Abuse referral completed? *Moved from Support Services / Systems Section	*BRANCHES FROM: Preceding field* Indicates the outcome of the alcohol or substance abuse services referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative
Breastfeeding referral	Indicates whether a referral was made regarding breastfeeding	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Breastfeeding referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the breastfeeding referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Cancer Treatment/Diagnosis referral	Indicates whether a referral was made regarding a cancer diagnosis or for cancer treatment	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Cancer Treatment/Diagnosis referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the cancer treatment/diagnosis referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative
Dental Services referral	Indicates whether a referral was made for dental services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Dental referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the referral for dental services	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Developmental Assessment/Screening referral	Indicates whether a referral was made for a developmental assessment or screening	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Developmental Assessment/Screening referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the developmental assessment/screening referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Diabetes Management referral	Indicates whether a referral was made regarding diabetes management	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Diabetes Management referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the diabetes management referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Early Childhood Intervention (Part C, Tiny-K) referral	Indicates whether a referral was made for early childhood intervention services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Early Childhood Intervention referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the referral for early childhood intervention services	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Abnormal PAP Test Follow-up referral	Indicates whether a referral was made for abnormal PAP test follow-up	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, FPAR
Abnormal PAP Test Follow-up referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the abnormal PAP test follow-up referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative, FPAR
Clinical Breast Exam Follow-up referral	Indicates whether a referral was made regarding follow up to a clinical breast exam	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, FPAR

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Clinical Breast Exam Follow-up referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the clinical breast exam follow-up referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative, FPAR
Hearing referral	Indicates whether a referral was made for hearing services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Hearing referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the hearing service referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
HIV Treatment referral	Indicates whether a referral was made for HIV treatment services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, FPAR
HIV Treatment referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the HIV treatment services referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative, FPAR
Immunizations referral	Indicates whether a referral was made for immunization(s)	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Immunization referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the immunization referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
MCH/HSHV referral	Indicates whether a referral for MCH services was made by other programs	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
MCH/HSHV referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the MCH referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Mental Health referral	Indicates whether a referral was made for Mental Health	Drop-down list (single choice)	Text	Yes|No	No	
Mental Health referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the Mental Health referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	
Out of County MCH/HSHV referral	Indicates whether a referral was made for Out of County MCH/HSHV services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Out of County MCH/HSHV referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the out/HSHV referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Prenatal Care or Education referral	Indicates whether a referral was made regarding Prenatal Care or Education	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Prenatal Care or Education referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the Prenatal Care or Education referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative
Postpartum Care or Education referral	Indicates whether a referral was made regarding Postpartum Care or Education	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Postpartum Care or Education referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the Postpartum Care or Education referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Reproductive Health/Family Planning referral	Indicates whether a referral for reproductive health/Family Planning services was made by other programs	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, PMI & TPTCM state reporting

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Reproductive Health/Family Planning referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the reproductive health / Family Planning referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative, PMI & TPTCM state reporting
Smoking Cessation: Kansas Tobacco Quitline referral	Indicates whether a referral was made to Kansas Tobacco Quitline	Drop-down list (single choice)	Text	Yes|No	No	MCHBG measure
Kansas Tobacco Quitline referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the Kansas Tobacco Quitline referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG measure
Smoking Cessation: Baby & Me Tobacco Free referral	Indicates whether a referral was made to Baby & Me Tobacco Free	Drop-down list (single choice)	Text	Yes|No	No	MCHBG measure
Baby & Me Tobacco Free referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the Baby & Me Tobacco Free referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG measure
Smoking Cessation: Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT™) referral	Indicates whether a referral was made to SCRIPT™	Drop-down list (single choice)	Text	Yes|No	No	

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
SCRIPT™ referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the SCRIPT referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	
Smoking Cessation: Other Program referral	Indicates whether a referral was made to Other smoking cessation program	Drop-down list (single choice)	Text	Yes|No	No	MCHBG measure
Other Smoking Cessation Program referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the Other smoking cessation program referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG measure
KDHE Special Health Care Needs Program referral	Indicates whether a referral was made to the KDHE special health care needs program	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
KDHE Special Health Care Needs Program referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the referral to the KDHE special health care needs program	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Speech/Language referral	Indicates whether a referral was made regarding speech/language services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Speech/Language referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the speech services referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Vision referral	Indicates whether a referral was made regarding vision services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Vision referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the vision services referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Weight Management referral	Indicates whether a referral was made regarding weight management	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Weight Management referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the weight management referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Well Woman Visit referral	Indicates whether a referral was made regarding a well woman visit	Drop-down list (single choice)	Text	1,Yes|0,No	No	MCHBG narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Well Woman Visit referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the well woman visit referral	Drop-down list (single choice)	Text	0,No|1,Yes- Client Accepted Services|2,Yes- Client Declined Services|3,Yes- Client Lost to Follow Up	No	MCHBG narrative
WIC Referral	Indicates whether a referral was made to WIC	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
WIC referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the WIC referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG narrative
Other Medical referral	Indicates whether a referral was made for other medical services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Other Medical referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the referral for other medical services	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative
Cash Assistance referral	Indicates whether a referral was made for cash assistance services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Child Care Subsidy referral	Indicates whether a referral was made for Child Care Subsidy services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Employment Resources referral	Indicates whether a referral was made for employment resources	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Food/Food Stamps (not WIC) referral	Indicates whether a referral was made for food or food stamps (not WIC)	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Health Care Coverage referral	Indicates whether a referral was made regarding health care coverage	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Health Care Coverage referral completed?	*BRANCHES FROM: Preceding field* Indicates the outcome of the health care coverage referral	Drop-down list (single choice)	Text	No|Yes- Client Accepted Services|Yes- Client Declined Services|Yes- Client Lost to Follow Up	No	MCHBG & FP narrative
Adoption Counseling referral	Indicates whether a referral was made for adoption counseling services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative
Child Care referral	Indicates whether a referral was made for child care services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Clothing referral	Indicates whether a referral was made regarding clothing services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Fatherhood Initiatives referral	Indicates whether a referral was made regarding fatherhood initiatives.	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, PMI & TPTCM state reporting
Housing referral	Indicates whether a referral was made regarding housing services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Immigration Services referral	Indicates whether a referral was made regarding immigration services.	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative, PMI & TPTCM state reporting
Legal Assistance referral	Indicates whether a referral was made for legal assistance	Drop-down list (single choice)	Text	Yes|No	No	MCHBG narrative
Transportation referral	Indicates whether a referral was made regarding transportation services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative, PMI & TPTCM reporting, program coodination
Utilities Assistance referral	Indicates whether a referral was made for utilities assistance	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative, PMI & TPTCM reporting, program coodination

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Youth Services referral	Indicates whether a referral was made for youth services	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative, PMI & TPTCM reporting, program coodination
Other referral	Indicates whether a referral was made that does not fit one of the categories on this form	Drop-down list (single choice)	Text	Yes|No	No	MCHBG & FP narrative, PMI & TPTCM reporting, program coodination
Specify Other referral:	Type of referral made if Other is selected on the previous question	Text	Text		No	Tied to question above
Comments:	Comments on the referral(s) being made	Narrative	Text		No	Narrative field as needed by users
If this is a Family Planning Visit is the visit confidential? *Note: This question appears in the form of an overlay when a user clicks 'save' or 'submit'*	Denotes whether this program visit is confidential. *Note: This applies to Family Planning visits ONLY all other programs including BaM, MCH, TPTCM, and PMI should click Not Confidential.*	Text	Text	Confidential (Restricted)/Not Confidential (Unrestricted)	Yes	FP requires based on client request

KDHE Program Referral Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element

**Form/fields are only completed if referral(s) made and only for type(s) made.

FPAR	Family Planning Annual Report (Required to maintain FP funding) (Federal)
MCHBG	MCH Block Grant (Title V Annual Application and Report required for annual funding) (Federal)
PMI	Pregnancy Maintenance Initiative (Report to Legislature Pursuant to KSA 65-1, 159a) (State)
TPTCM	Teen Pregnancy Targeted Case Management Report to the Legislature & Medicaid (State)
FP	Family Planning (Title X Annual Application and Report required for annual funding) (Federal)

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date of enrollment / first session attendance in BaM program. Because the BaM Service Form is updated after each session attendance, it is important to always reflect the date of **first** attendance, in this data field.	Date	Date (mm/dd/yyyy)		Yes	Document date client first entered the BaM program and began receiving services through the program; assists with data tracking purposes related to new participants enrolled in the program during a certain time frame
Provider / Clinic Name	Name of the provider or clinic where the client is receiving services	Text	Text	Please indicate the name of the client's physician or clinic.	No	Document client's provider, enabling contact of provider as needed, as well as for data tracking purposes
Expected Due Date:	Date that the client's baby is estimated to be due	Date	Date (mm/dd/yyyy)		No	Document date client's baby is expected to be due; assists with client tracking and data collection
Initial Survey Completed:	Date that the client completed the Initial Survey	Date	Date (mm/dd/yyyy)		No	Tracks completion of required components of BaM program. Should be completed as a part of the program enrollment process.; assists with client tracking and data collection
BaM Consent Form Signed	Date the client signed the BaM consent form	Date	Date (mm/dd/yyyy)		No	Tracks completion of required components of BaM program. Should be completed as a part of the program enrollment process

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Tobacco Use Survey completed:	Date that the client completed the Tobacco Use Survey	Date	Date (mm/dd/yyyy)		No	Tracks completion of required components of BaM program. Should be completed as a part of the program enrollment process
Date of attendance at Session 1, Prenatal Care:	Date of attendance at Session 1, Prenatal Care:	Date	Date (mm/dd/yyyy)		No	Documents/tracks session attendance by client
Session 1, Prenatal Care Education Provided:	Education provided at this session (select all, or those that apply to your site)	Drop-down list (multiple choice)	Text	Alcohol/Substance Abuse|Father Involvement|Health Care Coverage/Medicaid Eligibility|Lifestyle risk factors/prenatal exposures|Medical Home|Nutrition|Oral Health|Prenatal Care|Preterm Labor|Smoking Cessation / Second-hand exposure|State/Local Resources	No	Documents/tracks topics client received information/education on (corresponds with educational topics reported on in ATL reporting documents)
Date of attendance at Session 2, Pregnancy Health:	Date of attendance at Session 2, Pregnancy Health:	Date	Date (mm/dd/yyyy)		No	Documents/tracks session attendance by client

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Session 2, Pregnancy Health Education Provided:	Education provided at this session (select all, or those that apply to your site)	Drop-down list (multiple choice)	Text	Alcohol/substance Abuse|Child Development|Family Violence|Father Involvement|Injury prevention/safety|Lifestyle risk factors / prenatal exposures|Nutrition|Parenting|Smoking Cessation / Second-hand exposure|State/Local Resources|Weight Management|Mental Health|Stress Management	No	Documents/tracks topics client received information/education on (corresponds with educational topics reported on in ATL reporting documents).
Date of attendance at Session 3, Labor and Delivery:	Date of attendance at Session 3, Labor and Delivery:	Date	Date (mm/dd/yyyy)		No	Documents/tracks session attendance by client
Session 3, Labor and Delivery Education Provided:	Education provided at this session (select all, or those that apply to your site)	Drop-down list (multiple choice)	Text	Father Involvement|Labor/Childbirth|Preterm Labor|State/Local Resources	No	Documents/tracks topics client received information/education on (corresponds with educational topics reported on in ATL reporting documents)
Date of attendance at Session 4, Infant Feeding:	Date of attendance at Session 4, Infant Feeding:	Date	Date (mm/dd/yyyy)		No	Documents/tracks session attendance by client

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Session 4, Infant Feeding Education Provided:	Education provided at this session (select all, or those that apply to your site)	Drop-down list (multiple choice)	Text	Breastfeeding|Father Involvement|Nutrition|State/Local Resources|Infant Care|Injury Prevention/Safety	No	Documents/tracks topics client received information/education on (corresponds with educational topics reported on in ATL reporting documents).
Date of attendance at Session 5, Infant Care:	Date of attendance at Session 5, Infant Care:	Date	Date (mm/dd/yyyy)		No	Documents/tracks session attendance by client
Session 5, Infant Care Education Provided:	Education provided at this session (select all, or those that apply to your site)	Drop-down list (multiple choice)	Text	Car seat safety/installation|Child Development|Father Involvement|Immunizations|Infant Care|Injury Prevention/Safety|Medical Home|Parenting|Safe Sleep|Smoking Cessation / Second-hand Exposure|State/Local Resources|Well Child/Adolescent	No	Documents/tracks topics client received information/education on (corresponds with educational topics reported on in ATL reporting documents)
Date of attendance at Session 6, Postpartum Care:	Date of attendance at Session 6, Postpartum Care:	Date	Date (mm/dd/yyyy)		No	Documents/tracks session attendance by client

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Session 6, Postpartum Care Education Provided:	Education provided at this session (select all, or those that apply to your site)	Drop-down list (multiple choice)	Text	Alcohol/substance Abuse|Father Involvement|Healthcare Coverage/Medicaid Eligibility|Immunizations|Lifestyle risk factors/prenatal exposures|Medical Home|Nutrition|Postpartum Care|Postpartum Depression|Preconception/Interconception|Reproductive Health / Family Planning|Smoking Cessation / Second-hand Exposure|State/Local Resources|Suicide Prevention|Teen Pregnancy Prevention|Weight Management|Well Woman/Man	No	Documents/tracks topics client received information/education on (corresponds with educational topics reported on in ATL reporting documents)
Completion Status:	Level at which the client completed the program	Drop-down list (single choice)	Text	Completed 4 or more sessions|Completed <4 sessions prior to delivery / EDD	No	Documents level at which the client completed the program; assists with client tracking and data collection
Completion Survey Completed: Complete only if 4 or more sessions	Date that client completed the Completion Survey (completed upon program completion, when 4 or more sessions were attended)	Date	Date (mm/dd/yyyy)		No	Tracks completion of required components of BaM program. Should be completed as a part of the graduation or program completion/exiting process. Assists with client tracking and data

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Baby Delivered:	Date that client delivered her baby	Date	Date (mm/dd/yyyy)		No	Documents date of birth of client's baby. Assists with client tracking and data collection
Delivery Outcome:	Outcome of pregnancy/delivery	Drop-down list (single choice)	Text	Live birth|Live birth but neonatal death (less than 28 days)|Stillbirth (equal to or greater than 20 weeks gestation)|Miscarriage (less than 20 weeks gestation	No	Documents outcome of pregnancy/deliver. Assists with client tracking and data collection
Birth Outcome Card Completed:	Date that client completed the Birth Outcome Card	Date	Date (mm/dd/yyyy)		No	Tracks completion of required components of BaM program. Should be completed following the birth of the client's baby, when 4 or more sessions were attended. Assists with client tracking and data collection
Postpartum visit provided?	Whether a postpartum visit was made to client	Drop-down list (single choice)	Text	Yes|No	No	Documents whether or not a postpartum visit was provided to the client following the birth of client's baby. This service is encouraged in partnership with Healthy Start Home Visiting programs, or other home visitation services available through partnerships at each site. Assists with client tracking and data collection

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Date of postpartum visit:	Date of postpartum visit to client	Date	Date (mm/dd/yyyy)		No	Documents the date a postpartum visit was provided to the client following the birth of client's baby. Assists with client tracking and data collection
Setting of Visit:	Setting of postpartum visit	Drop-down list (single choice)	Text	Home|Clinic|School|Hospital|Other Community Setting	No	Documents the setting where a postpartum visit was provided to the client following the birth of client's baby. Assists with client tracking and data collection
Incentive Selected: New location on form	Type of incentive selected by client after completing 4 or more sessions	Text	Text		No	Documents type of incentive selected by client; assists with client tracking
Incentive Delivered:	Date that client's incentive was delivered	Date	Date (mm/dd/yyyy)		No	Documents that client's earned incentive was delivered, upon completion of the BaM program. Assists with client tracking
Is mother breastfeeding?		Drop-down list (single choice)	Text	1,Yes|0,No	No	
Follow-up provided (select all that apply):	Branches from "Yes" to preceding question	Drop-down list (multiple choice)	Text	1,3 days pp|2,1 week pp|3,2 weeks pp|4,6 weeks pp|5,Other	No	
Date of 3 days postpartum visit:	Branches from corresponding selection	Date	Date (mm/dd/yyyy)		No	

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Date of 1 weeks postpartum visit:	Branches from corresponding selection	Date	Date (mm/dd/yyyy)		No	
Date of 2 weeks postpartum visit:	Branches from corresponding selection	Date	Date (mm/dd/yyyy)		No	
Date of 6 weeks postpartum visit:	Branches from corresponding selection	Date	Date (mm/dd/yyyy)		No	
Date of other postpartum visit:	Branches from corresponding selection	Date	Date (mm/dd/yyyy)		No	
Edinburgh Completed (Session 2):	Date that client completed the Edinburgh with session 2	Date	Date (mm/dd/yyyy)		No	Documents/tracks completion of Edinburgh with session 2, as outlined in the Mental Health Integration component of the program
Edinburgh Score (Session 2):	Client's score on Edinburgh completed with session 2	Text	Numeric		No	Assists with client tracking, data collection, and potential need for referral and follow-up based on score of Edinburgh
Edinburgh Completed (Session 6):	Date that client completed the Edinburgh with session 6	Date	Date (mm/dd/yyyy)		No	Documents/tracks completion of Edinburgh with session 6, as outlined in the Mental Health Integration component of the program

Becoming a Mom Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Edinburgh Score (Session 6):	Client's score on Edinburgh completed with session 6	Text	Numeric		No	Assists with client tracking, data collection, and potential need for referral and follow-up based on score of Edinburgh
Edinburgh Completed (Postpartum):	Date that client completed the Edinburgh postpartum	Date	Date (mm/dd/yyyy)		No	Documents/tracks completion of Edinburgh during a postpartum visit, as outlined in the Mental Health Integration component of the program
Edinburgh Score (Postpartum):	Client's score on Edinburgh completed postpartum	Text	Numeric		No	Assists with client tracking, data collection, and potential need for referral and follow-up based on score of Edinburgh

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Which child was involved?	Name of the baby referenced in this form	Drop-down list (single choice)	Dynamic Child	*Options will include all associated children*	No	Assists with client tracking and linking of mom and baby
Baby's Date of Birth		Date	Date (mm/dd/yyyy)			
Date of Activity	Date of services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Documents the date the birth outcome data was collected and form was completed, as a required component of program completion. Assists with client tracking and data collection.
~~Primary Instructor's Name:~~	~~Name of Becoming a Mom instructor~~	~~Text~~	~~Text~~		~~No~~	~~Documents name of instructor/s for evaluation purposes~~
~~Secondary Instructor (if applicable)~~	~~Name of Becoming a Mom instructor, if there is a secondary instructor~~	~~Text~~	~~Text~~		~~No~~	~~Documents name of instructor/s for evaluation purposes~~
What is the name of the hospital where you gave birth?	Name of the hospital where client gave birth	Text	Text		No	Documents name of birthing facility/hospital; for evaluation purposes

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
At what gestational age was your baby born?	Gestational Age of baby at birth	Drop-down list (single choice)	Text	Less than 32 weeks|32 to 36 weeks|37 to 38 weeks|39 weeks or after	Yes	Documents gestational age of baby at birth; for evaluation purposes (intended to be verified with birth/medical record)
What was your baby's weight at birth?	Baby's weight at birth	Drop-down list (single choice)	Text	Less than 3lbs 4oz (1500 grams)|More than 3lbs 4oz (1500 grams) but less than 5lbs 8oz (2500 grams)|5lbs 8oz or more	Yes	Documents weight of baby at birth; for evaluation purposes (intended to be verified with birth/medical record)
Were you induced (meaning your labor was started by your healthcare provider instead of starting on its own)?	Whether the client was induced	Drop-down list (single choice)	Text	Yes|No	No	Documents if delivery was induced; for evaluation purposes (intended to be verified with birth/medical record)
Why were you induced?	If client was induced, why	Drop-down list (single choice)	Text	Medically necessary (Doctor ordered / suggested)|Elective (at mother's request)|Other|Unknown	No	Documents reason for induction; for evaluation purposes (intended to be verified with birth/medical record)
Other reason:	If client was induced for 'other' reason, what that reason was	Narrative	Text		No	Documents "other" reason for induction; for evaluation purposes (intended to be verified with birth/medical record)

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
How was your baby delivered?	Whether baby was born vaginally or through cesarean	Drop-down list (single choice)	Text	Vaginally|Cesarean	No	Documents method of delivery; for evaluation purposes (intended to be verified with birth/medical record)
Why Cesarean Delivery?	If baby was born through cesarean, why	Drop-down list (single choice)	Text	Medically Necessary (Doctor ordered / suggested)|Elective (at mother's request)|Unknown	No	Documents reason for cesarean delivery; for evaluation purposes (intended to be verified with birth/medical record)
Did you develop any health condition(s) during your pregnancy or since the birth of your baby?	Whether client developed any health conditions during her pregnancy	Drop-down list (single choice)	Text	Yes|No	No	Documents any health condition that occurred during pregnancy; for evaluation purposes (intended to be verified with birth/medical record)

