



## Consent to Participate in the First 5 San Mateo County Evaluation

I agree to share my answers on this interview with First 5 San Mateo County (F5SMC), its evaluators (SRI International), and the program I am working with today < \_\_\_\_\_ >.  
*Enter Program Name*

This information will help F5SMC learn about the families they serve. I understand that:

- This interview asks for my name, my children's names, our birthdays, zip code, ethnicity, and language spoken.
- It also asks about my child's health, our family's well-being, and services we have received.
- I will be asked to complete this interview at the beginning and end of this program, or every six months.
- The interview should take 15 to 20 minutes to complete.
- I can skip any question that I do not want to answer.
- If my children got developmental screenings, the results will be shared with F5SMC and its evaluators.
- Only a few F5SMC staff and its evaluators will be able to see my answers, and reports will not include my private information.
- Program staff from < \_\_\_\_\_ > are not allowed to share my private information with anyone, unless they think I, or my child, is in danger.
- There are no known risks to completing this interview. My answers might help to improve services for families in San Mateo County.
- It is very important to F5SMC that my information is safe, so it will be protected as required by law.
- If I do not complete this interview, my family can still receive services from this program.
- My consent to share my answers will end 10 years from today. I can always change my mind and have my information erased. To do this I send a written request to: **Jenifer Clark, First 5 San Mateo County, 1700 S. El Camino Real, Suite 405, San Mateo, CA 94402.**
- I can ask for a copy of this page to take home with me.

**I consent to complete this interview and share my information.**

Please print your name, sign and date below, and begin interview on next page

\_\_\_\_\_  
Parent/Guardian's **printed name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
Date Signed

## Intake Interview

IMPORTANT: Please use a BLACK pen. Mark responses boxes with an "X." Use block printing for any text or numeric responses. If you wish to change a response, mark the correct response and CIRCLE it.

Today's Date (MM/DD/YYYY):   /   /

Participant's ID (if applicable)

<b>Name of Parent/Caregiver:</b>			
Last	First	Middle	
<b>Date of Birth</b> (MM/DD/YYYY):	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Home Zip Code:</b>	<b>Prenatal Participant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Primary Language:</b> (Mark one only.)			
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other			
<b>Race/Ethnicity:</b> (Mark all that apply.)			
<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Alaska Native or American Indian <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Other			

<b>Name of Child 1 (age 0–5)</b> —Child who will benefit from services or whose birthday is coming up next			
Last	First	Middle	
<b>Date of Birth</b> (MM/DD/YYYY):	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Home Zip Code:</b>	
<b>Child's Primary Language:</b> (Mark one only.)			
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other			
<b>Child's Race/Ethnicity:</b> (Mark all that apply.)			
<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Alaska Native or American Indian <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Other:			

### This section is to be completed by the service provider.

**Date of most recent ASQ administration:** (MM/DD/YYYY) \_\_\_ / \_\_\_ / \_\_\_\_\_

**Interval of ASQ:** (Mark one only.)

- |                                    |                                    |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> 2 months  | <input type="checkbox"/> 4 months  | <input type="checkbox"/> 6 months  | <input type="checkbox"/> 8 months  | <input type="checkbox"/> 9 months  |
| <input type="checkbox"/> 10 months | <input type="checkbox"/> 12 months | <input type="checkbox"/> 14 months | <input type="checkbox"/> 16 months | <input type="checkbox"/> 18 months |
| <input type="checkbox"/> 20 months | <input type="checkbox"/> 22 months | <input type="checkbox"/> 24 months | <input type="checkbox"/> 27 months | <input type="checkbox"/> 30 months |
| <input type="checkbox"/> 33 months | <input type="checkbox"/> 36 months | <input type="checkbox"/> 42 months | <input type="checkbox"/> 48 months | <input type="checkbox"/> 54 months |
| <input type="checkbox"/> 60 months | <input type="checkbox"/> Unknown   |                                    |                                    |                                    |

**ASQ Subscale Scores:**

Communication:      Gross Motor:      Fine Motor:      Problem-solving:      Personal-social:

**Date of most recent ASQ:SE administration:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**Interval of ASQ:SE:** (Mark one only.)

