DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01118 (01/2024)

STATE OF WISCONSIN

FORWARDHEALTH
CHILD CARE COORDINATION
FAMILY QUESTIONNAIRE

INSTRUCTIONS: Type or print clearly. Refer to the Family Questionnaire Instructions, F-01118A. Refer to the key at the end of the form for symbol descriptions. Elements in **bold** indicate initial screen questions.

SECTION I – GENERAL INFORMATION

1. Name – Mother (Last, First, Middle Initial)	2. Address – Mother (Street, City, State, and Zip Code)
3. Date of Birth – Mother	**4. Age – Mother** < 18 years = **(70)** 18–20 years = **(15)**
5. Member ID – Child	6. Phone Number – Home ❑ No phone or phone is often disconnected = **(15)**
7. How can we contact you?	
8. Are other agency staff visiting your home? ❑ Yes ❑ No If yes, list if known.	
9. Name – Infant	10. Gender – Infant ❑ Female ❑ Male
11. Birth Weight If very low birth weight < 3.3 lbs. (1500 grams) = **(70)** If low birth weight < 5.5 lbs. (2500 grams) = **(30)** If birth weight > 10 lbs. (4540 grams) = **(10)**	**12. Date of Birth** If pre-term (gestational age < 37 weeks) = **(70)**
13. Name – HMO	14. Name – Primary Care Doctor / Clinic If none or unable to answer = **(10)**

SECTION II – EMPLOYMENT

1. Are you employed? ❑ No ❑ Yes If yes, what is your occupation?	2. If you are employed, how many hours do you usually work in a week?
3. What shift? (Days, Evenings, Nights)	4. Do you feel your child care arrangements are safe and nurturing? ❑ No = **(15)** ❑ Yes

Reset Page 1 Only

Points (Subtotal) _____

5. If returning to work or school, when will you go back?

6. What was the last grade you finished?

Eighth grade or less = **(40)**
> Eighth grade but < 12th grade = **(15)**

7. What are your sources of income? (Check all that apply.)

- ❑ Parents
- ❑ Job
- ❑ Partner / Spouse
- ❑ Unemployment Benefits
- ❑ Child Support Payments
- ❑ Other _____

SECTION III – FAMILY FUNCTIONING

1. Are you married or single?

- ❑ Married
- ❑ Single (Includes Never Married, Separated, Divorced, Widowed)

2. Do you speak English?

- ❑ Very Well
- ❑ A Little = **(10)**
- ❑ Not at All = **(15)**

3. Do you read English?

- ❑ Very Well
- ❑ A Little = **(10)**
- ❑ Not at All = **(15)**

4. If you are of school age now, are you enrolled and do you attend school regularly?

- ❑ No = **(10)**
- ❑ Yes
- ❑ I am working on my GED certificate or have completed it
- ❑ I have dropped out = **(10)**

5. Have you received or are you currently receiving special or exceptional education services?

- ❑ No
- ❑ Yes = **(10)**

6. How many children do you have?

If first child = **(10)**
If > four children = **(40)**
If > two children and mother is < 18 = **(40)**

7. Within the last 12 months, have any of your children been taken away from you?

- ❑ No
- ❑ Yes = **(40)**
  If yes, how many? _____

8. Where do you live?

- ❑ House
- ❑ Apartment
- ❑ Mobile Home
- ❑ With Friends = **(10)**
- ❑ With Other Family Members = **(10)**
- ❑ Homeless (Including Shelter, Hotel, or Motel) = **(70)**
- ❑ Other (Specify) _____

Points (Subtotal) _____

Reset Page 2 Only

9. Who is currently living in your home? (Name, Age, Relationship)

10. Where you live now, do you have the following?

Running Water?	❑ Yes	❑ No
Hot Water?	❑ Yes	❑ No
Working Appliances (Stove, Refrigerator)?	❑ Yes	❑ No
Working Bathroom / Bathing Facilities?	❑ Yes	❑ No
Working Smoke Detector?	❑ Yes	❑ No
Working Fire Extinguisher?	❑ Yes	❑ No

Each "No" = **(5)** Total Points: _____

11. Is there chipping paint inside / outside your home?

❑ No
❑ Yes = **(10)**

12. How many times have you moved in the last year?

> 2 times = **(20)**

13. Do you think you will need to move in the next 12 months?

❑ No
❑ Yes

14. How long have you been living in the present neighborhood?

15. What do you think of your neighborhood?

❑ It is a good place to live.
❑ It is an okay place to live.
❑ It is a bad place to live.