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Please indicate the ~~medical~~ health condition(s) you developed	If client developed health conditions during pregnancy, what those conditions were	Drop-down list (multiple choice)	Text	Anemia|Anxiety|Blood Clotting Disorder|Cholestasis (liver condition occuring late in pregnancy)|Depression|Eclampsia (high blood pressure that causes seizures)|Gestational Diabetes|Heart Disease / Cardiac Condition|High Blood Pressure|Lung Disease / Respiratory Condition|Lupus / Other Auto-Immune Disease|Placenta Previa|Placental Abruption|Pre-eclampsia|Pre-Term labor|Seizures (that are not caused by high blood pressure)|Substance Use Disorder or Relapse (inability to control the use of a legal or illegal drug or medication, alcohol, or nicotine)|Thyroid Disease|Other	No	Documents the type/s of health condition/s that occurred during pregnancy; for evaluation purposes (intended to be verified with birth/medical record)
Other ~~medical~~ health condition:	If client developed an 'other' health condition, what that condition was	Text	Text		No	Documents the "other" type/s of health condition/s that occurred during pregnancy; for evaluation purposes (intended to be verified with birth/medical record)

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Have you had/scheduled your first postpartum check-up?	Whether the client has had or has scheduled a postpartum check-up	Drop-down list (single choice)	Text	Yes|Not yet, but I plan to|No, I do not plan to schedule postpartum care	No	Documents whether the client has had or has scheduled a postpartum check-up; for evaluation purposes (intended to be verified by medical record)
Where are you going/planning to go for postpartum care?	If the client has had a postpartum check-up, type of facility where she is receiving care	Drop-down list (single choice)	Text	Private Health Care Provider|Public Health Clinic|Military Provider|Other|Not currently receiving postpartum care	No	Documents the type of facility where she is receiving care / plans to receive care postpartumly; for evaluation purposes and client tracking
Would you like to become pregnant within the next year?		Drop-down list (single choice)	Text	1,Yes|0,No|2,Unsure|3,Ok either way	No	
Have you talked to your doctor about options for preventing pregnancy?	Whether client has talked to a doctor about options for preventing pregnancy	Drop-down list (single choice)	Text	Yes|No	No	Documents whether client has talked to a doctor about options for preventing pregnancy; intended to trigger offering of information, resources, and/or referral related to prevention of pregnancy; for evaluation purposes
Are you using or do you plan to use any method to prevent pregnancy?	Whether client is currently using or plans to use a method to prevent pregnancy	Drop-down list (single choice)	Text	Yes|No	No	Documents whether client is using or plans to use a method to prevent pregnancy; intended to trigger offering of information, resources, and/or referral related to prevention of pregnancy; for evaluation purposes

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
What method(s) are you using / planning to use?	Contraceptive method(s) client is using or planning to use	Drop-down list (multiple choice)	Text	Diaphragm|IUD|Pill|Natural Family Planning|Condom|Shot|Arm Implant|Tubal Ligation/Vasectomy|Don't know|Nothing|Other	No	Documents contraceptive method client is using or planning to use; for evaluation purposes and data collection
If other, please specify other contraceptive method:	Branches from answer of "Other" to preceding question	Text	Text		No	
Are you taking prenatal vitamins or multi-vitamins containing folic acid?	Frequency client is taking multivitamins or prenatal vitamins	Drop-down list (single choice)	Text	Everyday|4-6 times per week|1-3 times per week|Not taking	No	Documents frequency client is taking multivitamins or prenatal vitamins; for evaluation purposes
I currently smoke __ cigarettes per day.	Frequency client is smoking cigarettes	Drop-down list (single choice)	Text	0|Less than 1/2 pack|1/2 to a full pack|More than a pack	No	Documents frequency client is smoking cigarettes; intended to trigger offering of resources and/or referral for smoking cessation support; for evaluation purposes

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Listed below are some things about quitting smoking that a doctor, nurse, or other health care worker might have done during any of your prenatal care visits (If you smoked during your pregnancy, please check all that were done for you)	Branches from any response other than "0" to preceding question	Multi Select	Text	1,Spending time with me discussing how to quit smoking|2,Suggest that I set a specific date to stop smoking|3,Suggest I attend a class or program to stop smoking|4,Provide me with booklets, videos, or other materials to help me quit smoking on my own|5,Refer me to counseling for help with quitting|6,Ask if a family member or friend would support my decision to quit|7,Refer me to a national or state quit line (like KanQuit)|8,Recommend using Nicotine gum|9,Recommend using a nicotine patch|10,Prescribe a nicotine nasal spray or nicotine inhaler|11,Prescribe a pill like Zyban (also known as Wellbutrin or bupropion) to help me quit|12,Prescribe a pill like Chantix (also known as varenicline) to help me quit		
Have you had/scheduled your baby's first check-up?	Whether the baby's first check-up has been scheduled	Drop-down list (single choice)	Text	Yes|No	No	Documents whether the baby's first check-up has been scheduled or completed; for evaluation purposes and client tracking

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
What has kept you from scheduling your baby's first check-up?	Branches from "no" to preceding question	Multi Select	Text	1,No doctor|2,No insurance or any way of paying for it|3,No transportation|4,No childcare for my other children|5,Other	No	
Please describe other reason:	Branches from 'Other' to preceding question	Text	Text		No	
What type of insurance do you have for your baby?	Baby's type of insurance	Drop-down list (single choice)	Text	Private insurance|Medicaid (or have applied for)|Tricare|Don't have insurance|Other	No	Documents baby's type of insurance; intended to trigger offering of resources and/or assistance, if baby has no insurance; for evaluation purposes and client tracking
At birth, did your baby have any medical conditions/concerns which required NICU admission?	Whether the baby had any medical conditions at birth requiring NICU admission	Drop-down list (single choice)	Text	Yes|No	No	Documents whether the baby had any medical conditions at birth requiring NICU admission; intended to trigger offering of resources and/or assistance, if baby has a medical condition that could benefit from such support; for evaluation purposes and client tracking (intended to be verified with birth/medical record)

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Please indicate the conditions/concerns:	Medical condition(s) the baby had at birth requiring NICU admission	Drop-down list (multiple choice)	Text	Feeding or weight gain concern|Heart Condition|Jaundice|Low birth weight|Low blood sugar|Prematurity|Respiratory condition|Seizures or other neurological condition|Other	No	Documents what medical condition the baby may have had at birth requiring NICU admission; intended to trigger offering of resources and/or assistance, if baby has a medical condition that could benefit from such support; for evaluation purposes and client tracking (intended to be verified with birth/medical record)
If other condition, please specify:	Medical condition(s) the baby had at birth requiring NICU admission not previously listed	Text	Text		No	Documents what "other" medical condition the baby may have had at birth requiring NICU admission; intended to trigger offering of resources and/or assistance, if baby has a medical condition that could benefit from such support; for evaluation purposes and client tracking (intended to be verified with birth/medical record)

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Are you currently breastfeeding your baby?	Whether the client is breastfeeding at the time of completing the Birth Outcome Card	Drop-down list (single choice)	Text	Yes|No	No	Documents whether the client is breastfeeding at the time of completing the Birth Outcome Card; for evaluation purposes; tracking of breastfeeding continuation rate
Did you breastfeed at all?	If the client is not breastfeeding at the time of completing the Birth Outcome Card, whether she nursed at all	Drop-down list (single choice)	Text	Yes|No	No	Documents whether the client ever initiated breastfeeding after the baby's birth; for evaluation purposes; tracking of breastfeeding initiation rate (intended to be verified with birth/medical/WIC record)

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
How long did you breastfeed?	If the client did nurse, how long?	Drop-down list (single choice)	Text	Only while in the hospital|Less than one week|One to six weeks|More than six weeks	No	Documents how long the client breastfed; for evaluation purposes; tracking of breastfeeding continuation rate (intended to be verified with birth/medical/WIC record)
Are you using:	If the client is currently breastfeeding, is she using only mother's milk or supplementing with formula	Drop-down list (single choice)	Text	Only mother's milk (breast or bottle)|Both mother's milk and formula	No	Documents if the client is currently breastfeeding, is she using only mother's milk or supplementing with formula; for evaluation purposes; tracking of breastfeeding exclusivicity rate (intended to be verified with birth/medical/WIC record)
Did any information that you learned in class change your mind about:	Intentions related to breastfeeding client changed her mind about after learning new information during class	Drop-down list (multiple choice)	Text	Whether to breastfeed|How long to breastfeed|Your confidence about breastfeeding|None of these	No	Documents intentions related to breastfeeding client changed her mind about after learning new information during class; for evaluation purposes

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I put my baby to sleep on his/her: (check all that apply)		Multi Select	Text	1,Back|2,Side|3,Stomach	No	
My baby is put down to sleep: (check all that apply)		Multi Select	Text	1,In a crib / bassinet or portable crib|2,In an adult bed or couch or recliner with me|3,In a car seat / carrier or bouncer or swing	No	
I ____ talk(ed) about Safe Sleep with my child's other care providers (family members, childcare providers, etc).		Single Select	Text	1,Have|2,Plan to|3,Do not plan to	No	

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
MCH Home Visiting (i.e. prenatal or postpartum visit in home or other location by Health Department or BaM program staff) or other Home Visitation Program Services:	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Childcare Services (e.g. Childcare Aware, Health Dept. Childcare licensing)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Medicaid/KanCare (i.e. application or eligibility specialist)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Substance Abuse Services	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Tobacco Cessation (i.e. KS Quitline, local resources, cessation program, other online resources)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Domestic Violence Prevention	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Mental Health Services (i.e. Postpartum Support International. The Pregnancy & Postpartum Resource Center of KS, your OB provider, local counseling agencies and/or services, etc.):	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Kansas Infant Death and SIDS Network (Safe Sleep information; Bereavement/Infant Loss Services, etc.):	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Women, Infants, and Children (WIC) Services:	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Breastfeeding Support Services (Help from local breastfeeding support staff, volunteers, or support groups, La Leche League, etc.)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Car Seat Installation	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Parenting / Early Childhood Services (ie. Parents as Teachers, Early Head Start, other local parenting services / Infant-Toddler developmental services, etc.)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Transportation (i.e. paid for through medicaid provider, bus or other local transportation services, etc.)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes

Becoming a Mom Birth Outcome Card

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Housing (e.g. homeless shelter, Section 8 Housing assistance)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Other Pregnancy Resources (i.e. Text-4-Baby, Count the Kicks, other local pregnancy services or childbirth classes, etc.):	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Other: (e.g. local food programs/resources other than WIC, Cloth diapering resources)	Whether client has contacted, plans to contact or does not plan to contact resources not previously listed	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
If other community resource, please specify:	Other resources client has contacted or plans to contact	Text	Text		No	Documents what "other" resource the client has contacted or plans to contact; for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date of enrollment / first session attendance in BaM program	Date	Date (mm/dd/yyyy)		Yes	Document date client first entered the BaM program and began receiving services through the program
Primary Instructor's Name:	Name of Becoming a Mom instructor	Text	Text		No	Documents name of instructor/s for evaluation purposes
Secondary Instructor (if applicable)	Name of Becoming a Mom instructor, if there is a secondary instructor	Text	Text		No	Documents name of instructor/s for evaluation purposes
Attended Becoming a Mom® group session: (check all that apply)	Mode of attendance	Drop-down list (multiple choice)	Text	1,In-person|2,Virtually (Skype, Zoom, FaceTime, etc.)	No	Documents mode of attendance for evaluation purposes
What best describes your reason for attending virtually: (check all that apply)	Reason for virtual attendance	Drop-down list (multiple choice)	Text	1,Prefer to attend virtually|2,Transportation issues|3,Child care issues|4,COVID-19|5,Other	No	Documents reason for attending virtually
If other, please describe:		Text	Text		No	

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
How did you ~~first hear~~ learn about Becoming a Mom / Comenzando bien? (check all that apply)	How client learned about BaM	Drop-down list (multiple choice)	Text	Family/Friend|Clinic|Hospital|School|WIC|KanCare Case Manager|Flier|Other	No	Document referral source / for evaluation purposes
Is this your first pregnancy?	Whether this is the client's first pregnancy	Drop-down list (single choice)	Text	Yes|No	No	Document if this is a first pregnancy / for evaluation purposes
Have you had a previous preterm birth? (gestational age of baby less than 37 weeks)	Whether the client has ever had a premature birth	Drop-down list (single choice)	Text	Yes|No	No	Document history of premature births, which serves as a risk factor for future premature births; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals
Was it a singleton pregnancy, meaning you were pregnant with only one baby?	Branches from answer of "Yes" to preceding question	Drop-down list (single choice)	Text	1,Yes|0,No	No	

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Was the premature birth spontaneous, meaning you went into labor on your own?	*BRANCHES FROM: If answer to Preceding Field is Yes*	Drop-down list (single choice)	Text	Yes|No	No	Document history of premature births, which serves as a risk factor for future premature births; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals
~~How many babies have you had weighing less than 5lbs 8oz?~~	~~If this is not client's first pregnancy, number of times she has given birth to a baby weighing less than 5lbs, 8oz~~	~~Text~~	~~Numeric~~		~~No~~	~~Document history of LBW baby, which serves as a risk factor for future LBW baby; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals~~
Have you ever had a baby that weighed less than 5 lbs. 8 oz.?	If this is not client's first pregnancy, has she given birth to a baby weighing less than 5lbs, 8oz	Drop-down list (single choice)	Text	1,Yes|0,No	No	Document history of LBW baby, which serves as a risk factor for future LBW baby; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals
~~How many miscarriages have you had?~~	~~If this is not client's first pregnancy, number of times she has had a miscarriage~~	~~Text~~	~~Numeric~~		~~No~~	~~Document history of miscarriages; intended to be used in an effort to provide additional services/resources/referrals~~

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Have you had more than one miscarriage?	If this is not client's first pregnancy, has she had more than one miscarriage	Drop-down list (single choice)	Text	1,Yes|0,No	No	Document history of more than one miscarriage; intended to be used in an effort to provide additional services/resources/referrals
Have you had a baby that was not born alive?	If this is not client's first pregnancy, whether she has had a baby not born alive	Drop-down list (single choice)	Text	Yes|No	No	Document history of stillbirth; intended to be used in an effort to provide additional services/resources/referrals
Have you had a baby who passed away during its first year of life?	If this is not client's first pregnancy, whether she has had a baby that died during the first year of his/her life	Drop-down list (single choice)	Text	Yes|No	No	Document history of infant death; intended to be used in an effort to provide additional services/resources/referrals
Do you have any other children living in the home?	Whether the client has any other biological children who live with her on at least a part time basis	Drop-down list (single choice)	Text	Yes|No	No	Required for BG forms and narrative, HSHV/CIF report
Indicate the number of client's and partner's biological children in the home age < 1	Number of *biological* children under one year old who live with client on at least a part time basis	Text	Numeric		No	Required for BG forms and narrative, HSHV/CIF report
Indicate the number of client and partner's biological children in the home age 1-11	Number of *biological* children between 1 and 11 years old who live with client on at least a part time basis	Text	Numeric		No	Required for BG forms and narrative, HSHV/CIF report

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Indicate the number of client and partner's biological children in the home age 12-22	Number of *biological* children between 12 and 22 years old who live with client on at least a part time basis	Text	Numeric		No	Required for BG forms and narrative, HSHV/CIF report
Number of children with Special Health Care Needs	Number of client's biological children who have diagnosed special health care needs	Text	Numeric		No	Required for BG forms and budget; intended to be used in an effort to provide additional services/resources/referrals
How pregnant are you now?	Client's current trimester	Drop-down list (single choice)	Text	1st Trimester (1-13 weeks)|2nd Trimester (14-27 weeks)|3rd Trimester (28+ weeks)	No	Document trimester in pregnancy that client engaged in the BaM program; for evaluation purposes
When is your due date?	Date that the client's baby is expected to be due	Date	Date (mm/dd/yyyy)		No	Document date client's baby is expected to be due. Assists with client tracking and data collection
Have you had your first prenatal appointment?	Whether client has had her first prenatal appointment	Drop-down list (single choice)	Text	Yes|No	Yes	Document whether or not client is receiving prenatal care; intended to be used in an effort to provide additional services/resources/referrals
Is your appointment scheduled?	*BRANCHES FROM: If answer to the preceeding qusetion is No*	Drop-down list (single choice)	Text	Yes|No	No	Document whether or not client has scheduled prenatal care; intended to be used in an effort to provide additional services/resources/referrals

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
What is the reason for no prenatal appointment?	*BRANCHES FROM: If answer to the preceeding qusetion is No*	Drop-down list (single choice)	Text	1,No provider available|5,Provider will not begin care until later (I am too early in my pregnancy)|6,Unable to take off work or school|7,No childcare available for other children|2,No health insurance coverage/no ability to pay|3,No transportation|4,Other	No	Document reason client has not scheduled a prenatal care appointment; intended to be used in an effort to provide additional services/resources/referrals
Describe 'other' reason	*BRANCHES FROM: If answer to the preceeding qusetion is Other*	Text	Text		No	Document reason client has not scheduled a prenatal care appointment; intended to be used in an effort to provide additional services/resources/referrals
What trimester did you begin seeing a health care provider for this pregnancy?	Trimester during which client first saw a healthcare provider	Drop-down list (single choice)	Text	1st Trimester 1-13 weeks|2nd Trimester 14-27 weeks|3rd Trimester 28+ weeks|Not seeing a health care provider	Yes	Document date of entry into prenatal care; for evaluation purposes related to access to care
What is the name of your healthcare provider/clinic?	Name of client's provider or clinic	Text	Text		No	Document client's provider, enabling contact of provider as needed, as well as for data tracking purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Did you have any of the following health conditions prior to pregnancy?	Client's health problems	Drop-down list (multiple choice)	Text	9,Anemia|12,Anxiety|6,Asthma|13,Blood Clotting Disorder|11,Depression|1,Diabetes|4,Heart Disease / Cardiac Condition|7,High Blood Pressure|14,Lung Disease / Respiratory Condition|5,Lupus/Other auto-immune disease|15,Obesity|2,Seizures|3,Sickle Cell Disease|17,Substance Use Disorder (inability to control the use of a legal or illegal drug or medication, alcohol, or nicotine)|16,Thyroid Disease|10,Other|0,None	No	Document health problems that can indicate a need for additional monitoring in pregnancy; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals; for evaluation purposes
Have you developed any health condition(s) so far in your pregnancy?		Drop-down list (single choice)	Text	1,Yes|0,No	No	

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Please indicate the ~~medical~~ health condition(s) you have developed:	Branches from answer of "1,Yes" to preceding question	Drop-down list (multiple choice)	Text	7,Anemia|13,Anxiety|15,Cholestasis (liver condition occuring late in pregnancy)|12,Depression|4,Eclampsia (high blood pressure that causes seizures)|1,Gestational Diabetes|10,High blood pressure|6,Placenta Previa|11,Pre-eclampsia|2,Pre-term labor|5,Seizures (that are not caused by high blood pressure)|14,Substance Use Disorder or Relapse (inability to control the use of a legal or illegal drug or medication, alcohol, or nicotine)|9,Other	No	Documents health problems that can indicate a need for additional monitoring in pregnancy; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals; for evaluation purposes
Other ~~medical~~ health condition:	Branches from answer of "9,Other" to preceding question	Text	Text		No	Document "other" health problems that can indicate a need for additional monitoring in pregnancy; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals; for evaluation purposes
Has your healthcare provider told you that you have a "high risk" pregnancy?	Whether client has been told by a medical professional that her current pregnancy is 'high risk'	Drop-down list (single choice)	Text	Yes|No	No	Document identified "high risk" pregnancy that can indicate a need for additional monitoring ; intended to be used in an effort to provide additional services/resources/referrals; for evaluation purposes
Please indicate the reason(s):	Reason(s) client has been told her current pregnancy is 'high risk'	Text	Text		No	Document the indicator of the high risk pregnancy

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Are you enrolled in the WIC program?	Whether client is enrolled in WIC	Drop-down list (single choice)	Text	Yes|No	No	Document WIC enrollment status; intended to be used in an effort to identify those not enrolled in WIC who may be eligible; warm referral or direct scheduling should follow; pre-program (intervention), for evaluation purposes
I attend scheduled prenatal care visits with my healthcare provider (Doctor or Nurse Midwife):	How often client is attending prenatal care visits with healthcare provider	Drop-down list (single choice)	Text	1x per month|More than 1x per month|Less than 1x per month|I have never had a prenatal care visit	No	Document level of utilization of prenatal care; intended to identify client not attending prenatal care visits regularly, in an effort to provide additional services/resources/referrals; pre-program (intervention), for evaluation purposes
The following sometimes prevents me from attending my prenatal appointments:	What barriers prevent client from attending prenatal care appointments	Drop-down list (multiple choice)	Text	Nothing|Child Care|Transportation|No documentation|No healthcare provider|Worried about payment|Work/School|Other	No	Document barriers to regular prenatal care, in an effort to provide additional services/resources/referrals; pre-program (intervention), for evaluation purposes
Specify other barrier to attending prenatal appointments:	What "other" barriers prevent client from attending prenatal care appointments	Text	Text		No	Document "other" barriers to regular prenatal care; intended to identify barriers, in an effort to provide additional services/resources/referrals; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I currently take prenatal or multi-vitamins containing folic acid:	How often client takes a prenatal or multi-vitamin containing folic acid	Drop-down list (single choice)	Text	Everyday|4-6 times per week|1-3 times per week|Never	No	Document frequency of prenatal or multi-vitamin consumption; intended to identify client not taking prenatal or multi-vitamin on a daily basis, in an effort to provide additional education and resources as needed; pre-program (intervention), for evaluation purposes
Which of the following are signs of preterm labor / labor?	What symptoms does client recognize as signs of preterm labor / labor	Drop-down list (multiple choice)	Text	Vaginal bleeding|Increased vaginal pressure or the feeling that your baby is pushing down|Low, dull backache|Belly cramps with or without diarrhea|Cramps that feel like your period|None of the above	No	Document client knowledge of signs of preterm labor / labor; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I should do the following if I'm experiencing preterm labor (labor before 37 weeks gestation):	What client knows she should do if experiencing preterm labor	Drop-down list (multiple choice)	Text	Call my healthcare provider|Stop what I'm doing and rest on my left side for one hour|Drink 2-3 glasses of water or juice|None of the above	No	Document client knowledge of what to do if experiencing preterm labor; pre-program (intervention), for evaluation purposes
~~The following postpartum symptoms are normal for a mother to experience after delivery:~~	~~What postpartum symptoms does client recognize as normal for a mother to experience after delivery~~	~~Drop-down list (multiple choice)~~	~~Text~~	~~After discharge from the hopital, bleeding through more than one pad in one hour|Fever|Differences in bladder control|Night sweats|Extreme Fatigue (can't get out of bed or care for self or baby)|Baby blues for a day or two|Nonstop crying|Panic for no reason|Needing to nap|Lack of interest in your baby~~	~~No~~	~~Document client knowledge of postpartum symptoms that are normal for a mother to experience after delivery; pre-program (intervention), for evaluation purposes~~