- |                                    |                                    |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> 6 months  | <input type="checkbox"/> 12 months | <input type="checkbox"/> 18 months | <input type="checkbox"/> 24 months | <input type="checkbox"/> 30 months |
| <input type="checkbox"/> 36 months | <input type="checkbox"/> 48 months | <input type="checkbox"/> 60 months | <input type="checkbox"/> Unknown   |                                    |

**ASQ:SE Total Score:**

**This section is to be completed by the service provider soon after completion of the Intake Interview.**

**Family Concerns:** Families have unique strengths and challenges. In your work with this family to date, which of the following concerns or service needs have you identified for the family? (*Mark all that apply.*)

<input type="checkbox"/> Dental services	<input type="checkbox"/> Nutrition / food assistance
<input type="checkbox"/> Developmental concern - Adaptive	<input type="checkbox"/> Parent education / family literacy
<input type="checkbox"/> Developmental concern - Cognitive	<input type="checkbox"/> Recreation / fitness
<input type="checkbox"/> Developmental concern - Communication	<input type="checkbox"/> Substance use / abuse
<input type="checkbox"/> Developmental concern - Physical	<input type="checkbox"/> Transportation
<input type="checkbox"/> Developmental concern -Social or emotional	<input type="checkbox"/> Vocational / educational
<input type="checkbox"/> Developmental concern - Other(specify): _____	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Early care and education / child care	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Family planning / prenatal care	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Family support (social worker / care coordinator)	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Family violence support	
<input type="checkbox"/> Health insurance	
<input type="checkbox"/> Health / medical services	
<input type="checkbox"/> Housing assistance	
<input type="checkbox"/> Legal assistance	
<input type="checkbox"/> Mental health services	

DRAFT

**This section is to be completed by the service provider while interviewing the parent/caregiver.**

To answer the questions below, think about your child <Child 1: \_\_\_\_\_> who will benefit from this program's services. If more than one child will benefit, think about your child age 0-5 whose birthday is coming up next.

1. **Please ask only biological mother:** How many months pregnant were you when you first saw a doctor? (Mark one only.)

- 0-4 months pregnant
- More than 4 months pregnant
- I did not see a doctor during this pregnancy
- Don't know/Declined/Not applicable

2. **Please ask only biological mother:** Did you ever breastfeed your child <Child 1: \_\_\_\_\_>? (Mark one only.)

- Yes
- No →(Skip to Question 3)
- Declined/Not applicable →(Skip to Question 3)

2a. **If yes,** how old was your child <Child 1: \_\_\_\_\_> when breastfeeding ended?

- \_\_\_ Number of months when ended
- Still breastfeeding
  - Don't know/Declined/Not applicable

3. What type of health insurance does your child <Child 1: \_\_\_\_\_> have now? (Mark all that apply.)

- Uninsured
- Insurance purchased directly by parent/guardian (including COBRA)
- Insurance provided by employer
- Medi-Cal (full scope or emergency)
- Healthy Families
- Healthy Kids/California Kids/ or similar program
- Application pending (please specify type): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_
- Don't know/Declined

4. How many times last year did your child <Child 1: \_\_\_\_\_> see a doctor for a "well-child" check-up? A well-child check-up is a general check-up when your child is not sick or hurt. (Mark one only.)

- 0 times
- 1 time
- 2-3 times
- 4-5 times
- 6 times or more
- Don't know/Declined

5. **Please ask only for child over 12 months of age:** When did your child <Child 1: \_\_\_\_\_> last see a dentist for a routine check-up? (Mark one only.)

- Not applicable - Child under 12 months of age
- Less than a year ago
- Between 1 to 2 years ago
- 2 years ago or more
- Never
- Don't know/Declined

6. **Please ask only for child age 3-5:** Since your child <Child 1: \_\_\_\_\_> turned 3, has he or she ever gone to preschool regularly? Preschool could be Head Start, pre-kindergarten, or a child care center. By regularly, we mean at least two times a week and for at least 6 months. (Mark one only.)

- Not Applicable (Child under 3 years of age)
- Recently enrolled (Regularly attended less than 6 months.)
- Yes (Regularly attended 6 months or more.)
- No (Has never attended regularly.)
- Don't know/Declined

7: In a usual week, how often does your family do these things with your child <Child 1: \_\_\_\_\_>? (Mark one only for each row.)

	Not at All	1 to 2 Days	3 to 4 Days	5 to 6 Days	Every Day	Don't Know / Declined
a) Read stories or look at picture books?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Play music or sing songs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How much does your child <Child 1: \_\_\_\_\_> watch TV or play videos or computer games in a day? (Mark one only.)

- Not at all
- Less than 1 hour a day
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours
- Don't know/Declined

9. Sometimes parents have concerns about how their child is developing. For these next questions, rate your level of concern for your child <Child 1: \_\_\_\_\_> as: Not Concerned, Concerned, A Little Concerned.<sup>1</sup> (Mark one only for each row.)