16. What is the best thing about your neighborhood?

17. What is the worst thing about your neighborhood?

18. In the past two years, your neighborhood has become:

❑ A better place to live
❑ Stayed the same
❑ A bad place to live

19. Do your children have a safe play area both inside and outside the home?

❑ No = **(5)**
❑ Yes

20. If not at home, where else can they play? (Check all that apply.)

❑ At Relatives'	❑ Nowhere = **(15)**
❑ Park	❑ School Playground
❑ Community Center	❑ Other: _____

21. Have you witnessed acts of violence in your neighborhood? (If so, describe these acts and the impressions they had on you.)

Reset Page 3 Only

Points (Subtotal) _____

22. Does your family own a vehicle?

- ❑ No
- ❑ Yes

23. If yes, what is the condition of the vehicle?

- ❑ Good
- ❑ Average
- ❑ Below Average

24. If you do not have a vehicle, how do you get around?

- ❑ Get a ride from friends / relatives
- ❑ Use public transportation
- ❑ Walk
- ❑ Other _____

25. How often do you have transportation to get where you need to go?

- ❑ Always
- ❑ Occasionally
- ❑ Rarely or Never = **(10)**

26. If you use a vehicle, does everyone use car seats or seat belts?

- ❑ Always
- ❑ Sometimes
- ❑ Never = **(5)**

Explain:

SECTION IV – HEALTH

1. Where do you go for your regular health care (for example, checkups, shots)?

- ❑ Family Doctor / Primary Care Provider / Clinic
- ❑ Emergency Room
- ❑ Other

2. Have any of your children been hospitalized in the past six months?

- ❑ No
- ❑ Yes = **(10)**

If yes, for what type of medical concerns?

3. Have your children between 6 months and 6 years of age been tested for lead poisoning?

- ❑ No = **(5)**
- ❑ Yes
- ❑ Don't Know = **(5)**
- ❑ Not Applicable (Skip to Element 6)

4. If yes, have you received the results?

- ❑ No = **(5)**
- ❑ Yes

Points (Subtotal) _____

Reset Page 4 Only

5. If the results require follow-up, has this occurred?

- ❑ No = **(5)**
- ❑ Yes

6. Do you have a record of your child's immunizations?

- ❑ No = **(5)**
- ❑ Yes

7. If your child(ren) are 3 years or older, are they seeing a dentist?

- ❑ No = **(5)**
- ❑ Yes
- ❑ Not Applicable

8. How many months pregnant were you when you started seeing a medical provider (doctor, nurse practitioner, nurse midwife) for prenatal care?

_____ weeks or _____ months

13–15 weeks = **(5)** 16–23 weeks = **(10)** > 24 weeks **= (20)**

9. Did you receive prenatal care coordination services during this pregnancy?

- ❑ No
- ❑ Yes = **(70)**

10. How was your health during this pregnancy?

- ❑ Fine, no problems
- ❑ Some problems (for example, nausea, tiredness)
- ❑ Serious problems (for example, high blood pressure, diabetes) = **(10)**
  Explain:

11. Did your baby stay in a "special care" nursery for more than one day?

- ❑ No
- ❑ Yes = **(10)**
  If yes, how many days?

12. Which of the following was your pregnancy?

- ❑ Planned
- ❑ Unplanned = **(5)**
- ❑ Result of sexual assault = **(40)**

13. How do you feel now that the baby is born?

- ❑ Happy
- ❑ Unsure **–** a little bit happy, a little bit unhappy = **(10)**
- ❑ Very upset about it = **(20)**

14. How does the father of the baby (or your partner) feel about the newborn?

- ❑ Happy
- ❑ Unsure **–** a little bit happy, a little bit unhappy = **(10)**
- ❑ Very upset about it = **(20)**

15. Do you have any history of prenatal or postpartum depression, raging, or "scary" thoughts about the baby?

- ❑ No
- ❑ Yes = **(40)**

16. Do you plan to have another baby?

- ❑ No
- ❑ Yes
  If yes, how soon?

17. Are you currently using birth control?

- ❑ No
- ❑ Yes

18. Do you understand how to use the product?

- ❑ No = **(5)**
- ❑ Yes

Points (Subtotal) _____

Reset Page 5 Only

19. Have you experienced any problems getting the necessary supplies, medication, or services?

- ❑ No
- ❑ Yes = **(5)**

20. Do you or your children receive Supplemental Security Income (SSI) benefits or special services for a health problem?

- ❑ No
- ❑ Yes = **(20)**
  If yes, who?

  What services?

  If receiving mental health-related services = **(50)**

21. Are your children in a Women, Infants, and Children Supplemental Nutrition Program (WIC)?

- ❑ No
- ❑ Yes
  If yes, where?