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I should **call my healthcare provider** if I am experiencing the following post-birth symptoms: (check all that apply)	What post-birth symptoms does client recognize as warranting a call to her provider	Drop-down list (multiple choice)	Text	1,Bleeding that is soaking through one pad per hour or more |2,Blood clots the size of a quarter or smaller|3,Blood clots the size of an egg or bigger|4,Incision that is tender to touch or with movement|5,Incision with spreading redness to the skin around the incision|6,Incision with foul smelling cloudy drainage|7,Incision with small amount of pink watery drainage|8,Red or swollen leg, that is painful or warm to touch|9,Night sweats without a fever|10,Temperature of 100.4 or higher|11,Headaches that are relieved with pain medicine|12,Headache that does not get better with medicine or bad headache with vision changes|13,Intense anger, worry, or unhappiness|14,Extreme mood swings|15,Difficulty caring for yourself or your baby|16,Feeling overwhelmed but able to care for yourself and your baby|17,Less or little interest in things you used to enjoy|18,Needing to take a nap|19,Having scary, upsetting thoughts that don't go away|20,Having trouble managing your emotions or feeling tearful|0,None of the above	No	Document client knowledge of post-birth symptoms that warrant calling her provider

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I should **call 911** if I am experiencing the following post-birth symptoms: (check all that apply)	What post-birth symptoms does client recognize as warranting calling 911	Drop-down list (multiple choice)	Text	1,Pain in chest|2,Obstructed breathing or shortness of breath|3,Seizures|4,Thoughts of hurting yourself or someone else|5,Feeling hopeless and total despair|6,Feeling detached from reality, unreal, or like you're in a dream|7,Feeling suspicious or afraid of people or events|8,Seeing, hearing, or feeling things that aren't there|9,Severe confusion|0,None of the above	No	Document client knowledge of post-birth symptoms that warrant calling 911
If I experience depression and/or anxiety during or after my pregnancy, I am _____ about available resources in my community.	How knowledgable is client about available resources in her community if she experiences depression and/or anxiety during or after her pregnancy	Drop-down list (single choice)	Text	Very knowledgeable|Knowledgeable|A little knowledgeable|Not knowledgeable	No	Document client knowledge of available community resources if experiencing depression and/or anxiety druing or after pregnancy; pre-program (intervention), for evaluation purposes
If I experience depression and/or anxiety during or after my pregnancy, I am _____ to talk with my healthcare provider and/or access available resources.	How likely is client to talk with her healthcare provider and/or access available resources, if she experiences depression and/or anxiety during or after her pregnancy	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Document how likely client is to talk with her healthcare provider and/or access available resources, if she experiences depression and/or anxiety during or after her pregnancy; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I have talked to my healthcare provider about medications that I'm taking (prescription and/or over the counter, herbal, etc.)	Whether client has talked to her healthcare provider about medications she is taking (prescription and/or over the counter, herbal, etc.)	Drop-down list (single choice)	Text	Yes|No|N/A- not taking any medications	No	Document whether client has talked to her healthcare provider about medications she is taking (prescription and/or over the counter, herbal, etc.); pre-program (intervention), for evaluation purposes
If I am considering taking medications (prescription and/or over the counter, herbal, etc.) I am _____ to talk to my healthcare provider before taking them.	How likely is client to talk with her healthcare provider before taking medications (prescription and/or over the counter, herbal, etc.)	Drop-down list (single choice)	Text	Very Likely|Likely|Somewhat Likely|Not Likely	No	Document how likely client is to talk with her healthcare provider before taking medications; pre-program (intervention), for evaluation purposes
I walk or do at least 30 minutes of moderate, low-impact physical activity ___ days per week.	How often client walks or does at least 30 minutes of moderate, low-impact physical activity per week	Drop-down list (single choice)	Text	0|1-3|4-6|7	No	Document frequency that client walks or does at least 30 minutes of moderate, low-impact physical activity per week; pre-program (intervention), for evaluation purposes
I currently smoke __ cigarettes per day.	How many cigarettes client smokes per day	Drop-down list (single choice)	Text	0|Less than 1/2 pack|1/2 to a full pack|More than a pack	No	Document how many cigarettes client smokes per day, pre-program (intervention); in an effort to provide additional services/resources/referrals; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I am _____ to develop a birth plan and talk to my healthcare provider about it.	How likely is client to develop a birth plan and talk with her healthcare provider about it	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Documents how likely is client to develop a birth plan and talk with her healthcare provider about it; pre-program (intervention), for evaluation purposes
A pregnancy is full-term when it reaches ___ weeks.	How many weeks gestation does the client recognize as a full-term pregnancy	Drop-down list (single choice)	Text	36|37|38|39 or more Due to ACOG's most recent definition, please change the choice options to read: 34-36|37-38|39-40	No	Documents how many weeks gestation the client recognizes as a full-term pregnancy; pre-program (intervention), for evaluation purposes
The following are benefits of a full term pregnancy:	What does the client recognize as benefits of a full term pregnancy	Drop-down list (multiple choice)	Text	Baby's brain growth and development|Baby's lung development and maturity|Less likely to be admitted to the Neonatal Intensive Care Unit (NICU)|Improved ability to breastfeed	No	Documents what the client recognizes as benefits of a full term pregnancy; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
The following is true about breastfeeding: (Select all that apply)	What does the client recognize to be true about breastfeeding	Drop-down list (multiple choice)	Text	My baby will be less likely to have diabetes later in life|I will lower my risk of some types of cancer|My breastfeeding experience should not be painful|The frequency of my breastfeeding within the first 48 hours after birth can have an effect on my ability to produce enough milk for my baby	No	Documents what the client recognizes to be true about breastfeeding; pre-program (intervention), for evaluation purposes
I am ____ to breastfeed my baby.	How likely is the client to breastfeed her baby	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not Likely|Uncertain	No	Documents how likely the client is to breastfeed her baby; pre-program (intervention), for evaluation purposes
If I have difficulty breastfeeding my baby or if I have questions about breastfeeding, I know about ____ available resource(s) in my community.	How knowledgable is client about available resources in her community if she experiences difficulty with breastfeeding her baby or has questions about breastfeeding	Drop-down list (single choice)	Text	One|More than one|I don't know about any	No	Document client knowledge of available community resources if experiencing difficulty with breastfeeding her baby or has questions about breastfeeding; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I feel ____ about my ability to breastfeed my baby.	How confident does the client feel about her ability to breastfeed her baby	Drop-down list (single choice)	Text	Very Confident|Confident|Somewhat Confident|Not Confident	No	Documents how confident the client feels about her ability to breastfeed her baby; pre-program (intervention), for evaluation purposes
After delivery, I plan to take prenatal vitamins or multi-vitamins containing folic acid:	How often does the client plan to take prenatal vitamins or multi-vitamins containing folic acid after delivery	Drop-down list (single choice)	Text	Everyday|4-6 times per week|1-3 times per week|Never	No	Documents how often the client plans to take prenatal vitamins or multi-vitamins containing folic acid after delivery; pre-program (intervention), for evaluation purposes
I will put my baby to sleep on his/her: (select all that apply)	What position does the client plan to put her baby to sleep on	Drop-down list (multiple choice)	Text	Back|Side|Stomach	No	Documents what position the client plans to put her baby to sleep on; pre-program (intervention), for evaluation purposes
At home, my baby will sleep: (select all that apply)	What sleep environment does the client plan for her baby to sleep in at home	Drop-down list (multiple choice)	Text	In a crib, bassinet, or portable crib|In an adult bed, couch, or recliner with me|In a car seat, carrier, bouncer, or swing	No	Documents what sleep environment the client plans for her baby to sleep in at home; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I am ___ to talk about Safe Sleep with my child's other care providers (family members, childcare providers, etc)? (changed from "will or have talked" to better align with wording and choice options of other questions and show a change in attitude about the subject pre - to - post assessment)	How likely the client is to talk to her child's other care providers (family members, childcare providers, etc) about Safe Sleep	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Documents how likely the client is to talk to her child's other care providers (family members, childcare providers, etc) about Safe Sleep; pre-program (intervention), for evaluation purposes
I am ____ to talk to my healthcare provider during my prenatal care about methods for preventing pregnancy after the birth of my baby:	How likely is the client to talk to her healthcare provider during her prenatal care about methods for preventing pregnancy after the birth of her baby	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Documents how likely the client is to talk to her healthcare provider during her prenatal care about methods for preventing pregnancy after the birth of her baby; pre-program (intervention), for evaluation purposes
What method(s) are you planning to use/talk to your healthcare provider about? (Select all that apply)	Which method does the client plan to use/talk to her healthcare provider about	Drop-down list (multiple choice)	Text	Diaphragm|IUD (Intra-Uterine Device)|Pill|Natural Family Planning|Condom|Shot|Arm Implant|Tubal Ligation/Vasectomy|Don't plan to talk to the doctor about this	No	Documents which method the client plans to use/talk to her healthcare provider about; pre-program (intervention), for evaluation purposes

Becoming a Mom Initial Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
I believe there is _____ to my health and the health of my next baby if I wait a minimum of 18 months before my next pregnancy.	How beneficial does the client think it is to her health and the health of her next baby if she waits a minimum of 18 months before her next pregnancy	Drop-down list (single choice)	Text	Great benefit|Some benefit|No benefit	No	Documents how beneficial the client thinks it is to her health and the health of her next baby if she waits a minimum of 18 months before her next pregnancy; pre-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date of enrollment / first session attendance in BaM program	Date	Date (mm/dd/yyyy)		Yes	Document date of Completion Survey completion
Primary Instructor's Name:	Name of Becoming a Mom instructor	Text	Text		No	Documents name of instructor/s for evaluation purposes
Secondary Instructor (if applicable)	Name of Becoming a Mom instructor, if there is a secondary instructor	Text	Text		No	Documents name of instructor/s for evaluation purposes
Attended Becoming a Mom® group session: (check all that apply)	Mode of attendance	Drop-down list (multiple choice)	Text	1,In-person|2,Virtually	No	Documents mode of attendance for evaluation purposes
What best describes your reason for attending virtually: (check all that apply)	Reason for virtual attendance	Drop-down list (multiple choice)	Text	1,Prefer to attend virtually|2,Transportation issues|3,Child care issues|4,COVID-19|5,Other	No	Documents reason for attending virtually
If "other", please describe:		Text	Text		No	
Have you developed any health condition(s) so far in your pregnancy?		Single Select	Text	1,Yes|0,No		

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Please indicate the ~~medical~~ health condition(s) you have developed:	Client's health problems	Drop-down list (multiple choice)	Text	5,Anemia|15,Anxiety|18,Cholestasis (liver condition occuring late in pregnancy)|14,Depression|11,Eclampsia (high blood pressure that causes seizures)|8,Gestational Diabetes|16,High blood pressure|13,Placenta Previa|17,Pre-eclampsia|9,Pre-term labor|12,Seizures (that are not caused by high blood pressure)|19,Substance Use Disorder or Relapse (inability to control the use of a legal or illegal drug or medication, alcohol, or nicotine)|6,Other	No	Document health problems that can indicate a need for additional monitoring in pregnancy; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals; for evaluation purposes
Other ~~medical~~ health condition:	Branches from answer of "6,Other" to preceding question	Text	Text		No	Document "other" health problems that can indicate a need for additional monitoring in pregnancy; intended to be used to identify those at risk, in an effort to provide additional services/resources/referrals; for evaluation purposes
Has your healthcare provider told you that you have a "high risk" pregnancy?	Whether client has been told by a medical professional that her current pregnancy is 'high risk'	Drop-down list (single choice)	Text	Yes|No	No	Document identified "high risk" pregnancy that can indicate a need for additional monitoring ; intended to be used in an effort to provide additional services/resources/referrals; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Please indicate the reason(s):	Reason(s) client has been told her current pregnancy is 'high risk'	Text	Text		No	Document the indicator of the high risk pregnancy
Are you enrolled in the WIC program?	Whether client is enrolled in WIC	Drop-down list (single choice)	Text	Yes|No	No	Document WIC enrollment status; intended to be used in an effort to identify those not enrolled in WIC who may be eligible; warm referral or direct scheduling should follow; post-program (intervention), for evaluation purposes
I attend scheduled prenatal care visits with my healthcare provider (Doctor or Nurse Midwife):	Average frequency client has attended prenatal visits during her entire pregnancy	Drop-down list (single choice)	Text	1x per month|More than 1x per month|Less than 1x per month|I have never had a prenatal care visit	No	Document level of utilization of prenatal care; intended to identify client not attending prenatal care visits regularly, in an effort to provide additional services/resources/referrals; post-program (intervention), for evaluation purposes
The following sometimes prevents me from attending my prenatal appointments:	Barriers to client attending prenatal appointments	Drop-down list (multiple choice)	Text	Nothing|Child Care|Transportation|No documentation|No healthcare provider|Worried about payment|Work/School|Other	No	Document barriers to regular prenatal care, in an effort to provide additional services/resources/referrals; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Specify other barriers to attending prenatal appointments:	What "other" barriers prevent client from attending prenatal care appointments	Text	Text		No	Document "other" barriers to regular prenatal care; intended to identify barriers, in an effort to provide additional services/resources/referrals; post-program (intervention), for evaluation purposes
I currently take prenatal or multi-vitamins containing folic acid:	How often client takes a prenatal or multi-vitamin containing folic acid	Drop-down list (single choice)	Text	Everyday|4-6 times per week|1-3 times per week|Never	No	Document frequency of prenatal or multi-vitamin consumption; intended to identify client not taking prenatal or multi-vitamin on a daily basis, in an effort to provide additional education and resources as needed; post-program (intervention), for evaluation purposes
Which of the following are signs of preterm labor / labor?	What symptoms does client recognize as signs of preterm labor / labor	Drop-down list (multiple choice)	Text	Vaginal bleeding|Increased vaginal pressure or the feeling that your baby is pushing down|Low, dull backache|Belly cramps with or without diarrhea|Cramps that feel like your period|None of the above	No	Document client knowledge of signs of preterm labor / labor; post-program (intervention), for evaluation purposes
I should do the following if I'm experiencing preterm labor (labor before 37 weeks gestation):	What client knows she should do if experiencing preterm labor	Drop-down list (multiple choice)	Text	Call my healthcare provider|Stop what I'm doing and rest on my left side for one hour|Drink 2-3 glasses of water or juice|None of the above	No	Document client knowledge of what to do if experiencing preterm labor; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
~~The following postpartum symptoms are normal for a mother to experience after delivery:~~	~~What postpartum symptoms does client recognize as normal for a mother to experience after delivery~~	~~Drop-down list (multiple choice)~~	~~Text~~	~~After discharge from the hopital, bleeding through more than one pad in one hour|Fever|Differences in bladder control|Night sweats|Extreme Fatigue (can't get out of bed or care for self or baby)|Baby blues for a day or two|Nonstop crying|Panic for no reason|Needing to nap|Lack of interest in your baby~~	~~No~~	~~Document client knowledge of postpartum symptoms that are normal for a mother to experience after delivery; post-program (intervention), for evaluation purposes~~

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
I should **call my healthcare provider** if I am experiencing the following post-birth symptoms: (check all that apply)	What post-birth symptoms does client recognize as warranting a call to her provider	Drop-down list (multiple choice)	Text	1,Bleeding that is soaking through one pad per hour or more |2,Blood clots the size of a quarter or smaller|3,Blood clots the size of an egg or bigger|4,Incision that is tender to touch or with movement|5,Incision with spreading redness to the skin around the incision|6,Incision with foul smelling cloudy drainage|7,Incision with small amount of pink watery drainage|8,Red or swollen leg, that is painful or warm to touch|9,Night sweats without a fever|10,Temperature of 100.4 or higher|11,Headaches that are relieved with pain medicine|12,Headache that does not get better with medicine or bad headache with vision changes|13,Intense anger, worry, or unhappiness|14,Extreme mood swings|15,Difficulty caring for yourself or your baby|16,Feeling overwhelmed but able to care for yourself and your baby|17,Less or little interest in things you used to enjoy|18,Needing to take a nap|19,Having scary, upsetting thoughts that don't go away|20,Having trouble managing your emotions or feeling tearful|0,None of the above	No	Document client knowledge of post-birth symptoms that warrant calling her provider