	Are you...?		
	Not Concerned	Concerned	A Little Concerned
a) Do you have any concerns about how your child is behind others or can't do what other kids can?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you have any concerns about how your child talks and makes speech sounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Do you have any concerns about how your child understands what you say?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Do you have any concerns about how your child uses his or her hands and fingers to do things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Do you have any concerns about how your child uses his or her arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Do you have any concerns about how your child behaves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Do you have any concerns about how your child gets along with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Do you have any concerns about how your child is learning to do things for himself or herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Do you have any concerns about how your child is learning preschool or school skills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Do you have any concerns about how your child sees or hears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>1</sup> The items in question 9 are drawn from the survey edition of Parents' Evaluation of Developmental Status (PEDS) and do not have immediate clinical application. Users interested in early detection will need to purchase the actual test ([www.pedstest.com](http://www.pedstest.com)). The survey version items are copyrighted and may not be used without express permission from the author ([Frances.P.Glascoe@Vanderbilt.edu](mailto:Frances.P.Glascoe@Vanderbilt.edu)).

10. Has a doctor or other professional ever told you that your child <Child 1: \_\_\_\_\_> has a developmental delay or disability?

- No
- Yes
- Don't know/Declined*

10b. Does your child have an IFSP (Individual Family Service Plan) or IEP?

- No
- Yes
- In progress
- Don't know/Declined

11. In the last 6 months, has anyone referred your child <Child 1: \_\_\_\_\_> or family to these services?

Services	Referred for services?	If yes, did you receive services?	If no, Why?
a. Dental services (only if child is over 1 year of age)	<input type="checkbox"/> NA – Child under 1 <input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other
b. Basic needs (e.g. emergency shelter, food, clothing)	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other
c. Developmental service (e.g., speech, language, hearing, occupational or physical therapy)	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other
d. Child care or preschool	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other
e. Medical, surgical, or specialty health services	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other
f. Child mental/behavioral health services (e.g., behaviorist, psychologist, psychiatrist)	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other

g. Adult mental/behavioral health services (e.g., family therapist, psychologist, psychiatrist)	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could fit my needs <input type="checkbox"/> Other
h. Substance use/abuse treatment services for a family member	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other
i. Any other services for your child or family (specify; e.g., legal services)	<input type="checkbox"/> No <input type="checkbox"/> Yes; <b>If yes</b> , answer if you received the service. →	<input type="checkbox"/> Yes <input type="checkbox"/> No; <b>If no</b> , answer the main reason services were not received. →	<input type="checkbox"/> Not interested <input type="checkbox"/> On waiting list <input type="checkbox"/> Could not find provider who could meet my needs <input type="checkbox"/> Other

12. How many family members live with you?

Number of **young** children **age 0-5**:  0  1  2  3  4  5 or more

Number of children **age 6-18**:  0  1  2  3  4  5 or more

Number of adults (including yourself):  1  2  3  4  5 or more

13. Which is closest to your family's total income last year? (*Mark one only.*)

- \$10,000 or less
- \$10,001 – \$20,000
- \$20,001 – \$30,000
- \$30,001 – \$40,000
- \$40,001 – \$50,000
- \$50,001 – \$60,000
- \$60,001 – \$70,000
- \$70,001 – \$80,000
- \$80,001 – and above
- Don't know/Declined*

14. What is the highest grade or year of school that you completed? (*Mark one only.*)

- No formal schooling
- Less than 9<sup>th</sup> grade
- Some high school
- High school diploma/GED
- Some college or technical school
- Associate or technical degree
- Bachelor's degree
- Graduate or professional degree (e.g, MA, PhD, JD, MD)
- Don't know/Declined*

**NOTE TO SERVICE PROVIDERS: Service providers can choose to either read Question 15 (a-n) to parent in an interview format and complete for parent, or ask parent to complete these items on their own. The service provider should be available to answer any questions the parent may have.**

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15. Please read each item below carefully. Then rate how often the statements are true for you, from "Almost Always" to "Never." If you do not want to answer a question, leave it blank. (Mark (X) one for each row.)

	Always	Most of the time	Sometimes	Hardly ever	Never
a) I know how to keep my child healthy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I know how to guide my child's behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I know how to meet my child's needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I know what my child should be able to do at this age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I can get the services my family needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I follow regular schedules and routines for my child (e.g., bed times, meal times).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I know how to help my child learn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I know how to be a good parent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I have enough food to feed my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I have friends and family to turn to for support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I am worried about our housing (e.g., needs fixing, too crowded, too expensive).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) I worry that someone in my close family has a drug or alcohol problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I feel like I need help with my sadness or depression.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Someone in my life makes me feel threatened or unsafe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>