22. How are you currently feeding your baby?

- ❑ Breast Feed
- ❑ Bottle Feed
- ❑ Both Breast and Bottle

23. At what age do you plan to start feeding cereal / baby food to your new baby?

- ❑ Birth–3 months = **(5)**
- ❑ 4–6 months
- ❑ I do not know = **(5)**

24. Are any of your children on a special diet or receiving special foods or drinks?

- ❑ No
- ❑ Yes = **(5)**
  If yes, what?

25. Do you or your children ever eat non-food items (for example, dirt, sand, starch, paint chips)?

- ❑ No
- ❑ Yes = **(20)**

26. Do you sometimes run out of food before you are able to buy more?

- ❑ No
- ❑ Yes = **(10)**

SECTION V – PARENTING ATTITUDES / SKILLS

1. How do you feel about the way you were raised as a child?

- ❑ Very positive; I had a happy childhood; my parents were very caring.
- ❑ Okay; my parents tried to do their best; my parents were caring.
- ❑ Negative; I received no nurturing. = **(10)**
- ❑ Very negative; I was punished frequently and received little or no nurturing. = **(40)**

2. If you plan to parent differently than you were raised, how much support / encouragement will you get from your family / friends?

- ❑ A Lot
- ❑ A Little
- ❑ Very Little = **(10)**
- ❑ None = **(20)**

3. When you want advice about parenting, who do you go to? (Check all that apply.)

- ❑ Parents
- ❑ Community "Helping Organizations"
- ❑ Grandparents / Family
- ❑ Friends
- ❑ I Do Not Have Anyone to Ask = **(10)**
- ❑ Father of the Child / Partner
- ❑ Doctor / Nurse
- ❑ "It Comes Naturally" = **(10)**
- ❑ Books / Magazines

Points (Subtotal) _____

Reset Page 6 Only

4. Do you ever feel your infant cries or is demanding "on purpose" or just to irritate you?

- ❑ No
- ❑ Yes = **(40)**

If yes, explain.

5. At what age do you think your baby will do the following?

Be Potty Trained _____

Sleep All Night _____

Begin to Walk _____

If answer is unrealistic = **(15)**

6. Do you have an adequate supply or access to toys, books, games, or other play equipment?

- ❑ No
- ❑ Yes

7. When your children are playing or having fun, do you join them?

- ❑ Most of the Time
- ❑ Occasionally = **(5)**
- ❑ Rarely = **(10)**

8. How helpful is the child's father (or your partner) in raising this child and other children in your household?

- ❑ Very Helpful
- ❑ Helps When Requested to Help
- ❑ Not Helpful = **(10)**

9. Finish this sentence.

I think my / our children are _____

Use of strong negatives, such as "interfere with my activities," "too demanding," "too much work," "ugly," "stupid," "bad" = **(20)**

SECTION VI – TOBACCO, ALCOHOL, AND OTHER DRUGS

1. Do you or anyone else in your household smoke?

- ❑ No
- ❑ Yes

2. If yes, do you have "rules" governing when and where not to smoke?

- ❑ No = **(20)**
- ❑ Yes

I need to ask you a few questions about drinking and drug use. It will help us take better care of you and your children. Be sure to include beer, wine, and liquor in your answers to the following questions.

3. How often do you have a drink with alcohol?

- ❑ Never or rarely
- ❑ Once or twice a month
- ❑ Once or twice a week
- ❑ Every day

> twice a month = **(20)**

4. How many drinks containing alcohol do you have on a typical day when you are drinking?

- ❑ Zero to two
- ❑ Three to four
- ❑ Five to seven
- ❑ Eight or more

> Two = **(20)**

5. Have people annoyed you by criticizing your drinking?

- ❑ No
- ❑ Yes = **(20)**
- ❑ I never drink.

6. Have you ever felt you should cut down on your drinking?

- ❑ No
- ❑ Yes = **(20)**
- ❑ I never drink.

Points (Subtotal) _____

Reset Page 7 Only

7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

- ❑ No
- ❑ Yes = **(20)**
- ❑ I never drink.

8. **In the past 12 months, have you injected a non-prescribed drug or used any other street drugs (for example, marijuana, hash, cocaine, heroin, crack, amphetamines)?**

- ❑ No
- ❑ Yes = **(70)**

9. **Does anyone who is involved in caring for your children abuse alcohol or other drugs?**

- ❑ No
- ❑ Yes = **(20)**
  If yes, explain.

SECTION VII – PERSONAL SUPPORT / COPING SKILLS

1. **How do you deal with stress and anger?** (Check all that apply.)