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
I should **call 911** if I am experiencing the following post-birth symptoms: (check all that apply)	What post-birth symptoms does client recognize as warranting calling 911	Drop-down list (multiple choice)	Text	1,Pain in chest|2,Obstructed breathing or shortness of breath|3,Seizures|4,Thoughts of hurting yourself or someone else|5,Feeling hopeless and total despair|6,Feeling detached from reality, unreal, or like you're in a dream|7,Feeling suspicious or afraid of people or events|8,Seeing, hearing, or feeling things that aren't there|9,Severe confusion|0,None of the above	No	Document client knowledge of post-birth symptoms that warrant calling 911
If I experience depression and/or anxiety during or after my pregnancy, I am _____ about available resources in my community.	How knowledgable is client about available resources in her community if she experiences depression and/or anxiety during or after her pregnancy	Drop-down list (single choice)	Text	Very knowledgeable|Knowledgeable|A little knowledgeable|Not knowledgeable	No	Document client knowledge of available community resources if experiencing depression and/or anxiety druing or after pregnancy; post-program (intervention), for evaluation purposes
If I experience depression and/or anxiety during or after my pregnancy, I am _____ to talk with my healthcare provider and/or access available resources.	How likely is client to talk with her healthcare provider and/or access available resources, if she experiences depression and/or anxiety during or after her pregnancy	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Document how likely client is to talk with her healthcare provider and/or access available resources, if she experiences depression and/or anxiety during or after her pregnancy; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
I have talked to my healthcare provider about medications that I'm taking (prescription and/or over the counter, herbal, etc.)	Whether client has talked to her healthcare provider about medications she is taking (prescription and/or over the counter, herbal, etc.)	Drop-down list (single choice)	Text	Yes|No|N/A- not taking any medications	No	Document whether client has talked to her healthcare provider about medications she is taking (prescription and/or over the counter, herbal, etc.); post-program (intervention), for evaluation purposes
If I am considering taking medications (prescription and/or over the counter, herbal, etc.) I am _____ to talk to my healthcare provider before taking them.	How likely is client to talk with her healthcare provider before taking medications (prescription and/or over the counter, herbal, etc.)	Drop-down list (single choice)	Text	Very Likely|Likely|Somewhat Likely|Not Likely	No	Document how likely client is to talk with her healthcare provider before taking medications; post-program (intervention), for evaluation purposes
I walk or do at least 30 minutes of moderate, low-impact physical activity ___ days per week.	How often client walks or does at least 30 minutes of moderate, low-impact physical activity per week	Drop-down list (single choice)	Text	0|1-3|4-6|7	No	Document frequency that client walks or does at least 30 minutes of moderate, low-impact physical activity per week; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
I currently smoke __ cigarettes per day.	How many cigarettes client smokes per day	Drop-down list (single choice)	Text	0|Less than 1/2 pack|1/2 to a full pack|More than a pack	No	Document how many cigarettes client smokes per day, pre-program (intervention); in an effort to provide additional services/resources/referrals; post-program (intervention), for evaluation purposes
I am _____ to develop a birth plan and talk to my healthcare provider about it.	How likely is client to develop a birth plan and talk with her healthcare provider about it	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Documents how likely is client to develop a birth plan and talk with her healthcare provider about it; post-program (intervention), for evaluation purposes
A pregnancy is full-term when it reaches ___ weeks.	How many weeks gestation does the client recognize as a full-term pregnancy	Drop-down list (single choice)	Text	36|37|38|39 or more Due to ACOG's most recent definition, please change the choice options to read: 34-36|37-38|39-40	No	Documents how many weeks gestation the client recognizes as a full-term pregnancy; post-program (intervention), for evaluation purposes
The following are benefits of a full term pregnancy:	What does the client recognize as benefits of a full term pregnancy	Drop-down list (multiple choice)	Text	Baby's brain growth and development|Baby's lung development and maturity|Less likely to be admitted to the Neonatal Intensive Care Unit (NICU)|Improved ability to breastfeed	No	Documents what the client recognizes as benefits of a full term pregnancy; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
The following is true about breastfeeding: (Select all that apply)	What does the client recognize to be true about breastfeeding	Drop-down list (multiple choice)	Text	My baby will be less likely to have diabetes later in life|I will lower my risk of some types of cancer|My breastfeeding experience should not be painful|The frequency of my breastfeeding within the first 48 hours after birth can have an effect on my ability to produce enough milk for my baby	No	Documents what the client recognizes to be true about breastfeeding; post-program (intervention), for evaluation purposes
I am ____ to breastfeed my baby.	How likely is the client to breastfeed her baby	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not Likely|Uncertain	No	Documents how likely the client is to breastfeed her baby; post-program (intervention), for evaluation purposes
If I have difficulty breastfeeding my baby or if I have questions about breastfeeding, I know about ____ available resource(s) in my community.	How knowledgable is client about available resources in her community if she experiences difficulty with breastfeeding her baby or has questions about breastfeeding	Drop-down list (single choice)	Text	One|More than one|I don't know about any	No	Document client knowledge of available community resources if experiencing difficulty with breastfeeding her baby or has questions about breastfeeding; post-program (intervention), for evaluation purposes
I feel ____ about my ability to breastfeed my baby.	How confident does the client feel about her ability to breastfeed her baby	Drop-down list (single choice)	Text	Very Confident|Confident|Somewhat Confident|Not Confident	No	Documents how confident the client feels about her ability to breastfeed her baby; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
After delivery, I plan to take prenatal vitamins or multi-vitamins containing folic acid:	How often does the client plan to take prenatal vitamins or multi-vitamins containing folic acid after delivery	Drop-down list (single choice)	Text	Everyday|4-6 times per week|1-3 times per week|Never	No	Documents how often the client plans to take prenatal vitamins or multi-vitamins containing folic acid after delivery; post-program (intervention), for evaluation purposes
I will put my baby to sleep on his/her: (select all that apply)	What position does the client plan to put her baby to sleep on	Drop-down list (multiple choice)	Text	Back|Side|Stomach	No	Documents what position the client plans to put her baby to sleep on; post-program (intervention), for evaluation purposes
At home, my baby will sleep: (select all that apply)	What sleep environment does the client plan for her baby to sleep in at home	Drop-down list (multiple choice)	Text	In a crib, bassinet, or portable crib|In an adult bed, couch, or recliner with me|In a car seat, carrier, bouncer, or swing	No	Documents what sleep environment the client plans for her baby to sleep in at home; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
I am ___ to talk about Safe Sleep with my child's other care providers (family members, childcare providers, etc)? (changed from "will or have talked" to better align with wording and choice options of other questions and show a change in attitude about the subject pre - to - post assessment)	How likely the client is to talk to her child's other care providers (family members, childcare providers, etc) about Safe Sleep	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Documents how likely the client is to talk to her child's other care providers (family members, childcare providers, etc) about Safe Sleep; pre-program (intervention), for evaluation purposes
I am ____ to talk to my healthcare provider during my prenatal care about methods for preventing pregnancy after the birth of my baby:	How likely is the client to talk to her healthcare provider during her prenatal care about methods for preventing pregnancy after the birth of her baby	Drop-down list (single choice)	Text	Very likely|Likely|Somewhat likely|Not likely	No	Documents how likely the client is to talk to her healthcare provider during her prenatal care about methods for preventing pregnancy after the birth of her baby; post-program (intervention), for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
What method are you planning to use/talk to your healthcare provider about? (Select all that apply)	Which method does the client plan to use/talk to her healthcare provider about	Drop-down list (multiple choice)	Text	Diaphragm|IUD (Intra-Uterine Device)|Pill|Natural Family Planning|Condom|Shot|Arm Implant|Tubal Ligation/Vasectomy|Don't plan to talk to the doctor about this	No	Documents which method the client plans to use/talk to her healthcare provider about; post-program (intervention), for evaluation purposes
I believe there is _____ to my health and the health of my next baby if I wait a minimum of 18 months before my next pregnancy.	How beneficial does the client think it is to her health and the health of her next baby if she waits a minimum of 18 months before her next pregnancy	Drop-down list (single choice)	Text	Great benefit|Some benefit|No benefit	No	Documents how beneficial the client thinks it is to her health and the health of her next baby if she waits a minimum of 18 months before her next pregnancy; post-program (intervention), for evaluation purposes
MCH Home Visiting (i.e. prenatal or postpartum visit in home or other location by Health Department or BaM program staff) or other Home Visitation Program Services:	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Childcare Services (e.g. Childcare Aware, Health Dept. Childcare licensing)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Medicaid/KanCare (i.e. application or eligibility specialist)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Substance Abuse Services	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Tobacco Cessation (i.e. KS Quitline, local resources, cessation program, other online resources)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Domestic Violence Prevention	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Mental Health Services (i.e. Postpartum Support International. The Pregnancy & Postpartum Resource Center of KS, your OB provider, local counseling agencies and/or services, etc.):	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Kansas Infant Death and SIDS Network (Safe Sleep information; Bereavement/Infant Loss Services, etc.):	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Women, Infants, and Children (WIC) Services:	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Breastfeeding Support Services (Help from local breastfeeding support staff, volunteers, or support groups, La Leche League, etc.)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Car Seat Installation	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Parenting / Early Childhood Services (ie. Parents as Teachers, Early Head Start, other local parenting services / Infant-Toddler developmental services, etc.)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Transportation (i.e. paid for through medicaid provider, bus or other local transportation services, etc.)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Housing (e.g. homeless shelter, Section 8 Housing assistance)	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Other Pregnancy Resources (i.e. Text-4-Baby, Count the Kicks, other local pregnancy services or childbirth classes, etc.):	Whether client has contacted, plans to contact or does not plan to contact this type of resource	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents whether client has contacted, plans to contact or does not plan to contact this type of resource; for evaluation purposes
Other (i.e. local food program, cloth diapering resources, etc.)	Other resources client has contacted or plans to contact	Drop-down list (single choice)	Text	Have Contacted|Plan to Contact|Do Not Plan to Contact	No	Documents what "other" resource the client has contacted or plans to contact; for evaluation purposes
If other community resource, please specify:		Text	Text		No	Documents what "Other" Services the client has, or plans to contact; post-program (intervention), for evaluation purposes
How was your overall experience with the Becoming a Mom / Comenzando bien program?	How does the client rate her overall experience with the Becoming a Mom / Comenzando bien program	Drop-down list (single choice)	Text	Excellent|Good|Fair|Poor	No	Documents how the client rates her overall experience with the Becoming a Mom / Comenzando bien program; for evaluation purposes
I felt a connection to and supported by other pregnant women in the classes.	How connected to and supported does the client feel by other pregnant women in the classes.	Drop-down list (single choice)	Text	Strongly Agree|Agree|Neutral|Disagree|Strongly Disagree	No	Documents how connected to and supported does the client feel by other pregnant women in the classes; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
I felt a connection to and supported by my class teacher/instructor or group leader.	How connected to and supported does the client feel by the class teacher/instructor	Drop-down list (single choice)	Text	Strongly Agree|Agree|Neutral|Disagree|Strongly Disagree	No	Documents how connected to and supported does the client feel by the class teacher /instructor; for evaluation purposes
How hard was the information in the Becoming a Mom / Comenzando bien sessions to understand?	How hard does the client feel the information in the Becoming a Mom / Comenzando bien sessions was to understand	Drop-down list (single choice)	Text	Very Hard|Hard|Just Right|Easy|Very Easy	No	Documents how hard does the client feel the information in the Becoming a Mom / Comenzando bien sessions was to understand; for evaluation purposes
How much new information did you learn from the Becoming a Mom / Comenzando bien program?	How much new information does the client feel she learned from the Becoming a Mom / Comenzando bien program	Drop-down list (single choice)	Text	None|Some|A lot	No	Documents how much new information does the client feel she learned from the Becoming a Mom / Comenzando bien program; for evaluation purposes
The Becoming a Mom / Comenzando bien teacher/instructor: (Select all that apply)	How would the client best describe the Becoming a Mom / Comenzando bien teacher/ instructor	Drop-down list (multiple choice)	Text	Was lively|Was boring|Did not know the topics well|Helped me with my problems|Treated me with respect|Encouraged me to ask questions|Was hard to follow|Knew the topics well	No	Documents how would the client best describe the Becoming a Mom / Comenzando bien teacher/ instructor; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
How helpful/valuable was Session 1, the Prenatal Care session (Common discomforts, prenatal care, conditions/complications, preterm labor, etc)?	How helpful/valuable does the client feel Session 1, the Prenatal Care session (Common discomforts, prenatal care, conditions/complications, etc) was	Drop-down list (single choice)	Text	Not helpful/valuable|A little helpful/valuable|Somewhat helpful/valuable|Very helpful/valuable|Extremely helpful/valuable|Did not attend	No	Documents how helpful/valuable the client feels Session 1, the Prenatal Care session (Common discomforts, prenatal care, conditions/complications, preterm labor, etc) was; for evaluation purposes
How helpful/valuable was Session 2, the Pregnancy Health session (medications, avoiding alcohol, smoking, weight gain, healthy diet and exercise, effects of: stress, certain foods, infections, environmental exposures, etc)?	How helpful/valuable does the client feel Session 2, the Pregnancy Health session (medications, avoiding alcohol, smoking, weight gain, healthy diet and exercise, effects of: stress, certain foods, infections, environmental exposures, etc) was	Drop-down list (single choice)	Text	Not helpful/valuable|A little helpful/valuable|Somewhat helpful/valuable|Very helpful/valuable|Extremely helpful/valuable|Did not attend	No	Documents how helpful/valuable the client feels Session 2, the Pregnancy Health session (medications, avoiding alcohol, smoking, weight gain, healthy diet and exercise, effects of: stress, certain foods, infections, environmental exposures, etc) was; for evaluation purposes
How helpful/valuable was Session 3, the Labor and Delivery session (preterm labor, labor and birth, coping mechanisms, birth plan, etc)?	How helpful/valuable does the client feel Session 3, the Labor and Delivery session (preterm labor, labor and birth, coping mechanisms, birth plan, etc) was	Drop-down list (single choice)	Text	Not helpful/valuable|A little helpful/valuable|Somewhat helpful/valuable|Very helpful/valuable|Extremely helpful/valuable|Did not attend	No	Documents how helpful/valuable the client feels Session 3, the Labor and Delivery session (preterm labor, labor and birth, coping mechanisms, birth plan, etc) was; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
How helpful/valuable was Session 4, the Infant Feeding session (breastfeeding, bottle feeding, hunger cues, etc)?	How helpful/valuable does the client feel Session 4, the Infant Feeding session (breastfeeding, bottle feeding, hunger cues, etc) was	Drop-down list (single choice)	Text	Not helpful/valuable|A little helpful/valuable|Somewhat helpful/valuable|Very helpful/valuable|Extremely helpful/valuable|Did not attend	No	Documents how helpful/valuable the client feels Session 4, the Infant Feeding session (breastfeeding, bottle feeding, hunger cues, etc) was; for evaluation purposes
How helpful/valuable was Session 5, the Infant Care session (Period of Purple Crying, infant calming techniques, safe swaddling, SIDS risk reduction / safe sleep, infant car seat installation and other infant safety topics)?	How helpful/valuable does the client feel Session 5, the Infant Care session (Period of Purple Crying, infant calming techniques, safe swaddling, SIDS risk reduction / safe sleep, infant car seat installation and other infant safety topics) was	Drop-down list (single choice)	Text	Not helpful/valuable|A little helpful/valuable|Somewhat helpful/valuable|Very helpful/valuable|Extremely helpful/valuable|Did not attend	No	Documents how helpful/valuable the client feels Session 5, the Infant Care session (Period of Purple Crying, infant calming techniques, safe swaddling, SIDS risk reduction / safe sleep, infant car seat installation and other infant safety topics) was; for evaluation purposes
How helpful/valuable was Session 6, the Postpartum Care session (physical changes, emotional changes, keeping healthy after baby|birth spacing, family planning options, etc)?	How helpful/valuable does the client feel Session 6, the Postpartum Care session (physical changes, emotional changes, keeping healthy after baby|birth spacing, family planning options, etc) was	Drop-down list (single choice)	Text	Not helpful/valuable|A little helpful/valuable|Somewhat helpful/valuable|Very helpful/valuable|Extremely helpful/valuable|Did not attend	No	Documents how helpful/valuable the client feels Session 6, the Postpartum Care session (physical changes, emotional changes, keeping healthy after baby|birth spacing, family planning options, etc) was; for evaluation purposes

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Please provide any additional feedback you may have regarding the Becoming a Mom / Comenzando bien program:	What additional feedback would the client like to provide regarding the Becoming a Mom / Comenzando bien program	Narrative	Text		No	Documents what additional feedback the client would like to provide regarding the Becoming a Mom / Comenzando bien program; for evaluation purposes
If you attended any sessions virtually, please complete the following evaluation questions:		Explanation	Text			
What type of electronic device did you use for participating in Becoming a Mom/Comenzando bien® sessions?	What kind of device did the client use to participate virtually	(Multi-select)	Text	1,Cellular phone|2,Tablet|3,Laptop|4,Home computer|5,Computer at a public location (i.e. library)		Documents the type of device used to participate virtually
What type of internet service did you use for connecting virtually to Becoming a Mom/Comenzando bien® sessions?	What kind of internet service did the client use to participate virtually	(Multi-select)	Text	1,Cellular internet/data|2,Hot spot|3,Home Wi-Fi|4,Public Wi-Fi		Documents the type of internet service used to participate virtually

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
What difficulties did you experience with virtual participation? (check all that apply)	What difficulties the client experienced particpating virtually	(Multi-select)	Text	1,Wi-Fi connectivity issues (interruptions in internet connection)|2,No home Wi-Fi, had to use a friend or family members' or public Wi-Fi|3,Disruptions in my home environment interfering with my ability to concentrate|4,I did not feel as connected to the instructor due to my virtual participation|5,I did not feel as connected to other participants due to my virtual participation|6,I did not experience any difficulties related to virtual participation|7,Other difficulties		Documents difficulties the client experienced particpating virtually
If "other difficulties", please describe:		Text	Text			
How satisfied are you with your experience participating in the Becoming a Mom/Comenzando bien® sessions virtually?	Satisfaction level with virtual participation	Single select	Text	1,Not Satisfied|2,A little satisfied|3,Somewhat satisfied|4,Very satisfied|5,Extremely satisfied		Documents satisfaction level with virtual participation
I would like the opportunity to participate in Becoming a Mom/Comenzando bien® and/or other helpful services virtually in the future.	Desire to participate in services virtually in the future		Text	1,Strongly disagree|2,Disagree|3,Neither agree nor disagree|4,Agree|5,Strongly agree		Documents desire to participate in services virtually in the future

Becoming a Mom Completion Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Please provide any additional feedback you may have regarding your virtual participation in Becoming a Mom/Comenzando bien®, including what, if anything, could have made the experience better:	Additional feedback client would like to provide regarding participating in the Becoming a Mom / Comenzando bien program virtually	Text	Text			Documents additional feedback client would like to provide regarding participating in the Becoming a Mom / Comenzando bien program virtually

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Visit for Caregiver/Adult or Child?	Whether the visit was for the caregiver/adult or a child	Drop-down list (single choice)	Text	Caregiver/Adult|Child	Yes	Associate the form to an adult or child in the family
Which caregiver was involved?	*BRANCHES FROM: "Visit for Caregiver/Adult or Child?"* Name of the adult client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	No	Link activity form to client
Which child was involved?	The name if the child at the visit (if applicable)	Drop-down list (single choice)	Dynamic Child	*Options will include all associated children*	No	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Population Served	Population category of client	Drop-down list (single choice)	Text	Prenatal/Pregnant Woman|Post-Partum Woman|Woman (18-44 years)|Infant (< 1year)|Child (1-11 years)|Adolescent (12-22 years)	Yes	MCHBG form and budget
Were both parents present for the visit?	Whether both parents were present at the infant, child, prenatal/pregnant woman or post-partum woman visit.	Drop-down list (single choice)	Text	Yes|No|N/A - Services for Woman or Adolescent	Yes	HSHV/CIF report

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Setting of Visit:	Type of location where the visit took place	Drop-down list (single choice)	Text	Home|Clinic|School|Hospital|Other Community Setting|Virtual	Yes	HSHV/CIF report
Is this a MCH Home Visiting Service?	Whether this visit is a Healthy Start visit	Drop-down list (single choice)	Text	Yes|No	Yes	HSHV/CIF report
Is this client a participant in the KS OD2A Pilot Project?	*BRANCHES FROM: Preceding field*	Drop-down list (single choice)	Text	1,Yes|0,No	No	KS OD2A Pilot Project with BHP
Provider (Staff or Medical):	Type of provider conducting the visit	Drop-down list (single choice)	Text	1,Physician|2,Physician Assistant|3,Registered Nurse|4,APRN/CNM|10,LPN|5,Licensed Social Worker|6,Para-professional (MCH Home Visitor)|7,Registered/Licensed Dietitian|8,Dentist/Hygienist|9,Other	Yes	HSHV/CIF report
Specify:	*BRANCHES FROM: Preceding field* Other provider conducting the visit	Text	Text		No	Tied to question above

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Indicate the number of client's and partner's children in the home age < 1	Number of client's and partner's children under the age of 1 year living in the home	Text	Numeric		Yes	HSHV/CIF report
Indicate the number of client's and partner's children in the home age 1-11	Number of client's and partner's children at least 1 year old and younger than 12 years old living in the home	Text	Numeric		Yes	HSHV/CIF report
Indicate the number of client's and partner's children in the home age 12-22	Number of client's and partner's children at least 12 years old and younger than 23 years old living in the home	Text	Numeric		Yes	HSHV/CIF report
Are you pregnant?	Whether the client is pregnant	Drop-down list (single choice)	Text	Yes|No|N/A-Services for infant, child, or male	Yes	Required to link following questions

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Initiated Prenatal Care (PNC):	*BRANCHES FROM: "Are you pregnant?"* The trimester that the pregnant client initiated prenatal care	Drop-down list (single choice)	Text	1st Trimester|2nd Trimester|3rd Trimester|No PNC initiated	No	Tied to question above
Name of Provider	*BRANCHES FROM: "Are you pregnant?"* Name of the client's prenatal care provider	Text	Text		No	Tied to question above
Have you given birth in the last year or is this visit for an infant?	Whether the client has given birth in the last 12 months or the visit is for an infant	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG measure, HSHV/CIF report
Was it a preterm birth?	*BRANCHES FROM: Preceding Field*	Drop-down list (single choice)	Text	1,Yes|0,No	No	Tied to question above; MCHBG measure
Breastfeeding ?	*BRANCHES FROM: Preceding Field* Whether the client who gave birth within the last 12 months is currently breastfeeding	Drop-down list (single choice)	Text	Yes Currently Breastfeeding|No	No	Tied to question above; MCHBG measure

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Infant's date of birth	*BRANCHES FROM: If answer to Breastfeeding Field is Yes* Date infant was born	Date	Date (mm/dd/yyyy)		No	Tied to Breastfeeding question; MCHBG measure
Did you initiate breastfeeding at birth?	*BRANCHES FROM: If answer to Preceding Field is No* Whether the client who gave birth within the last 12 months but is not currently breastfeeding initiated breastfeeding at the baby's birth	Drop-down list (single choice)	Text	Yes|No	No	Tied to Breastfeeding question; MCHBG measure, HSHV/CIF report
How long did you exclusively breastfeed?	*BRANCHES FROM: Preceding Field* How long (specify weeks/months) the client who gave birth within the last 12 months but is not currently breastfeeding, exclusively breastfed her baby	Drop-down list (single choice)	Alphanumeric	Less than 1 month|1 month|2 months|3 months|4 months|5 months|6 months|7 months|8 months|9 months|10 months|11 months|12 months+	No	Tied to question above; MCHBG measure, HSHV/CIF report

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Would you (and/or your partner) like to become pregnant in the next year?	Whether the client wants to become pregnant in the next 12 months	Drop-down list (single choice)	Text	Yes|No|Client is unsure| Client is ok either way|N/A - Services for infant or child	Yes	MCHBG Reproductive Life Planning & Coordination with FP
Do you smoke?	Whether the client currently smokes cigarettes, cigars, cigarillos, etc.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG measure, HSHV/CIF report
Does anyone else in the household smoke?	Whether anyone living in the same home as the client smokes cigarettes, cigars, cigarillos, etc.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG measure, HSHV/CIF report
Do you use other nicotine products?	Whether the client currently uses other nicotine products.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG measure, HSHV/CIF report
Do you drink alcohol or use other substances?	Whether the client consumes alcohol or uses other substances	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG narrative, screening
Has the parent completed a child development screening tool for a child ages 9 months through 35 months, within the past year?	Whether the parent/caregiver completed a child development screening tool within the past 12 months.	Drop-down list (single choice)	Text	Yes|No|Client is unsure|N/A -Services for child over 4 years, adolescent, or adult	Yes	MCHBG measure

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Program Services (Select all that apply):	Program services provided during the visit	Drop-down list (multiple choice)	Text	Ages & Stages Questionnaire (ASQ)|Adverse Childhood Experiences (ACE)|Allergy Shot|BP/WT/Hgb|Blood/Lab Work|Breastfeeding Assessment|Breastfeeding Assistance/Counseling|Car Seat Installation/Check|Chlamydia Test|Contraception|Dental|Developmental Screening|Education|Fetal Heart Tones (FHT)|Glucose Tolerance Test|Gonorrhea Test|Hearing Screening|High-risk Case Management|HIV Test|Immunization|Injury Prevention|Kan Be Healthy|Lead Screening|Maternal Depression Counseling|~~Maternal Depression Screening~~|MCH Breast Exam|MCH Home Visit Education|MCH Pap Smear|Other Nursing Assessment|Other Service/Screening|Perinatal Mood and Anxiety Disorders|PHQ-9|Pregnancy Test|Prenatal/Post-Partum Nursing Assessment|Sick Visit|Smoking Cessation 5As/2As & R|Smoking Cessation Baby & Me Tobacco Free|Smoking Cessation Counseling|Smoking Cessation SCRIPT|Smoking Cessation Other|Sports Physical|STD/STI Treatment|Syphilis Test|Vision Screening|Well Adolescent Visit|Well Child Visit|Well Infant Visit|Well Woman Care/Annual Visit	Yes	MCHBG report, measures; HSHV/CIF report

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Specify other service/screening	Service or screening provided if Other selected in previous question	Text	Text		No	MCHBG report, measures; HSHV/CIF report

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Education Provided (Select all that apply. Complete only if education was provided.):		Check box (multiple choice)	Text	Alcohol/Substance Abuse|~~Behavioral Health (Other than Post-partum depression)~~ Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)|Breastfeeding|Bullying|Child development/Developmental Screening|Car seat safety/installation|Count the Kicks|Family Violence|Father Involvement|Health Care Coverage / Medicaid Eligibility|Immunizations|Infant Care|Injury prevention/safety|Labor/Childbirth|Lead Prevention|Lifestyle risk factors/prenatal exposures|Maternal Warning Signs|Medical Home|Nutrition|Oral Health|Parenting|Perinatal Mood and Anxiety Disorders|Postpartum care|~~Postpartum depression~~|Preconception/Interconception|Pre natal Care|Preterm Labor|Reproductive Health/Family Planning|Safe Sleep|Smoking Cessation/Second-hand exposure|State/local resources|Suicide Prevention|Teen Pregnancy Prevention|Transition|Weight Management|Well Adolescent|Well Child|Well Woman|WIC|Other	No	MCHBG report, measures; HSHV/CIF report

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Specify other education provided	For responses of "Other" in "Education Provided"	Text	Text		No	
Was a health risk screening tool administered? Check all that apply		Drop-down list (multiple choice)	Text	1,EPDS|2,PHQ-9|3,PHQ-A|4,GAD-7|5,ASSIST|6,CRAFFT|7,AUDIT|8,DAST|9,Other|0,N/A - No screening tool administered	No	
Specify other screening tool administered:	Branches from answer of "Other" to "Was a health risk screening tool administered?"	Drop-down list (single choice)	Text		No	
Are any referrals needed?	Whether the client needs to be referred for any services	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG report, measures; HSHV/CIF report

Maternal Child Health Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Comments		Narrative Text	Text		No	

MCHBG	MCH Block Grant (Title V Annual Application and Report required for annual funding) (Federal)
HSHV/CIF Report	Healthy Start Home Visitor/Children's Initiative Fund - HSHV is funded in part by the Kansas Children's Cabinet & Trust Fund which requires reporting on elements included on the MCH form.
FP	Family Planning (Title X Annual Application and Report required for annual funding) (Federal)

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Expected Delivery Date		Date	Date (mm/dd/yyyy)		No	
New Enrollee?	Indicates whether this is the client's first contact with the PMI program	Drop-down list (single choice)	Text	Yes|No	Yes	State reporting
Type of Visit:	Whether this visit is prenatal or postnatal	Drop-down list (single choice)	Text	Prenatal|Postnatal	Yes	State reporting
Initiated Prenatal Care (PNC)	*BRANCHES FROM: "Type of Visit"* When the prenatal client had their first prenatal care visit	Drop-down list (single choice)	Text	1st Trimester|2nd Trimester|3rd Trimester|No PNC initiated	No	State reporting
Complied with recommended PNC appointments after initiating care?	*BRANCHES FROM: "Type of Visit"* Whether the prenatal client attended prenatal care appointments as recommended	Drop-down list (single choice)	Text	Yes|No	No	State reporting
Attended at least one postnatal care visit?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client has attended at least one post-natal care visit	Drop-down list (single choice)	Text	Yes|No	No	State reporting
Date of infant's birth	*BRANCHES FROM: "Type of Visit"* When the post-natal client's baby was born	Date	Date (mm/dd/yyyy)		No	State reporting, program objective

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Gestational age of infant at birth (in weeks)	*BRANCHES FROM: "Type of Visit"* Gestational age of the post-natal client's baby at birth	Drop-down list (single choice)	Text	<32 weeks|32-37 weeks|>37 weeks	No	State reporting, program objective
Multiple Birth?	*BRANCHES FROM: "Type of Visit"* Whether the client had a multiple birth. Skip if not a multiple birth.	Drop-down list (single choice)	Text	Yes	No	State reporting
Infant received one-week visit to pediatrician/doctor?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client's baby had a pediatrician/doctor visit at one-week old	Drop-down list (single choice)	Text	Yes|No	No	State reporting
Infant placed for adoption?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client's baby was placed for adoption	Drop-down list (single choice)	Text	Yes|No	No	State reporting, program objective
Date of adoptive placement:	*BRANCHES FROM: "Infant placed for adoption?"* Date that the post-natal client's baby was placed for adoption if applicable	Date	Date (mm/dd/yyyy)		No	State reporting, program objective
Age of mother at time of adoptive placement:	*BRANCHES FROM: "Infant placed for adoption?"* Age of the post-natal client when her baby was placed for adoption if applicable	Text	Numeric		No	State reporting, program objective

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Fetal/infant death?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client experienced fetal or infant death	Drop-down list (single choice)	Text	Yes|No	No	State reporting, program objective
Date of death:	*BRANCHES FROM: "Fetal/infant death?"* Date of fetal or infant death if applicable	Date	Date (mm/dd/yyyy)		No	State reporting, program objective
Age/Time of death?	*BRANCHES FROM: "Fetal/infant death?"* Timing or age of the fetal/infant death if applicable	Drop-down list (single choice)	Text	Miscarriage|Fetal death/stillborn|<7 days|7-27 days|28-364 days	No	State reporting, program objective
Indicate the number of client's and partner's children in the home age < 1	Number of client's and partner's children under the age of 1 year living in the home	Text	Numeric		Yes	State reporting
Indicate the number of client's and partner's children in the home age 1-11	Number of client's and partner's children at least 1 year old and younger than 12 years old living in the home	Text	Numeric		Yes	State reporting
Indicate the number of client's and partner's children in the home age 12-22	Number of client's and partner's children at least 12 years old and younger than 23 years old living in the home	Text	Numeric		Yes	State reporting
Would you (and/or your partner) like to become pregnant in the next year?	Whether the client wants to become pregnant in the next 12 months	Drop-down list (single choice)	Text	Yes|No|Client is unsure| Client is ok either way|	Yes	MCHBG Reproductive Life Planning & Coordination with FP
Does the client smoke?	Whether the client currently smokes cigarettes, cigars, cigarillos, etc.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG Measure

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Does anyone else in the household smoke?	Whether anyone living in the same home as the client smokes cigarettes, cigars, cigarillos, etc.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG Measure
Does the client use other nicotine products?	Whether the client currently uses other nicotine products.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG Measure
Does the client drink alcohol or use other substances?	Whether the client consumes alcohol or uses other substances	Drop-down list (single choice)	Text	Yes|No	Yes	State reporting

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Direct Services Provided:	Services provided to the client during the visit	Check box (multiple choice)	Text	Adoption Counseling / Services|Alcohol / Substance Abuse Services|Behavioral Health Services|Budgeting|Child Care Assistance|Child Protection Information / Services|Counseling, other type not specified|Domestic Violence Information / Services|Education|Employment Assistance|Food Assistance|Healthcare Coverage Information|Housing Assistance|Information about Continuation of Education|Material Goods|Maternal Depression Screening|Parenting Support|Prenatal Support|Reproductive Health / Family Planning information|Smoking Cessation Counseling|Transportation Assistance|Utilities Assistance|Other	Yes	State reporting
Specify Other Service:	Service provided if Other is seelcted in previous question.	Text	Text		No	State reporting

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Education Provided (Select all that apply. Complete only if education was provided)	Education provided to client during the visit	Check box (multiple choice)	Text	Alcohol/Substance Abuse|~~Behavioral Health (Other than Post-partum depression)~~ Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)|Breastfeeding|Bullying|Child development/Developmental Screening|Car seat safety/installation|Count the Kicks|Family Violence|Father Involvement|Health Care Coverage / Medicaid Eligibility|Immunizations|Infant Care|Injury prevention/safety|Labor/Childbirth|Lead Prevention|Lifestyle risk factors/prenatal exposures|Maternal Warning Signs|Medical Home|Nutrition|Oral Health|Parenting|Perinatal Mood and Anxiety Disorders|Postpartum care|~~Postpartum depression~~|Preconception/Interconception|Prenatal Care|Preterm Labor|Reproductive Health/Family Planning|Safe Sleep|Smoking Cessation/Second-hand exposure|State/local resources|Suicide Prevention|Teen Pregnancy Prevention|Transition|Weight Management|Well Adolescent|Well Child|Well Woman|WIC|Other	No	State reporting

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Specify other education provided	For responses of "Other" in "Education Provided"	Text	Text		No	
Was a health risk screening tool administered? (Check all that apply)		Drop-down list (multiple choice)	Text	1,EPDS|2,PHQ-9|3,PHQ-A|4,GAD-7|5,ASSIST|6,CRAFFT|7,AUDIT|8,DAST|9,Other|0,N/A - No screening tool administered	No	
Specify other screening tool administered:	Branches from answer of "Other" to "Was a health risk screening tool administered?"	Drop-down list (single choice)	Text		No	
Client left the program for the following reason:	Reason that the client stopped participating in the program	Drop-down list (single choice)	Text	N/A- still participating|Completed Goals|Client Terminated Participation|Miscarriage|Infant age 6 months|Client left service area|Client cannot be located|Other	Yes	Report to Legislature Pursuant to KSA 65-1, 159a
Specify Other Reason:	*BRANCHES FROM: Preceding field* Reason client left the program if Other selected in previous question	Text	Text		No	Report to Legislature Pursuant to KSA 65-1, 159a
Exit Date	Date client left the program	Date	Date (mm/dd/yyyy)		No	Report to Legislature Pursuant to KSA 65-1, 159a
Are any referrals needed?	Whether the client needs to be referred for any services	Drop-down list (single choice)	Text	Yes|No	Yes	Report to Legislature Pursuant to KSA 65-1, 159a
Notes		Narrative	Text		No	

PMI Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
PMI	Pregnancy Maintenance Initiative (Report to Legislature Pursuant to KSA 65-1, 159a) (State)					

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Expected Delivery Date		Date	Date (mm/dd/yyyy)		No	
New Enrollee?	Indicates whether this is the client's first contact with the TPTCM program	Drop-down list (single choice)	Text	Yes|No	Yes	State reporting
Type of Visit:	Whether this visit is prenatal or post-natal	Drop-down list (single choice)	Text	Prenatal|Postnatal	Yes	State reporting
Initiated Prenatal Care (PNC)	*BRANCHES FROM: "Type of Visit"* When the prenatal client had their first prenatal care visit	Drop-down list (single choice)	Text	1st Trimester|2nd Trimester|3rd Trimester|No PNC initiated	No	State reporting; Tied to "Type of Visit" question

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Complied with recommended PNC appointments after initiating care?	*BRANCHES FROM: "Type of Visit"* Whether the prenatal client attended prenatal care appointments as recommended	Drop-down list (single choice)	Text	Yes|No	No	State reporting; Tied to "Initiated Prenatal Care" question
Attended at least one postnatal care visit?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client has attended at least one post-natal care visit	Drop-down list (single choice)	Text	Yes|No	No	State reporting; Tied to "Type of Visit" question
Date of infant's birth	*BRANCHES FROM: "Type of Visit"* When the post-natal client's baby was born	Date	Date (mm/dd/yyyy)		No	State reporting; Tied to "Type of Visit" question
Gestational age of infant at birth (in weeks)	*BRANCHES FROM: "Type of Visit"* Gestational age of the post-natal client's baby at birth	Drop-down list (single choice)	Text	<32 weeks|32-37 weeks|>37 weeks	No	State reporting; Tied to "Date of infant's birth" question
Multiple Birth	*BRANCHES FROM: "Type of Visit"* Whether the client had a multiple birth. Skip if not a multiple birth.	Drop-down list (single choice)	Text	Yes	No	State reporting

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Infant received one-week visit to pediatrician/doctor?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client's baby had a pediatrician/doctor visit at one-week old	Drop-down list (single choice)	Text	Yes|No	No	State reporting; Tied to "Date of infant's birth" question
Infant placed for adoption?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client's baby was placed for adoption	Drop-down list (single choice)	Text	Yes|No	No	State reporting; Tied to "Type of Visit" question
Date of adoptive placement:	*BRANCHES FROM: "Infant placed for adoption?"* Date that the post-natal client's baby was placed for adoption if applicable	Date	Date (mm/dd/yyyy)		No	State reporting; Tied to "Infant placed for adoption" question
Age of mother at time of adoptive placement:	*BRANCHES FROM: "Infant placed for adoption?"* Age of the post-natal client when her baby was placed for adoption if applicable	Text	Numeric		No	State reporting; Tied to "Infant placed for adoption" question
Fetal/infant death?	*BRANCHES FROM: "Type of Visit"* Whether the post-natal client experienced fetal or infant death	Drop-down list (single choice)	Text	Yes|No	No	State reporting; Tied to "Type of Visit" question

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Date of death:	*BRANCHES FROM: "Fetal/infant death?"* Date of fetal or infant death if applicable	Date	Date (mm/dd/yyyy)		No	State reporting; Tied to "Fetal/Infant Death" question
Age/Time of death?	*BRANCHES FROM: "Fetal/infant death?"* Timing or age of the fetal/infant death if applicable	Drop-down list (single choice)	Text	Miscarriage|Fetal death/stillborn|<7 days|7-27 days|28-364 days	No	State reporting; Tied to "Fetal/Infant Death" question
Indicate the number of client's and partner's children in the home age < 1 Autofill	Number of client's and partner's children under the age of 1 year living in the home	Text	Numeric		Yes	State reporting, program objective
Indicate the number of client's and partner's children in the home age 1-11 Autofill	Number of client's and partner's children at least 1 year old and younger than 12 years old living in the home	Text	Numeric		Yes	State reporting, program objective
Indicate the number of client's and partner's children in the home age 12-22 Autofill	Number of client's and partner's children at least 12 years old and younger than 23 years old living in the home	Text	Numeric		Yes	State reporting, program objective

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Number of children in the family who are current on immunizations and Kan Be Healthy (EPSDT)	Number of children in the client's family who are current on immunizations and Kan Be Healthy (EPSDT)	Text	Numeric		Yes	State reporting, program objective
Would you (and/or your partner) like to become pregnant in the next year?	Whether the client wants to become pregnant in the next 12 months	Drop-down list (single choice)	Text	Yes|No|Client is unsure| Client is ok either way	Yes	MCHBG Reproductive Life Planning & Coordination with FP
Does the client smoke?	Whether the client currently smokes cigarettes, cigars, cigarillos, etc.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG Measure
Does anyone else in the household smoke?	Whether anyone living in the same home as the client smokes cigarettes, cigars, cigarillos, etc.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG Measure
Does the client use other nicotine products?	Whether the client currently uses other nicotine products.	Drop-down list (single choice)	Text	Yes|No	Yes	MCHBG Measure
Does the client drink alcohol or use other substances?	Whether the client consumes alcohol or uses other substances	Drop-down list (single choice)	Text	Yes|No	Yes	State reporting

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Direct Services Provided:	Services provided to the client during the visit	Check box (multiple choice)	Text	Adoption Counseling / Services|Alcohol / Substance Abuse Services|Behavioral Health Services|Budgeting|Child Care Assistance|Child Protection Information / Services|Counseling, other type not specified|Domestic Violence Information / Services|Education|Employment Assistance|Food Assistance|Healthcare Coverage Information|Housing Assistance|Information about Continuation of Education|Material Goods|Maternal Depression Screening|Parenting Support|Prenatal Support|Reproductive Health / Family Planning information|Smoking Cessation Counseling|Transportation Assistance|Utilities Assistance|Other	Yes	State reporting
Specify Other Service:	Direct Service provided if Other selected in previous question	Text	Text		No	Tied to question above

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Education Provided (Select all that apply. Complete only if education was provided)	Education provided to client during the visit	Check box (multiple choice)	Text	Alcohol/Substance Abuse|~~Behavioral Health (Other than Post-partum depression)~~ Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)|Breastfeeding|Bullying|Child development/Developmental Screening|Car seat safety/installation|Count the Kicks|Family Violence|Father Involvement|Health Care Coverage / Medicaid Eligibility|Immunizations|Infant Care|Injury prevention/safety|Labor/Childbirth|Lead Prevention|Lifestyle risk factors/prenatal exposures|Maternal Warning Signs|Medical Home|Nutrition|Oral Health|Parenting|Perinatal Mood and Anxiety Disorders|Postpartum care|~~Postpartum depression~~|Preconception/Interconception|Prenatal Care|Preterm Labor|Reproductive Health/Family Planning|Safe Sleep|Smoking Cessation/Second-hand exposure|State/local resources|Suicide Prevention|Teen Pregnancy Prevention|Transition|Weight Management|Well Adolescent|Well Child|Well Woman|WIC|Other	No	State reporting

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Specify other education provided	For responses of "Other" in "Education Provided"	Text	Text		No	
Was a health risk screening tool administered? (Check all that apply)		Drop-down list (multiple choice)	Text	1,EPDS|2,PHQ-9|3,PHQ-A|4,GAD-7|5,ASSIST|6,CRAFFT|7,AUDIT|8,DAST|9,Other|0,N/A - No screening tool administered	No	
Specify other screening tool administered:	Branches from answer of "Other" to "Was a health risk screening tool administered?"	Drop-down list (single choice)	Text		No	
Client completed parent education classes?	Whether the client completed parent education classes	Drop-down list (single choice)	Text	Yes|No	Yes	state reporting, program objective
Date:	*BRANCHES FROM: Preceding field* Date of completion of parent education classes	Date	Date (mm/dd/yyyy)		No	Tied to question above
During program participation client enrolled in:	Educational program client enrolled in during program participation	Drop-down list (single choice)	Text	High School|GED Program|Vocation/Technical School|Community College|4-Year College or University|None	Yes	state reporting, program objective

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Child Protective Services involved with client?	Whether there is an open Child Protective Services Investigation	Drop-down list (single choice)	Text	Yes|No	Yes	state reporting, program objective
CPS involvement resolved with custody of children retained?	Whether the CPS investigation was resolved without the child being removed from the parent's care/custody	Drop-down list (single choice)	Text	Yes|No	No	state reporting, program objective
Second pregnancy after enrollment in program?	Whether the client became pregnant again after enrolling in the program	Drop-down list (single choice)	Text	Yes|No	Yes	state reporting, program objective
Date pregnancy reported	*BRANCHES FROM: "Second pregnancy after enrollment in program?"* Date that the client reported their second pregnancy after enrolling in the program	Date	Date (mm/dd/yyyy)		No	Tied to question above
Did client complete basic education or vocational goals prior to pregnancy?	*BRANCHES FROM: "Second pregnancy after enrollment in program?"* Whether the client completed education or vocational goals prior to their second pregnancy after enrolling in the program	Drop-down list (single choice)	Text	Yes|No	No	State reporting, program objective; Tied to "Second pregnancy after enrollment in program" question

TPTCM Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Client left the program for the following reason:	Reason that the client stopped participating in the program	Drop-down list (single choice)	Text	N/A- still participating|Completed Goals|Client Terminated Participation|Miscarriage|Infant age 12 months |Client reached age limit (21 years)|Client lost Medicaid eligibility|Client left service area|Client cannot be located|Other	Yes	state reporting, program objective
Specify Other Reason:	*BRANCHES FROM: Preceding field* Specify reason client left the program if Other selected in previous question.	Text	Text		No	Tied to question above
Exit Date	Date client left the program	Date	Date (mm/dd/yyyy)		No	state reporting, program objective
Are any referrals needed?	Whether the client needs to be referred for any services	Drop-down list (single choice)	Text	Yes|No	Yes	state reporting, program objective
Notes		Narrative	Text		No	

TPTCM Teen Pregnancy Targeted Case Management Report to the Legislature & Medicaid (State)

Family Planning Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the client (regardless of age) receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Provider (Staff or Medical)	Type of provider conducting the visit. Provider with the highest level of training who takes responsibility of client's assessment/care during visit is credited with the encounter.	Drop-down list (single choice)	Text	Physician|PA/APRN / CNM|Registered Nurse|Other	Yes	FPAR
Screenings Conducted (select all that apply):		Drop-down list (multiple choice)	Text	Tobacco Use|Alcohol Use Substance Use (legal or illegal)|Mental/Behavioral Health|Depression|Intimate Partner Violence|Human Trafficking|Diabetes|Hypertension	No	
Are you pregnant?	Whether the client is pregnant	Drop-down list (single choice)	Text	Yes|No|N/A-Services for infant, child, or male	Yes	Eligibility, service coordination