- ❑ Talk it out
- ❑ Calm down by taking a walk, doing some activity
- ❑ Not talk about it at all = **(5)**
- ❑ Take it out on somebody by yelling = **(5)**
- ❑ Get violent (for example, hitting, threatening with object or weapon) = **(50)**
- ❑ Have a drink or get high to calm my nerves = **(20)**
- ❑ Other _____

2. **How does the father of the baby (or your partner) deal with stress and anger?** (Check all that apply.)

- ❑ Talk it out
- ❑ Calm down by taking a walk, doing some activity
- ❑ Not talk about it at all = **(5)**
- ❑ Take it out on somebody by yelling = **(5)**
- ❑ Get violent (for example, hitting, threatening with object or weapon) = **(50)**
- ❑ Have a drink or get high to calm their nerves = **(20)**
- ❑ Other _____

3. **Have you or your children ever been emotionally or verbally abused by the father of the baby, your partner, or someone close to you?**

- ❑ No
- ❑ Yes = **(70)**

4. **Does the father of the baby (or your partner) currently physically, verbally, or emotionally abuse you or your children?**

- ❑ No
- ❑ Yes = **(70)**

5. **Have you or other household members been raped or forced to have sex against your / their will?**

- ❑ No
- ❑ Yes = **(30)**

6. **Does the abuser(s) still have access to you or your children?**

- ❑ No
- ❑ Yes = **(40)**

Points (Subtotal) _____

Reset Page 8 Only

7. Has anyone in your immediate household (parent, spouse, partner, sibling) been incarcerated / jailed for a crime in the past year or more than three times in the past five years?

- ❑ No
- ❑ Yes = **(40)**

8. Are you afraid of the father of the baby, your partner, or anyone else in your household?

- ❑ No
- ❑ Yes = **(20)**

9. Is there a gun in your home?

- ❑ No
- ❑ Yes = **(10)**

10. If yes, are the guns unloaded and stored in a locked place?

- ❑ No = **(15)**
- ❑ Yes

11. How many people do you know well enough to visit with in your neighborhood?

- ❑ None = **(5)**

12. How often do you spend time with friends or relatives?

- ❑ Never = **(10)**

13. Do you have someone you can talk with when you need to?

- ❑ No = **(20)**
- ❑ Yes

14. Do you find yourself feeling lonely?

- ❑ Quite Often
- ❑ Sometimes
- ❑ Almost Never

15. Is there anyone you can count on in case of an emergency?

- ❑ No = **(10)**
- ❑ Yes

16. Is there someone who could help you for as long as you needed their help?

- ❑ No
- ❑ Yes

17. Do you or others think of yourself as a resource in your community?

- ❑ No
- ❑ Yes

18. How often do you go to neighborhood activities such as spiritual ceremonies, support groups, or “club” functions?

- ❑ Never = **(5)**

19. How would you describe yourself to someone who does not know you?

20. Does your family have special traditions that they observe?

- ❑ No
- ❑ Yes
  If yes, explain.

21. Tell me about your family’s strengths.

- ❑ None = **(10)**

Points (Subtotal) _____

Reset Page 9 Only

22. Which of these things worry you a lot? (Check all that apply.)

- ❑ Money Problems = **(2)**
- ❑ Transportation = **(2)**
- ❑ My Job = **(2)**
- ❑ My Partner's Job or Unemployment = **(2)**
- ❑ Caring for This Baby or My Other Children = **(2)**
- ❑ Housing Problems or Getting Evicted = **(2)**
- ❑ Getting Child Care = **(2)**
- ❑ My Physical or Mental Health or Safety = **(2)**
- ❑ My Drinking or Drug Use = **(2)**
- ❑ My Relationship With My Partner = **(2)**
- ❑ My Child's Relationship With Their Father = **(2)**
- ❑ My Partner Is in Jail = **(2)**

23. Would you like help or information with any of these things?

- ❑ Discipline
- ❑ Child Development
- ❑ Parenting Skills
- ❑ Playing With Your Children
- ❑ Health Issues
- ❑ Employment Training
- ❑ Coping With Stress
- ❑ Family Planning or Pregnancy Prevention
- ❑ Community Resources for Parents

SECTION VIII – SIGNATURES

SIGNATURE – Care Coordinator	Assessment Date
SIGNATURE – Qualified Professional Reviewer	Assessment Date
SIGNATURE – Care Coordinator	Reassessment Date
SIGNATURE – Qualified Professional Reviewer	Reassessment Date

Points (Subtotal) _____

Total Points (All Pages) _____

Key:
> = Greater Than
< = Less Than

Reset Page 10 Only

Reset Form