Family Planning Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Would you (and/or your partner) like to become pregnant in the next year?	Whether the client wants to become pregnant in the next 12 months	Drop-down list (single choice)	Text	Yes|No|Client is unsure| Client is ok either way|N/A - Services for infant or child, male	Yes	FP, BG Reproductive Life Planning
Do you smoke?	Whether the client currently smokes cigarettes, cigars, cigarillos, etc.	Drop-down list (single choice)	Text	Yes|No	Yes	BG measure, screening/referral
Do you drink alcohol or use other substances?	Whether the client consumes alcohol or uses other substances	Drop-down list (single choice)	Text	Yes|No	Yes	BG screening/referral
Visit Type:	Whether this is an initial visit or a periodic/follow-up visit	Drop-down list (single choice)	Text	Initial Visit|Periodic/Follow-up Visit	Yes	FP report

Family Planning Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Program Services (select all that apply)	Program services provided during the visit	Drop-down list (multiple choice)	Text	Clinical Breast Exam|Chlamydia Test|Contraceptive Follow-up|Counseling for Tobacco Use|Counseling for Alcohol Use/ Substance Use (legal or illegal)|Counseling for Mental/Behavioral Health|Counseling for Depression|Counseling for Intimate Partner Violence|Counseling for Human Trafficking|Counseling for Diabetes|Counseling for Hypertension|Education|Gonorrhea Test|HIV Test|Pap Test|Pregnancy Test|Syphilis Test|Other STD/STI Test|Other Screening	Yes	FPAR
Pap Test Result	Result of Pap test (if applicable)	Drop-down list (single choice)	Text	Did not conduct Pap test|Normal|ASC or higher|HSIL or higher|Not conclusive	Yes	FPAR
Clinical Breast Exam Result	Result of Clinical Breast Exam (if applicable)	Drop-down list (single choice)	Text	Did not conduct Clinical Breast Exam|Normal|Abnormal	Yes	FPAR

Family Planning Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Referral for further evaluation based on the Clinical Breast Exam?	Whether a referral was made for the client to receive further evaluation based on her clinical breast exam result	Drop-down list (single choice)	Text	N/A|Yes|No	Yes	FPAR
HIV Test Result	HIV test result (if applicable)	Drop-down list (single choice)	Text	Did not conduct HIV Test|Positive|Negative	Yes	FPAR
Other STD/STI Test Type:	Type of other STD/STI test administered	Text	Text		No	FP report
Specify Other Screening Type:	Type of other screening provided	Text	Text		No	FP report
Type of Contraceptive Method at end of visit	Primary type of contraceptive method used by client at the end of the visit (including any contraceptive method initiated during the visit)	Drop-down list (single choice)	Text	Abstinence|Cervical Cap|Diaphragm|FAM/LAM|Female Condom|Female Sterilization|Hormonal Implant|Hormonal Injection (1 mo)|Hormonal Injection (3 mos)|IUD/IUS|Male Condom|Male: rely on female method(s)|Oral Contraceptive|Patch|Spermicide (Alone)|Sponge|Vasectomy|Vaginal Ring|Withdrawal or other method|Unknown/Not Reported|None	Yes	FPAR

Family Planning Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Specify Other Method:	*BRANCHES FROM: "Type of Contraceptive Method at end of visit"* Primary type of contraceptive method used by client not listed in previous question	Text	Text		No	FP report
Reason for no contraceptive method:	*BRANCHES FROM: "Type of Contraceptive Method at end of visit"* Reason why client is not currently using any contraceptive method	Drop-down list (single choice)	Text	Pregnant/Seeking Pregnancy|Other Reasons	No	FPAR
Specify:	*BRANCHES FROM: Preceding field* Reason client is not using contraceptive method if Other Reasons selected in previous question	Text	Text		No	Tied to question above
Duration of Visit (minutes)	Approximate number of minutes spent in direct contact with client by ALL service providers during visit.	Text	Numeric		Yes	FPAR
Are any referrals needed?	Whether the client needs to be referred for any services	Drop-down list (single choice)	Text	Yes|No	Yes	FP report

Family Planning Service Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
If this is a Family Planning Visit is the visit confidential? *Note: This question appears in the form of an overlay when a user clicks 'save' or 'submit'*	Denotes whether this Family Planning is confidential.	Text	Text	Confidential (Restricted)/Not Confidential (Unrestricted)	Yes	FP requires based on client request

FP report	Family Planning (Title X Annual Application and Progress Report required for annual funding) (Federal)
FPAR	Family Planning Annual Report (Required to maintain FP funding) (Federal)
BG measure	MCH Block Grant Measure (Title V Annual Application and Report required for annual funding) (Federal)

Edinburgh

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the client (regardless of age) receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Program	Program client participated in	Drop-down list (single choice)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	BG forms & narrative, FPAR & FP narrative, PMI & TPTCM reporting
Is this Edinburgh being provided to a mother during an MCH encounter for the child?	*BRANCHES FROM: Response of "Maternal Child Health (MCH/M&I)" to preceding question	Drop-down list (single choice)	Text	1,Yes|0,No	No	Document which Edinburgh was provided during a visit for a child and not the mother
1. I have been able to laugh and see the funny side of things:		Drop-down list (single choice)	Text	As much as I always could|Not quite so much|Definitely not so much now|Not at all	No	

Edinburgh

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
2. I have looked forward with enjoyment to things:		Drop-down list (single choice)	Text	As much as I ever did|Rather less than I used to|Definitely less than I used to|Hardly at all	No	
3. I have blamed myself unnecessarily when things went wrong:		Drop-down list (single choice)	Text	Yes most of the time|Yes some of the time|Not very often|No never	No	
4. I have been anxious or worried for no good reason:		Drop-down list (single choice)	Text	No not at all|Hardly ever|Yes sometimes|Yes very often	No	
5. I have felt scared or panicky for no good reason:		Drop-down list (single choice)	Text	Yes, quite a lot|Yes, sometimes|No, not much|No, not at all	No	
6. Things have been getting to me:		Drop-down list (single choice)	Text	Yes most of the time I haven't been able to cope at all|Yes sometimes I haven't been coping as well as usual|No most of the time I have coped quite well|No I have been coping as well as ever	No	

Edinburgh

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
7. I have been so unhappy that I have had difficulty sleeping:		Drop-down list (single choice)	Text	Yes most of the time|Yes sometimes|No not very often|No not at all	No	
8. I have felt sad or miserable:		Drop-down list (single choice)	Text	Yes most of the time|Yes quite often|Not very often|No not at all	No	
9. I have been so unhappy that I have been crying:		Drop-down list (single choice)	Text	Yes most of the time|Yes quite often|Only occasionally|No never	No	
10. The thought of harming myself has occurred to me:		Drop-down list (single choice)	Text	Yes quite often|Sometimes|Hardly ever|Never	No	
Total Score:		Text	Numeric		No	
Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	

Edinburgh

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Was a brief intervention provided?		Drop-down list (single select)	Text	1,Yes|0,No	No	To ensure appropriate service delivery
What brief intervention was provided?	Branches from answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient-motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	
~~What brief intervention was provided?~~ Please specify other intervention type:	Branches from answer of "Other" to "What brief intervention was provided?"	Text entry	Text		No	
Why was a brief intervention not provided?	Branches from answer of "No" to "Was a brief intervention provided?"	Text	Text		No	To ensure appropriate service delivery
Was a referral provided?		Drop-down list (single select)	Text	1,Yes|0,No	No	To ensure appropriate service delivery

Edinburgh

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
What provider type was ~~client~~ patient referred to?	Select all that apply	Drop-down list (multi select)	Text	6,Internal Mental Health Provider|7,External Mental Health Provider - CMHC|8,External Mental Health Provider - Private Practice|1,Primary Care Provider|2,OB/GYN|9,MCO/ MCO Care Coordinator|4,Community-Based Support Group|5,Other	No	To ensure appropriate service delivery
Please specify other provider type:	If provider type is not inlcuded on the drop down list, please specify type of provider referred to	Text	Text		No	To ensure appropriate service delivery
Why was a referral not provided?	Please describe why referral was not provided	Text	Text		No	To ensure appropriate service delivery
Was the patient in crisis?		Drop Down (Single Select)	Text	1,Yes|0,No	No	
~~If patient was in crisis, what action was taken?~~ What action was taken (brief summary):	Branches from answer of "Yes" to "Was the patient in crisis?"	Narrative	Text		No	

Edinburgh

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Primary Healthcare Coverage	*BRANCHES FROM: Response of "Yes" to "Is this Edinburgh being provided to to a mother during an MCH encounter for the child?" Client's primary type of healthcare coverage	Drop-down list (single choice)	Text	None/Self Pay|Private Insurance|TRICARE|KanCare/Medicaid|CHIP (Formerly HealthWave)|Medicare (client is on disability)|Unknown/Not Reported	No	BG form and narrative, FPAR, PMI & TPTCM reporting
Secondary Healthcare Coverage	*BRANCHES FROM: Response of "Yes" to "Is this Edinburgh being provided to to a mother during an MCH encounter for the child?" Client's secondary type of healthcare coverage, if applicable	Drop-down list (single choice)	Text	None/Self Pay|Private Insurance|TRICARE|KanCare/Medicaid|CHIP (Formerly HealthWave)|Medicare (client is on disability)|Unknown/Not Reported	No	BG form and narrative, FPAR, PMI & TPTCM reporting
Household Size (number of people living in the household)	*BRANCHES FROM: Response of "Yes" to "Is this Edinburgh being provided to to a mother during an MCH encounter for the child?" Total number of individuals living in the client's household	Text	Numeric		No	BG forms & narrative, FPAR (poverty level requirements)

Edinburgh

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Annual Household Income	*BRANCHES FROM: Response of "Yes" to "Is this Edinburgh being provided to to a mother during an MCH encounter for the child?" Client's reported or estimated annual income for all individuals living in the household, from all income sources. *Note: if the client has no information about income or refuses to provide their income information, enter '999999'*	Text	Numeric		No	BG forms & narrative, FPAR (poverty level requirements)
Annual Household Income	*BRANCHES FROM: Response of "Yes" to "Is this Edinburgh being provided to to a mother during an MCH encounter for the child?" Client's reported or estimated annual income for all individuals living in the household, from all income sources.	Drop-down list (single choice)	Text	Less than $10000|$10000 to $14999|$15000 to $19999|$20000 to $24999|$25000 to $34999|$35000 to 49999|$50000 or more|Don't Know|Refused	No	BG forms & narrative, FPAR (poverty level requirements)

Tobacco Use Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Link activity form to client
Visit for Caregiver/Adult or Child?	Whether the visit was for the caregiver/adult or a child	Drop-down list (single choice)	Text	Caregiver/Adult|Child	Yes	Associate the form to an adult or child in the family
Which caregiver was involved?	*BRANCHES FROM: "Visit for Caregiver/Adult or Child?"* Name of the adult client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	No	Link activity form to client
Which child was involved?	The name if the child at the visit (if applicable)	Drop-down list (single choice)	Dynamic Child	*Options will include all associated children*	No	Link activity form to client
Program		Drop-down list (single choice)	Text	Becoming a Mom|Family Planning|Maternal Child Health|PMI|TPTCM	No	
Are you pregnant?		Drop-down list (single choice)	Text	Yes|No	Yes	

Tobacco Use Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Please check the answer that best describes you:	*BRANCHES FROM Yes to "Are you pregnant?" Client's smoking status/history	Drop-down list (single choice)	Text	I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime|I STOPPED smoking BEFORE I found out I was pregnant|I STOPPED smoking AFTER I found out I was pregnant and I am not smoking now|I smoke SOME NOW, but I CUT DOWN SINCE I found out I was pregnant|I smoke REGULARLY NOW and have NOT CUT DOWN since I found out I was pregnant	No	
If not pregnant, please check the answer that best describes you:	*BRANCH FROM No to "Are you pregnant?"	Drop-down list (single choice)	Text	I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime|I STOPPED smoking in the past ONE YEAR|I STOPPED smoking OVER ONE YEAR AGO|I CURRENTLY smoke on a LESS THAN DAILY basis|I CURRENTLY smoke on a DAILY basis	No	

Tobacco Use Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Do you use electronic cigarettes or E-cigarettes?	Denotes whether client uses electronic cigarettes or E-cigarettes	Drop-down list (single choice)	Text	Yes|No	No	
Do you use smokeless tobacco products ?	Denotes whether client uses smokeless tobacco products	Drop-down list (single choice)	Text	Yes|No	No	
If yes, what kind of smokeless tobacco product do you use?	Denotes what kind of smokeless tobacco product the client uses	Text	Text		No	
How many smokers do you live with?	Number of individuals living with the client who smoke cigarettes, cigars, cigarillos, etc.	Text	Numeric		No	
What is your relationship to the above smoker(s)?	Client's relationship(s) to the individual(s) in the previous question	Drop-down list (multiple choice)	Text	Partner|Parent|Friend|Other	No	
Please specify relationship if 'other'	Relationship type not listed in previous question	Text	Text		No	
How often does anyone smoke inside your home or car?	Average frequency that there is an individual smoking in the home or car with the client	Drop-down list (single choice)	Text	Daily|Weekly|Monthly|Less than monthly|Never	No	

Tobacco Use Survey

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
If you smoke, in the last 30 days, how often did you smoke?	Client's smoking frequency	Drop-down list (single choice)	Text	Every day|Some days	No	
On an average day that you smoke, about how many cigarettes do you currently smoke?	Number of cigarettes smoked on an average day that the client smokes	Text	Numeric		No	
Are you interested in quitting smoking?	Whether the client is interested in quitting smoking	Drop-down list (single choice)	Text	Yes, in the next 30 days|Yes, but not now|I'm not interested in quitting	No	

PMI Birth Outcome Card

Question ID	Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
274	Which caregiver was involved?	Name of the client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
277	Date of Activity	Date grantee received the birth outcome information	Date	Date (mm/dd/yyyy)		Yes	Document date grantee received birth outcome information
687	Attended at least one postnatal care visit?	Whether the post-natal client has attended at least one post-natal care visit	Drop-down list (single choice)	Text	Yes|No	No	State reporting
944	Date of infant's birth	When the post-natal client's baby was born	Date	Date (mm/dd/yyyy)		Yes	State reporting, program objective
688	Gestational age of infant at birth (in weeks)	Gestational age of the post-natal client's baby at birth	Drop-down list (single choice)	Text	<32 weeks|32-37 weeks|>37 weeks	Yes	State reporting, program objective
5652	Multiple Birth?	Whether the client had a multiple birth	Drop-down list (single choice)	Text	Yes	No	State reporting
689	Infant received one-week visit to pediatrician/doctor?	Whether the post-natal client's baby had a pediatrician/doctor visit at one-week old	Drop-down list (single choice)	Text	Yes|No	No	State reporting
690	Infant placed for adoption?	Whether the post-natal client's baby was placed for adoption	Drop-down list (single choice)	Text	Yes|No	No	State reporting, program objective

941	Date of adoptive placement:	Date that the post-natal client's baby was placed for adoption if applicable	Date	Date (mm/dd/yyyy)		No	State reporting, program objective

942	Age of mother at time of adoptive placement:	Age of the post-natal client when her baby was placed for adoption if applicable	Text	Numeric		No	State reporting, program objective
691	Fetal/infant death?	Whether the post-natal client experienced fetal or infant death	Drop-down list (single choice)	Text	Yes|No	Yes	State reporting, program objective
945	Date of death:	*Branches from "Fetal/infant death?" if "Yes" is selected.* Date of fetal or infant death if applicable	Date	Date (mm/dd/yyyy)		No	State reporting, program objective
692	Age/Time of death?	*Branches from "Fetal/infant death?" if "Yes" is selected.* Timing or age of the fetal/infant death if applicable	Drop-down list (single choice)	Text	Miscarriage|Fetal death/stillborn|<7 days|7-27 days|28-364 days	No	State reporting, program objective

TPTCM Birth Outcome Card

Question ID	Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
274	Which caregiver was involved?	Name of the client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
277	Date of Activity	Date grantee received the birth outcome information	Date	Date (mm/dd/yyyy)		Yes	Document date grantee received birth outcome information
687	Attended at least one postnatal care visit?	Whether the post-natal client has attended at least one post-natal care visit	Drop-down list (single choice)	Text	Yes|No	No	State reporting
944	Date of infant's birth	When the post-natal client's baby was born	Date	Date (mm/dd/yyyy)		Yes	State reporting, program objective
688	Gestational age of infant at birth (in weeks)	Gestational age of the post-natal client's baby at birth	Drop-down list (single choice)	Text	<32 weeks|32-37 weeks|>37 weeks	Yes	State reporting, program objective
5652	Multiple Birth?	Whether the client had a multiple birth	Drop-down list (single choice)	Text	Yes	No	State reporting
689	Infant received one-week visit to pediatrician/doctor?	Whether the post-natal client's baby had a pediatrician/doctor visit at one-week old	Drop-down list (single choice)	Text	Yes|No	No	State reporting
690	Infant placed for adoption?	Whether the post-natal client's baby was placed for adoption	Drop-down list (single choice)	Text	Yes|No	No	State reporting, program objective

941	Date of adoptive placement:	Date that the post-natal client's baby was placed for adoption if applicable	Date	Date (mm/dd/yyyy)		No	State reporting, program objective

942	Age of mother at time of adoptive placement:	Age of the post-natal client when her baby was placed for adoption if applicable	Text	Numeric		No	State reporting, program objective
691	Fetal/infant death?	Whether the post-natal client experienced fetal or infant death	Drop-down list (single choice)	Text	Yes|No	Yes	State reporting, program objective
945	Date of death:	*Branches from "Fetal/infant death?" if "Yes" is selected.* Date of fetal or infant death if applicable	Date	Date (mm/dd/yyyy)		No	State reporting, program objective
692	Age/Time of death?	*Branches from "Fetal/infant death?" if "Yes" is selected.* Timing or age of the fetal/infant death if applicable	Drop-down list (single choice)	Text	Miscarriage|Fetal death/stillborn|<7 days|7-27 days|28-364 days	No	State reporting, program objective

ASQ: SE-2

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	
Which child was involved?	Name of the child client receiving services documented in this form if applicable	Drop-down list (single choice)	Dynamic Child	*Options will include all associated children*	Yes	
Child's age (in months) at time of measurement	Child's age in months at the time of the screening	Text	Numeric		No	
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form if applicable	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	No	
If someone other than a caregiver completed the screen, pelase list their name	Name of person who completed the screen who wasn't the caregiver, if applicable	Text	Text		No	
Relationship to child	The relationship of the person completing the screen to the child receiving the screen	Text	Text		No	

Provider involved?		Text	Text		No	
ASQ:SE-2 Screening month	Mother's (and others) planned sleep position for the baby	Drop-down list (single choice)	Text	2|6|12|18|24|30|36|48|60	Yes	
ASQ:SE-2 Score	Mother's plan for where the baby will sleep at home	Text	Text		Yes	

ASQ-3

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required ?	Purpose of Question/Element
Date of Activity	Date client received services documented on this form	Date	Dynamic Date		Yes	
Which child was involved?	Name of the child client receiving services documented in this form if applicable	Drop-down list (single choice)	Dynamic Child		Yes	
Child's age (in months) at time of measurement	Child's age in months at the time of the screening	Text	Numeric		No	
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form if applicable	Drop-down list (single choice)	Dynamic Caregiver		No	
If someone other than a caregiver completed the screen, please list their name	Name of person who completed the screen who wasn't the caregiver, if applicable	Text	Text		No	
Relationship to child	The relationship of the person completing the screen to the child receiving the screen	Text	Text		No	
Which provider was involved?		Text	Text		No	
ASQ-3 Screening Month		Drop-down list (single choice)	Text	2|4|6|8|9|10|12|14|16|18|20|22|24|27|30|33|36|42|48|54|60	Yes	
Communication Area Score		Text	Numeric		No	
Gross Motor Area Score		Text	Numeric		No	
Fine Motor Area Score		Text	Numeric		No	

Problem-Solving Area Score		Text	Numeric		No	
Personal-Social Area Score		Text	Numeric		No	

Client Contact Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Visit for Caregiver/Adult or Child?	Whether the visit was for the caregiver/adult or a child	Drop-down list (single choice)	Text	Caregiver/Adult|Child	Yes	Associate the form to an adult or child in the family
Which caregiver was involved?	*BRANCHES FROM: "Visit for Caregiver/Adult or Child?"* Name of the adult client receiving services documented in this form	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	No	Link activity form to client
Which child was involved?	The name if the child at the visit (if applicable)	Drop-down list (single choice)	Dynamic Child	*Options will include all associated children*	No	Link activity form to client
Date of Activity		Date	Dynamic Date		No	

Client Contact Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Method of Contact		Drop-down list (single choice)	Text	1,Phone|2,In Person|3,Text	No	
What was discussed?		Drop-down list (multiple choice)	Text	1,Substance Use|2,Safety|3,Mental Health|4,Risk Factors|5,Perinatal Health|12,Prenatal	No	
Please describe		Text	Text		No	
Contact Duration		Drop-down list (single choice)	Text	1,<5 minutes|2,5-9 minutes|3,10-14 minutes|4,15-19 minutes|5,20-24 minutes|6,25-29 minutes|7,30 minutes	No	
Notes:		Narrative	Text		No	

Parental Health Screener

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form if applicable	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Over the last 2 weeks, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?	Indicates whether or not a referral is needed regarding issues for depression/suicidal thoughts	Drop-down list (single choice)	Text	Yes|No	Yes	Healthy Start benchmark
Over the last 2 weeks, have you been feeling bad about yourself, or have been feeling that you are a failure or have let yourself or your family down?	Indicates whether or not a referral is needed regarding issues for depression/suicidal thoughts	Drop-down list (single choice)	Text	Yes|No	Yes	Healthy Start benchmark
Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	Indicates whether or not a referral is needed regarding domestic violence	Drop-down list (single choice)	Text	Yes|No	Yes	Healthy Start benchmark
Are you afraid of your partner or someone else who is important to you?	Indicates whether or not a referral is needed regarding domestic violence	Drop-down list (single choice)	Text	Yes|No	Yes	Healthy Start benchmark

Parental Health Screener

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
In the past, have you had difficulties in your life due to substance use?	Indicates whether or not a referral is needed regarding substance abuse	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Please indicate which substances:	*Branches from preceding field*	Drop-down list (multiple choice)	Text	Alcohol|Drugs| Prescription medication	No	Coalition requirement
Since becoming pregnant, have you had difficulties in your life due to substance use?	Indicates whether or not a referral is needed regarding substance abuse while pregnant	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Please indicate which substance(s):	*Branches from preceding field*	Drop-down list (multiple choice)	Text	Alcohol|Drugs|Prescription medication	No	Coalition requirement
When you discipline your child, do you lose control?	Indicates whether or not a referral is needed regarding parenting-child relationship	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Do you have a reliable source of income?	Indicates whether or not a referral is needed for income assistance	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Can you afford your monthly bills?	Indicates whether or not a referral is needed for income assistance	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
In the last 6 months, have you ever had trouble affording food?	Indicates whether or not a referral is needed for income assistance	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement

Parental Health Screener

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Is there someone in your household who will soon be deployed or coming home from deployment?	Indicates whether or not a referral is needed for coping with a household family member in active military	Drop-down list (single choice)	Text	No|Deployed|Coming home from deployment|Soon to be deployed	Yes	Coalition requirement
Are there children in your home with medical/special needs?	Indicates whether or not a referral is needed for children in the home with special needs (medical or developmental)	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Have you had a baby born 3 weeks or more before the due date?	Indicates whether or not a referral is needed for poor pregnancy outcomes (risk factors)	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Have you had a baby that weighed less than 5 pounds, 8 ounces?	Indicates whether or not a referral is needed for poor pregnancy outcomes (risk factors)	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Have you smoked at least one cigarette in the past week?	Indicates whether or not a referral is needed for smoking	Drop-down list (single choice)	Text	Yes|No	Yes	Healthy Start benchmark
Is there someone you live with who currently smokes?	Indicates whether or not a referral is needed for smoking	Drop-down list (single choice)	Text	Yes|No	Yes	Healthy Start benchmark
Are you behind in your rent/mortgage?	Indicates whether or not a referral is needed for housing stability	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement

Parental Health Screener

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Is your home in bad condition (i.e., no running water; no electricity; broken appliances)?	Indicates whether or not a referral is needed for housing stability	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Do you have a safe, stable place to live?	Indicates whether or not a referral is needed for housing stability	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Have you had a baby that was not born alive?	Indicates whether or not a referral is needed for coping with infant loss	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Have you had a baby that died within the 1st year of life?	Indicates whether or not a referral is needed for coping with infant loss	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
Do you have reliable transportation?	Indicates whether or not a referral is needed for transportation	Drop-down list (single choice)	Text	Yes|No	Yes	Coalition requirement
If you have a child or children, how often do you or an adult family member read to/with your child(ren) during the week?	Indicates how often a child is read to by an adult	Drop-down list (single choice)	Text	Less than once per week|1-2 times per week|3-4 times per week|5-6 times per week|Everyday|N/A I don't have a child	Yes	HS Benchmark

One Key Question Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Services for Caregiver/Adult or Child/Adolescent?		Drop-down list (single choice)	Text	1,Caregiver/Adult|2,Child/Adolescent	yes	
Which Caregiver was involved?		Auto-generated	Text	*options based on family association*	no	
Which Child was involved?		Auto-generated	Text	*options based on family association*	no	
Date of Activity:		Date	Date (mm/dd/yyyy)		yes	
Program client enrolled in:		Check box (multiple choice)	Text	Family Planning|MCH|PMI|TPTCM	yes	
Population Served (Select One):	Population category of client	Drop-down list (single choice)	Text	Woman (22-44 years)|Male|Adolescent (12-21)	yes	To ensure appropriate service delivery
Have you ever been pregnant and/or delivered a child?		Drop-down list (single choice)	Text	1,Yes|0,No	no	To ensure appropriate service delivery
If Yes, what was the date your last pregnancy ended/delivered?	Date last pregnancy ended or delivered	Date	Date (mm/dd/yyyy)		no	To ensure appropriate service delivery

Would you like to become pregnant in the next year?		Drop-down list (single choice)	Text	1,Yes|2,Ok Either Way|3,Unsure|0,No	Yes	To ensure appropriate service delivery
Educated on:	Select all that apply	Check box (multiple choice)	Text	Birth Spacing|Folic Acid|Health Risks	no	To ensure appropriate service delivery
Referred for pre/interconception care?		Drop-down list (single choice)	Text	1,Yes|0,No	no	To ensure appropriate service delivery
Referred to:	Select all that apply	Check box (multiple choice)	Text	1,OB/GYN|2,Family Physician/Practice|3,Safety Net Clinic (FQHC, Rural Health Clinic, income-based or free clinics)|4,MCH Program|5,Family Planning Program|6,Other	no	To ensure appropriate service delivery
Please specify:	If referral was made to a provider not included on the referral list, please specify provider type	Text	Text		no	To ensure appropriate service delivery
Why? Barrier to referral:	Select all that apply	Check box (multiple choice)	Text	No referral source readily available|Inconvenient service times or locations|No Health Insurance|Client cannot afford care|Lack of transportation or child care|Lack of linguistically or culturally tailored services|Other	no	To ensure appropriate service delivery

Please specify:	If barrier to referral is not included on the barriers to referral list, please specify reason referral did not occur	Text	Text			To ensure appropriate service delivery
Currently on birth control:		Drop-down list (single choice)	Text	1,Yes|0,No	no	To ensure appropriate service delivery
Current method:	Select all that apply	Check box (multiple choice)	Text	1,IUD|Implant|2,Depo-Provera|3,Ring|4,Patch|5,Pills|6,Diaphragm|7,Condoms (male or female)|8,Sponge|9,Spermicide|10,Cervical Cap|11,Natural Family Planning/Fertility Awareness|12,Sterilization (client or partner)|13,Withdraw| 14,Other	no	To ensure appropriate service delivery
Please specify:	If current birth control method is not on the birth control list, please specify what type of birth control was used	Text	Text		no	To ensure appropriate service delivery

Discussed current birth control effectiveness, side effects and desired outcome:		Drop-down list (single choice)	Text	Yes|No	no	To ensure appropriate service delivery
Current birth control method changed?		Drop-down list (single choice)	Text	1,Yes|0,No	no	To ensure appropriate service delivery
Reason for switch:	Select all that apply	Check box (multiple choice)	Text	1,More effective method|2,Side effects of current method|3,Cost of current method|4,Convenience|5,Other	no	To ensure appropriate service delivery
Please specify:	If reason for switching birth control is not included on the drop down list, please specify what type of birth control was initiated	Text	Text		no	To ensure appropriate service delivery
If not currently on birth control, was a birth control method initiated?	Select appropriate choice	Drop-down list (single choice)	Text	1,Yes|2,Client did not want birth control|3,Referred for birth control initiation	no	To ensure appropriate service delivery

Type initiated:	Select all that apply	Check box (multiple choice)	Text	1,IUD|2,Implant|3,Depo-Provera|4,Ring|5,Patch|6,Pills|7,Diaphragm|8,Condoms (male or female)|9,Sponge|10,Spermicide|11,Cervical Cap|12,Natural Family Planning/Fertility Awareness|13,Sterilization (client or partner)|14,Withdraw| 15,Other	no	To ensure appropriate service delivery
Please specify:	If birth control initiated is not on the drop down list, please specify what birth control type was initiated	Text	Text		no	To ensure appropriate service delivery
Why? Please tell us:		Text	Text		no	To ensure appropriate service delivery
Did client accept birth control initiation referral?		Drop-down list (single choice)	Text	1,Yes|0,No	no	To ensure appropriate service delivery
Referred to:	Select all that apply	Check box (multiple choice)	Text	1,OB/GYN|2,Family Physician/Practice|3,Safety Net Clinic (FQHC, Rural Health Clinic, income-based or free clinics)|4,MCH Program|5,Family Planning Program|6,Other	no	To ensure appropriate service delivery

Please specify:	If referral was made to a provider not included on the referral list, please specify provider type	Text	Text		no	To ensure appropriate service delivery
Why? Barrier to referral:	Select all that apply	Check box (multiple choice)	Text	No referral source readily available|Inconvenient service times or locations|No Health Insurance|Client cannot afford care|Lack of transportation or child care|Lack of linguistically or culturally tailored services|Other	no	To ensure appropriate service delivery
Please specify:	If referral barrier is not included on the drop down list, please specify why referral was not made	Text	Text		no	To ensure appropriate service delivery
Emergency contraception provided:		Drop-down list (single choice)	Text	Yes|No|N/A	no	To ensure appropriate service delivery

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?		Auto-generated	Date (mm/dd/yyyy)		Yes	
Date of Activity		Date	Text		Yes	
Program		Drop Down (Single Select)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
In your life, which of the following substances have you ever used? (Non-medical use only)		Check Box (Multiple Choice)	Text	1,Tobacco products|2,Alcoholic beverages|3,Cannabis|4,Cocaine|5,Amphetamine type Stimulants|6,Inhalants|7,Sedatives or Sleeping Pills|8,Hallucinogens|9,Opioids|10,Other|0,Haven't used any non-prescribed substances	Yes	
In the past three months, how often have you used tobacco products?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use tobacco products?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
During the past three months, how often has your use of tobacco products led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	
During the past three months, how often have you failed to do what was normally expected of you because of your use of tobacco products?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of tobacco products?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Have you ever tried and failed to control, cut down or stop using tobacco products?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Tobacco involvement score:		Calculated field	Text		No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
In the past three months, how often have you used alcoholic beverages?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use alcoholic beverages?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of alcoholic beverages led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	
During the past three months, how often have you failed to do what was normally expected of you because of your use of alcoholic beverages?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of alcoholic beverages?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Have you ever tried and failed to control, cut down or stop using alcoholic beverages?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Alcohol involvement score:		Calculated field	Text		No	
In the past three months, how often have you used cannabis?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use cannabis?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of cannabis led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
During the past three months, how often have you failed to do what was normally expected of you because of your use of cannabis?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of cannabis?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Have you ever tried and failed to control, cut down or stop using cannabis?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Cannabis involvement score:		Calculated field	Text		No	
In the past three months, how often have you used cocaine?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
During the past three months, how often have you had a strong desire or urge to use cocaine?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of cocaine led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	
During the past three months, how often have you failed to do what was normally expected of you because of your use of cocaine?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of cocaine?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Have you ever tried and failed to control, cut down or stop using cocaine?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Cocaine involvement score:		Calculated field	Text		No	
In the past three months, how often have you used Amphetamine type stimulants?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use amphetamine type stimulants?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of amphetamine type stimulants led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
During the past three months, how often have you failed to do what was normally expected of you because of your use of amphetamine type stimulants?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of amphetamine type stimulants?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Have you ever tried and failed to control, cut down or stop using amphetamine type stimulants?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Amphetamine involvement score:		Calculated field	Text		No	
In the past three months, how often have you used inhalants?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
During the past three months, how often have you had a strong desire or urge to use inhalants?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of inhalants led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	
During the past three months, how often have you failed to do what was normally expected of you because of your use of inhalants?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of inhalants?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Have you ever tried and failed to control, cut down or stop using inhalants?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Inhalant involvement score:		Calculated field	Text		No	
In the past three months, how often have you used sedatives or sleeping pills?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use sedatives or sleeping pills?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of sedatives or sleeping pills led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	
During the past three months, how often have you failed to do what was normally expected of you because of your use of sedatives or sleeping pills?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Has a friend or relative or anyone else ever expressed concern about your use of sedatives or sleeping pills?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Have you ever tried and failed to control, cut down or stop using sedatives or sleeping pills?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Sedative or sleeping pill involvement score:		Calculated field	Text		No	
In the past three months, how often have you used hallucinogens?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use hallucinogens?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
During the past three months, how often has your use of hallucinogens led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	
During the past three months, how often have you failed to do what was normally expected of you because of your use of hallucinogens?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of hallucinogens?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Have you ever tried and failed to control, cut down or stop using hallucinogens?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Hallucinogen involvement score:		Calculated field	Text		No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
In the past three months, how often have you used opioids?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use opioids?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of opioids led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	
During the past three months, how often have you failed to do what was normally expected of you because of your use of opioids?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of opioids?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Have you ever tried and failed to control, cut down or stop using opioids?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Opioid involvement score:		Calculated field	Text		No	
Please indicate the other substance used:		Text	Text		No	
In the past three months, how often have you used this other substance?		Drop Down (Single Select)	Text	0,Never|2,Once or Twice|3,Monthly|4,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often have you had a strong desire or urge to use this other substance?		Drop Down (Single Select)	Text	0,Never|3,Once or Twice|4,Monthly|5,Weekly|6,Daily or Almost Daily	No	
During the past three months, how often has your use of this other substance led to health, social, legal or financial problems?		Drop Down (Single Select)	Text	0,Never|4,Once or Twice|5,Monthly|6,Weekly|7,Daily or Almost Daily	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
During the past three months, how often have you failed to do what was normally expected of you because of your use of this other substance?		Drop Down (Single Select)	Text	0,Never|5,Once or Twice|6,Monthly|7,Weekly|8,Daily or Almost Daily	No	
Has a friend or relative or anyone else ever expressed concern about your use of this other substance?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Have you ever tried and failed to control, cut down or stop using this other substance?		Drop Down (Single Select)	Text	0,No, Never|6,Yes, in the past 3 months|3,Yes, but not in the past 3 months	No	
Other substance involvement score:		Calculated field	Text		No	
Have you ever used any drug by injection?		Drop Down (Single Select)	Text	0,No, Never|2,Yes, in the past 3 months|1,Yes, but not in the past 3 months	No	
In the last 3 months how often did you inject?		Drop Down (Single Select)	Text	1,Once weekly or less OR fewer than 3 days in a row|2,More than once per week OR 3 or more days in a row	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	
Was a brief intevention provided?	Branches from score of 11 or greater on "Alcohol Score" or 4 or greater for all other substance scores	Drop Down (Single Select)	Text	1,Yes|0,No	No	
What brief intervention was provided?	Branches from answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient-motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
~~What brief intervention was provided?~~ Please specify other intervention type:	Branches from answer of "Other" to "What brief intervention was provided?"	Text entry	Text		No	
Why was a brief intervention not provided?	Branches from answer of "No" to "Was a brief intervention provided?"	Text entry	Text		No	
Was a referral provided?	Branches from score of 11 or greater on "Alcohol Score" or 4 or greater for all other substance scores	Drop Down (Single Select)	Text	1,Yes|0,No	No	
What provider type was the patient referred to?	Branches from answer of "Yes" to "Was a referral provided?"	Drop-down list (multi select)	Text	1,Beacon Health Options|2, Substance Use Treatment Provider|3,Internal Mental Health Provider|4,External Mental Health Provider - CMHC|5, External Mental Health Provider - Private Practice|6, MCO/MCO Care Coordinator|7,Community-Based Support Group|9,Primary Care Provider|8,Other	No	

ASSIST

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Why was a referral not provided?	Branches from answer of "No" to "Was a referral provided?"	Text entry	Text		No	
Please specify other provider type:	Branches from answer of "Other" to "What provider type was the patient referred to?"	Text entry	Text		No	
Was the patient in crisis?		Drop Down (Single Select)	Text	1,Yes|0,No	No	
~~If patient was in crisis, what action was taken?~~ What action was taken (brief summary):	Branches from answer of "Yes" to "Was the patient in crisis?"	Narrative	Text		No	

KDHE Case Notes

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?	Name of the caregiver/adult client receiving services documented in this form if applicable	Drop-down list (single choice)	Dynamic Caregiver	*Options will include all associated caregivers*	Yes	Link activity form to client
Date of Activity	Date client received services documented on this form	Date	Date (mm/dd/yyyy)		Yes	Document date client received services
Reason(s) for visit:	Reason(s) for the visit	Drop-down list (multiple choice)	Text	Thinking about hurting self|Feeling of guilt/being let-down|Recently physically hurt by other|Afraid of partner/other|Past substance use problem|Current substance use problem| Smoked in past week|Household smoker| Lose control when disciplining child | Kids with medical/special needs | Baby born 3 weeks+ premature | Baby weighed less than 5 lbs 8 oz | Baby not born alive | Baby died within 1st year | No reliable source of income|Can't afford monthly bills|Can't afford food| Home in bad condition | Need safe, stable place to live | Need reliable transportation | Behind in rent/mortgage| Deployed/returned home| Standard/initial/Follow-up visit | Other	No	Determine needs of client

Other	*BRANCHES FROM: Preceding field* Specify other visit reason if Other selected in previous question.	Text	Text		No	Determine other needs not listed of client
Was the client referred to your organization?	Determines if the client was referred to your organization	Drop-down list (single choice)	Yes/No		No	Case management
Date of referral	*BRANCHES FROM: Preceding field* Specify referral date	Date	Date (mm/dd/yyyy)		No	Case management
Organization making referral	Organization making referral	Text	Text		No	Case management
Reason for referral:	Reason(s) the referral was made	Narrative	Text		No	Case management
Date of appointment:	Date of the patient's appointment	Date	Date (mm/dd/yyyy)		No	Case management
Date patient was notified of appointment:	Date that the patient was notified about the appointment	Date	Date (mm/dd/yyyy)		No	Case management
Additional Notes:	Additional information not gathered above	Narrative	Text		No	Case management

KDHE Goal Tracking Form

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which caregiver was involved?		Drop-down list (single choice)	Dynamic Caregiver		Yes	
Date of Activity		Date	Dynamic Date		Yes	
Goal 1:		Narrative	Text		Yes	

Date Created:		Date	Date (mm/dd/yyyy)		Yes	
Category/Domain:		Drop-down list (single choice)	Text	1,Healthy relationships|2,Life skills|3,Career|4,Education|5,Health and safety|6,Family resources|7,Other	Yes	
Please explain other category/domain:		Text	Text		No	
Progress:		Drop-down list (single choice)	Text	1,Progress made|2, No progress made|3,Met|4,Unmet	No	
If unmet, please explain why:		Text	Text		No	
Notes:		Narrative	Text		No	
Goal 2:		Narrative	Text		No	
Date Created:		Date	Date (mm/dd/yyyy)		No	
Category/Domain:		Drop-down list (single choice)	Text	1,Healthy relationships|2,Life skills|3,Career|4,Education|5,Health and safety|6,Family resources|7,Other	No	

Please explain other category/domain:		Text	Text		No	
Progress:		Drop-down list (single choice)	Text	1,Progress made|2, No progress made|3,Met|4,Unmet	No	
If unmet, please explain why:		Text	Text		No	
Notes:		Narrative	Text		No	
Goal 3:		Narrative	Text		No	
Date Created:		Date	Date (mm/dd/yyyy)		No	
Category/Domain:		Drop-down list (single choice)	Text	1,Healthy relationships|2,Life skills|3,Career|4,Education|5,Health and safety|6,Family resources|7,Other	No	
Please explain other category/domain:		Text	Text		No	
Progress:		Drop-down list (single choice)	Text	1,Progress made|2, No progress made|3,Met|4,Unmet	No	
If unmet, please explain why:		Text	Text		No	
Notes:		Narrative	Text		No	
Goal 4:		Narrative	Text		No	
Date Created:		Date	Date (mm/dd/yyyy)		No	

Category/Domain:		Drop-down list (single choice)	Text	1,Healthy relationships|2,Life skills|3,Career|4,Education|5,Health and safety|6,Family resources|7,Other	No	
Please explain other category/domain:		Text	Text		No	
Progress:		Drop-down list (single choice)	Text	1,Progress made|2, No progress made|3,Met|4,Unmet	No	
If unmet, please explain why:		Text	Text		No	
Notes:		Narrative	Text		No	
Goal 5:		Narrative	Text		No	
Date Created:		Date	Date (mm/dd/yyyy)		No	
Category/Domain:		Drop-down list (single choice)	Text	1,Healthy relationships|2,Life skills|3,Career|4,Education|5,Health and safety|6,Family resources|7,Other	No	
Please explain other category/domain:		Text	Text		No	
Progress:		Drop-down list (single choice)	Text	1,Progress made|2, No progress made|3,Met|4,Unmet	No	
If unmet, please explain why:		Text	Text		No	
Notes:		Narrative	Text		No	

CRAFFT+N Interview

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which Caregiver Was Involved?		Drop-down list (single choice)	Dynamic Caregiver		Yes	
Date of Activity	Data family received services documented on this form	Date	Dynamic Date		Yes	Tracking
Program		Drop Down (Single Select)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	
During the PAST 12 MONTHS, on how many days did you: (enter 0 if none)		Explanation	Text		No	
Drink more than a few sips of beer, wine, or any drink containing alcohol?		Text	Numeric		No	
Use any marijuana (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "synthetic marijuana" (like "K2," "Spice")?		Text	Numeric		No	
Use anything else to get high (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)?		Text	Numeric		No	

Use a vaping device* containing nicotine or flavors, or use any tobacco products**?	Info bubble: *Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. **Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.	Text	Numeric		No	
Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	Branches from answer of "0" on questions 1, 2, 3, and 4 OR answer of "1" (or more) on questions 1, 2, or 3.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	Branches from answer of "1" (or more) on questions 1, 2, or 3.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Do you ever use alcohol or drugs while you are by yourself, or ALONE?	Branches from answer of "1" (or more) on questions 1, 2, or 3.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Do you ever FORGET things you did while using alcohol or drugs?	Branches from answer of "1" (or more) on questions 1, 2, or 3.	Drop-down list (single choice)	Text	1,Yes|0,No	No	

Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	Branches from answer of "1" (or more) on questions 1, 2, or 3.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Have you ever gotten into TROUBLE while you were using alcohol or drugs?	Branches from answer of "1" (or more) on questions 1, 2, or 3.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Have you ever tried to QUIT using, but couldn't?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Do you vape or use tobacco NOW because it is really hard to quit?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Have you ever felt like you were ADDICTED to vaping or tobacco?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Do you ever have strong CRAVINGS to vape or use tobacco?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Have you ever felt like you really NEEDED to vape or use tobacco?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Is it hard to keep from vaping or using tobacco in PLACES where you are not supposed to, like school?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	

When you HAVEN'T vaped or used tobacco in a while (or when you tried to stop using), did you find it hard to CONCENTRATE because you couldn't vape or use tobacco?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
When you HAVEN'T vaped or used tobacco in a while (or when you tried to stop using), did you feel more IRRITABLE because you couldn't vape or use tobacco?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
When you HAVEN'T vaped or used tobacco in a while (or when you tried to stop using), did you feel a strong NEED or urge to vape or use tobacco?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
When you HAVEN'T vaped or used tobacco in a while (or when you tried to stop using), did you feel NERVOUS, restless, or anxious because you couldn't vape or use tobacco?	Branches from answer of "1" (or more) on question 4.	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Score indicates patient is at a lower risk of health and other problems related to their current pattern of use. Provide positive reinforcement and follow up at next appointment.	Branches from answer of "0" on questions 1, 2, 3, and 4 AND answer of "No" on question "CAR"	Explanation	Text		No	

Score indicates patient is at a medium risk of health and other problems related to their current pattern of use, but risk counseling is needed for riding/driving. Provide brief intervention (education). Complete the plan of action form on the next page.	Branches from answer of "0" on questions 1, 2, 3, and 4 AND answer of "Yes" on question "CAR"	Explanation	Text		No	
Score indicates patient is at a medium risk of health and other problems related to their current pattern of use. Provide brief intervention (education on the adverse health effects of substance use and a clear recommendation to stop). Complete the plan of action form on the next page.	Branches from answer of "1" (or more) on questions 1, 2, or 3 AND answer of "No" to questions "CAR," "RELAX," "ALONE," "FORGET/FRIENDS," and "TROUBLE"	Explanation	Text		No	
Score indicates patient is at a medium risk of health and other problems related to their current pattern of use. Provide brief intervention (education on the adverse health effects of substance use and a clear recommendation to stop). Complete the plan of action form on the next page.	Branches from answer of "1" (or more) on questions 1, 2, or 3 AND answer of "Yes" to only one of questions "CAR," "RELAX," "ALONE," "FORGET/FRIENDS," and "TROUBLE"	Explanation	Text		No	

Score indicates patient is at a high risk of health and other problems related to their current pattern of use. Provide brief intervention and referral for further assessment. Complete the plan of action form on the next page.	Branches from answer of "1" (or more) on questions 1, 2, or 3 AND answer of "Yes" to two (or more) of questions "CAR," "RELAX," "ALONE," "FORGET/FRIENDS," and "TROUBLE"	Explanation	Text		No	
Score indicates patient is at a medium risk of health and other problems related to their current pattern of use. Provide brief intervention (education on the adverse health effects of substance use and a clear recommendation to stop). Complete the plan of action form on the next page.	Branches from answer of "1" (or more) on question 4 AND answer of "No" to "QUIT," "NOW," "ADDICTED," "CRAVINGS," "NEEDED," "PLACES," "CONCENTRATE," "IRRITABLE," "NEED," and "NERVOUS."	Explanation	Text		No	
Score indicates patient is at a high risk of health and other problems related to their current pattern of use. Provide brief intervention and referral for further assessment. Complete the plan of action form on the next page.	Branches from answer of "1" (or more) on question 4 AND answer of "Yes" to "QUIT," "NOW," "ADDICTED," "CRAVINGS," "NEEDED," "PLACES," "CONCENTRATE," "IRRITABLE," "NEED," or "NERVOUS."	Explanation	Text		No	

Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	
Was a brief intevention provided?	Branches from answer of "1" (or more) on questions 1, 2, 3, or 4, OR answer of "Yes" on question "CAR"	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What brief intervention was provided?	Answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	
Please specify other intervention type:	Answer of "Other" to "What brief intervention was provided?"	Text	Text		No	

Why was a brief intervention not provided?	Branches from answer of "No" to "Was a brief intervention provided?"	Text	Text		No	
Was a referral provided?	Branches from answer of "1" (or more) on questions 1, 2, or 3 AND answer of "Yes" to two (or more) of questions "CAR," "RELAX," "ALONE," "FORGET/FRIENDS," and "TROUBLE"	Drop-down list (single choice)	Text	1,Yes|0,No	No	
Was a referral provided?	Branches from answer of "1" (or more) on question 4 AND answer of "Yes" to "QUIT," "NOW," "ADDICTED," "CRAVINGS," "NEEDED," "PLACES," "CONCENTRATE," "IRRITABLE," "NEED," or "NERVOUS."	Drop-down list (single choice)	Text	1,Yes|0,No	No	

What provider type was the patient referred to?	Branches from answer of "Yes" to "Was a referral provided?"	Drop-down list (multiple choice)	Text	1,Beacon Health Options |2, Substance Use Treatment Provider|3,Internal Mental Health Provider|4,External Mental Health Provider - CMHC|5, External Mental Health Provider - Private Practice|6, MCO/MCO Care Coordinator|7,Community-Based Support Group|8,Primary Care Provider |9,Other	No	
Please specify other provider type:	Branches from answer of "9,Other" to "What provider type was patient referred to?"	Text	Text		No	
Why was a referral not provided?	Branches from answer of "No" to "Was a referral provided?"	Text	Text		No	
Was the patient in crisis?		Drop-down list (single choice)	Text	1,Yes|0,No	No	
What action was taken? (brief summary)	Branches from answer of "Yes" to "Was the patient in crisis?"	Text	Text		No	

GAD-7

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which Caregiver Was Involved?		Drop-down list (single choice)	Dynamic Caregiver		Yes	
Date of Activity	Date family received services documented on this form	Date	Dynamic Date		Yes	Tracking
Program		Drop Down (Single Select)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	
Over the last 2 weeks, how often have you been bothered by the following problems? (enter 0 if none)		Explanation	Text		No	
Feeling nervous, anxious or on edge		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Not being able to stop or control worrying		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Worrying too much about different things		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Trouble relaxing		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	

Being so restless that it is hard to sit still		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Becoming easily annoyed or irritable		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Feeling afraid as if something awful might happen		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Total Score		Calculated	Numeric	q1+q2+q3….q7	No	
Score indicates patient is at a low risk of experiencing anxiety. Provide positive reinforcement and follow up at next appointment.	GAD-7 score of 0, 1, 2, 3, or 4	Explanation	Text		No	
Score indicates patient could be experiencing mild symptoms of anxiety. Provide brief intervention (support, resources, available treatment options). Complete the plan of action form on the next page.	GAD-7 score of 5, 6, 7, 8, or 9	Explanation	Text		No	
Score indicates patient could be experiencing moderate symptoms of anxiety. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	GAD-7 score of 10, 11, 12, 13, or 14	Explanation	Text		No	
Score indicates patient could be experiencing severe symptoms of anxiety. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	GAD-7 score of 15, 16, 17, 18, 19, 20, or 21	Explanation	Text		No	

Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	
Was a brief intervention provided?	GAD-7 score of 5 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What brief intervention was provided?	Answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	
Please specify other intervention type:	Answer of "Other" to "What brief intervention was provided?"	Text	Text		No	
Why was a brief intervention not provided?	Answer of "No" to "Was a brief intervention	Text	Text		No	
Was a referral provided?	GAD-7 score of 10 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	

What provider type was the patient referred to?	Answer of "Yes" to "Was a referral provided?"	Drop-down list (multiple choice)	Text	1,Internal Mental Health Provider|2,External Mental Health Provider - CMHC|3,External Mental Health Provider - Private Practice|4,Primary Care Provider|5,OB/GYN|6,MCO/MCO Care Coordinator|7,Community-Based Support Group|8,Other	No	
Please specify other provider type:	Answer of "8,Other" to "What provider type was patient referred to?"	Text	Text		No	
Why was a referral not provided?	Answer of "No" to "Was a referral provided?"	Text	Text		No	
Was the patient in crisis?		Drop-down list (single choice)	Text	1,Yes|0,No	No	
What action was taken? (brief summary)	Answer of "Yes" to "Was the patient in crisis?"	Text	Text		No	

PHQ-9

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which Caregiver Was Involved?		Drop-down list (single choice)	Dynamic Caregiver		Yes	
Date of Activity	Date family received services documented on this form	Date	Dynamic Date		Yes	Tracking
Program		Drop Down (Single Select)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	
Over the past 2 weeks, how often have you been bothered by any of the following problems?		Explanation	Text		No	
Little interest or pleasure in doing things		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
feeling down, depressed or hopeless		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Trouble falling asleep, staying asleep, or sleeping too much		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Feeling tired or having little energy		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	

Poor appetite or overeating		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Feeling bad about yourself - or that you're a failure or have let y ourself or your family down		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Trouble concentrating on things, such as reading the newspaper or watching television		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Thoughts that you would be better off dead or of hurting yourself in some way		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?		Drop-down list (single choice)	Text	0,Not difficult at all|1,Somewhat difficult|2,Very difficult|3,Extremely difficult	No	
Total Score		Calculated	Numeric	q8301+q8302+q8303+q8304+q8305+q8306+q8307+q8308+q8309+q8310	No	
Score indicates patient is at a low risk of experiencing depression. Provide positive reinforcement and follow up at next appointment.	PHQ-9 score of 0, 1, 2, 3, or 4	Explanation	Text		No	

Score indicates patient could be experiencing mild symptoms of depression. Provide brief intervention (support, resources, available treatment options). Complete the plan of action form on the next page.	PHQ-9 score of 5, 6, 7, 8, or 9	Explanation	Text		No	
Score indicates patient could be experiencing moderate symptoms of depression. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PHQ-9 score of 10, 11, 12, 13, or 14	Explanation	Text		No	
Score indicates patient could be experiencing moderately severe symptoms of depression. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PHQ-9 score of 15, 16, 17, 18, or 19	Explanation	Text		No	
Score indicates patient could be experiencing severe symptoms of depression. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PHQ-9 score of 20 or higher	Explanation	Text		No	

Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	
Was a brief intervention provided?	PHQ-9 score of 5 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What brief intervention was provided?	Answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	
Please specify other intervention type:	Answer of "Other" to "What brief intervention was provided?"	Text	Text		No	
Why was a brief intervention not provided?	Answer of "No" to "Was a brief intervention provided?"	Text	Text		No	
Was a referral provided?	PHQ-9 score of 10 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	

What provider type was the patient referred to?	Answer of "Yes" to "Was a referral provided?"	Drop-down list (multiple choice)	Text	1,Internal Mental Health Provider|2,External Mental Health Provider - CMHC|3,External Mental Health Provider - Private Practice|4,Primary Care Provider|5,OB/GYN|6,MCO/MCO Care Coordinator|7,Community-Based Support Group|8,Other	No	
Please specify other provider type:	Answer of "8,Other" to "What provider type was patient referred to?"	Text	Text		No	
Why was a referral not provided?	Answer of "No" to "Was a referral provided?"	Text	Text		No	
Was the patient in crisis?	NA	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What action was taken? (brief summary)	Answer of "Yes" to "Was the patient in crisis?"	Text	Text		No	

PHQ-A

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which Caregiver Was Involved?		Drop-down list (single choice)	Dynamic Caregiver		Yes	
Date of Activity	Date family received services documented on this form	Date	Dynamic Date		Yes	Tracking
Program		Drop Down (Single Select)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	
Over the last 2 weeks, how often have you been bothered by any of the following		Explanation	Text		No	
Little interest or pleasure in doing things?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Feeling down, depressed, or hopeless?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Trouble falling or staying asleep, or sleeping too much?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Feeling tired or having little energy?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	

Poor appetite or overeating?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Feeling bad about yourself—or that you are a failure or have let yourself or your family down?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Trouble concentrating on things, such as reading the newspaper or watching television?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Thoughts that you would be better off dead or of hurting yourself in some way?		Drop-down list (single choice)	Text	0,Not at all|1,Several Days|2,More than Half Days|3,Nearly Every Day	No	
Total Score		Calculated	Numeric	q8276+q8277+q8278+q8279+q8280+q8281+q8282+q8283+q8284	No	
Score indicates patient is at a low risk of experiencing depression. Provide positive reinforcement and follow up at next appointment.	PHQ-A score of 0, 1, 2, 3, or 4	Explanation	Text		No	
Score indicates patient could be experiencing mild symptoms of depression. Provide brief intervention (support, resources, available treatment options). Complete the plan of action form on the next page.	PHQ-A score of 5, 6, 7, 8, or 9	Explanation	Text		No	

Score indicates patient could be experiencing moderate symptoms of depression. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PHQ-A score of 10, 11, 12, 13, or 14	Explanation	Text		No	
Score indicates patient could be experiencing moderately severe symptoms of depression. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PHQ-A score of 15, 16, 17, 18, or 19	Explanation	Text		No	
Score indicates patient could be experiencing severe symptoms of depression. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PHQ-A score of 20, 21, 22, 23, 24, 25, 26, or 27	Explanation	Text		No	
Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	
Was a brief intervention provided?	PHQ-A score of 5 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	

What brief intervention was provided?	Answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	
Please specify other intervention type:	Answer of "Other" to "What brief intervention was provided?"	Text	Text		No	
Why was a brief intervention not provided?	Answer of "No" to "Was a brief intervention provided?"	Text	Text		No	
Was a referral provided?	PHQ-A score of 10 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What provider type was the patient referred to?	Answer of "Yes" to "Was a referral provided?"	Drop-down list (multiple choice)	Text	1,Internal Mental Health Provider|2,External Mental Health Provider - CMHC|3,External Mental Health Provider - Private Practice|4,Primary Care Provider|5,MCO/MCO Care Coordinator|6,Community-Based Support Group|7,Other	No	
Please specify other provider type:	Answer of "7,Other" to "What provider type was patient referred to?"	Text	Text		No	

Why was a referral not provided?	Answer of "No" to "Was a referral provided?"	Text	Text		No	
Was the patient in crisis?	NA	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What action was taken? (brief summary)	Answer of "Yes" to "Was the patient in crisis?"	Text	Text		No	

PSC-17 Caregiver

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which Caregiver Was Involved?		Drop-down list (single choice)	Dynamic Caregiver		Yes	
Date of Activity	Date family received services documented on this form	Date	Dynamic Date		Yes	Tracking
Program		Drop Down (Single Select)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	
Please mark under the heading that best describes your child:		Explanation	Text		No	
Feels sad, unhappy		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Feels hopeless		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Is down on self		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Worries a lot		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	

Seems to be having less fun		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Fidgety, unable to sit still		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Daydreams too much		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Distracted easily		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Has trouble concentrating		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Acts as if driven by a motor		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Fights with other children		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Does not listen to rules		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Does not understand other people's feelings		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Teases others		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Blames others for his/her troubles		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Refuses to share		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	

Takes things that do not belong to him/her		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Does your child have any emotional or behavioral problems for which she/he needs help?		Drop-down list (single choice)	Text	1,Yes|0,No	No	
Total Score		Calculated	Numeric	q8254+q8255+q8256+q8257+q8258+q8259+q8260+q8261+q8262+q8263+q8264+q8265+q8266+q8267+q8268+q8269+q8270+q8271	No	
Score indicates patient is at a low or moderate risk of experiencing emotional and behavioral concerns. Provide positive reinforcement and follow up at next appointment.	PSC-17 score of 0-14	Explanation	Text		No	
Score indicates patient os at risk of experiencing emotional and behavioral concerns.Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PSC-17 score of 15+	Explanation	Text		No	
Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	

Was a brief intevention provided?	PSC-17 score of 15+	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What brief intervention was provided?	Answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	
Please specify other intervention type:	Answer of "Other" to "What brief intervention was provided?"	Text	Text		No	
Why was a brief intervention not provided?	Answer of "No" to "Was a brief intervention provided?"	Text	Text		No	
Was a referral provided?	PSC-17 score of 15 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What provider type was the patient referred to?	Answer of "Yes" to "Was a referral provided?"	Drop-down list (multiple choice)	Text	1,Internal Mental Health Provider|2,External Mental Health Provider - CMHC|3,External Mental Health Provider - Private Practice|4,Primary Care Provider|5,MCO/MCO Care Coordinator|6,Community-Based Support Group|7,Other	No	

Please specify other provider type:	Answer of "7,Other" to "What provider type was patient referred to?"	Text	Text		No	
Why was a referral not provided?	Answer of "No" to "Was a referral provided?"	Text	Text		No	
Was the patient in crisis?	NA	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What action was taken? (brief summary)	Answer of "Yes" to "Was the patient in crisis?"	Text	Text		No	

PSC-17 Child

Question Label	Description/Definition	Data Type	Response Format	Response Options	System Required?	Purpose of Question/Element
Which Child Was Involved?		Drop-down list (single choice)	Dynamic Child		Yes	
Date of Activity	Date family received services documented on this form	Date	Dynamic Date		Yes	Tracking
Program		Drop Down (Single Select)	Text	Becoming a Mom|Family Planning|Maternal Child Health (MCH/M&I)|Pregnancy Maintenance (PMI)|Teen Pregnancy (TPTCM)|Kansas Connecting Communities	Yes	
Please mark under the heading that best fits you:		Explanation	Text	0,Never|1,Sometimes|2,Often	No	
Fidgety, unable to sit still		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Feel sad, unhappy		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Daydream too much		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Refuse to share		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Do not understand other people's feelings		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	

Feel hopeless		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Have trouble concentrating		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Fight with other children		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Down on yourself		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Blame others for your troubles		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Seem to be having less fun		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Do not listen to rules		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Act as if driven by a motor		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Tease others		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Worry a lot		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Take things that do not belong to you		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	
Distract easily		Drop-down list (single choice)	Text	0,Never|1,Sometimes|2,Often	No	

Total Score		Calculated	Numeric	q8225+q8226+q8227+q8228+q8229+q8230+q8231+q8232+q8233+q8234+q8235+q8236+q8237+q8238+q8239+q8240+q8241	No	
Score indicates patient is at a low or moderate risk of experiencing emotional and behavioral concerns. Provide positive reinforcement and follow up at next appointment.	PSC-17 score of 0-14	Explanation	Text		No	
Score indicates patient os at risk of experiencing emotional and behavioral concerns.Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.	PSC-17 score of 15+	Explanation	Text		No	
Programs Providing Follow-up: (select all that apply)	Please list any additonal programs who provided follow-up services to this client based on their Edinburgh score	Drop-down list (multi select)	Text	1,Becoming a Mom|2,Family Planning|3,Maternal Child Health (MCH/M&I)|4,Pregnancy Maintenance Initiative (PMI)|5,Teen Pregnancy Targeted Case Management (TPTCM)|6,Kansas Connecting Communities (KCC)	No	
Was a brief intevention provided?	PSC-17 score of 15+	Drop-down list (single choice)	Text	1,Yes|0,No	No	

What brief intervention was provided?	Answer of "Yes" to "Was a brief intervention provided?"	Drop-down list (multi select)	Text	1,Reviewed screening results|2,Made clinical recommendations|3,Provided education, community, and/or treatment resources|4,Measured patient motivation and/or readiness to change|5,Reinforced self-efficacy|6,Other	No	
Please specify other intervention type:	Answer of "Other" to "What brief intervention was provided?"	Text	Text		No	
Why was a brief intervention not provided?	Answer of "No" to "Was a brief intervention provided?"	Text	Text		No	
Was a referral provided?	PSC-17 score of 15 or higher	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What provider type was the patient referred to?	Answer of "Yes" to "Was a referral provided?"	Drop-down list (multiple choice)	Text	1,Internal Mental Health Provider|2,External Mental Health Provider - CMHC|3,External Mental Health Provider - Private Practice|4,Primary Care Provider|5,MCO/MCO Care Coordinator|6,Community-Based Support Group|7,Other	No	
Please specify other provider type:	Answer of "7,Other" to "What provider type was patient referred to?"	Text	Text		No	

Why was a referral not provided?	Answer of "No" to "Was a referral provided?"	Text	Text		No	
Was the patient in crisis?	NA	Drop-down list (single choice)	Text	1,Yes|0,No	No	
What action was taken? (brief summary)	Answer of "Yes" to "Was the patient in crisis?"	Text	Text		No	