

For internal use only:

Agency ID □□□

Child ID □□□□ Parent ID □□□□

FIRST 5 Santa Clara County
Family Resource Center Follow-up Survey

Dear _____ of _____
Parent/Guardian(s) Child Name

This information will help FIRST 5 learn about the families they serve. By completing this survey, remember:

- You can skip one or more questions.
- Only a few FIRST 5 staff and its evaluators will be able to see your answers.
- Reports will not include your private information.
- There are no known risks to completing this survey.
- Your answers will assist in improving program services for families in Santa Clara County.
- It is very important to FIRST 5 that your information is safe, so it will be protected as required by law.
- If you do not complete this survey, your family can still receive services from FIRST 5.

I consent to complete this survey and share my information.

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

Parent/Guardian's **printed name**

Signature

Date Signed

OR

I do not want to participate in this survey.

You are still eligible for the raffle. Just send the incomplete survey back in the envelope provided.

(Continued)

To start, we ask questions about your child’s health and medical care. (For questions about a specific child, think about your child listed on the front page.)

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

<input type="checkbox"/> Uninsured	<input type="checkbox"/> Insurance purchased directly by parent/guardian
<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employer-purchased health insurance
<input type="checkbox"/> Healthy Families	<input type="checkbox"/> Healthy Kids
<input type="checkbox"/> Don't know/Declined	<input type="checkbox"/> Other or application pending (please specify): _____
2. **In the past 6 months**, how many times did this child 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.

0 times 1 time 2-3 times 4-5 times 6 or more times Don't know/Declined
3. **In the last 6 months**, how many times did you visit the emergency room with this child?

Never Once 2-3 times 4 or more times Don't know/Declined
4. When did this child last see a dentist or dental hygienist for dental care?

<input type="checkbox"/> Child is under 1 year of age	<input type="checkbox"/> Less than a year ago	<input type="checkbox"/> Between 1 to 2 years ago
<input type="checkbox"/> 2 years ago or more	<input type="checkbox"/> Never	<input type="checkbox"/> Don't know//Declined
5. Have you smoked cigarettes at all in the past 30 days? (check one only)

Yes No Declined to state
6. Has anyone in your household smoked in the past 30 days? (check one only)

Yes No Declined to state
7. If you smoke, do you want information about cessation programs? (check one only)

Yes No Declined to state

8. Sometimes parents have concerns about how their child is developing. Do you have any concerns about...?

	Are you...?		
	Not Concerned ☺	A Little Concerned ☹	Concerned ☹
a) How this child talks and makes speech sounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) How this child understands what you say?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) How this child uses his or her arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) How this child gets along with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. **In a usual day**, how many servings does this child have of...? (Note: only answer if this child is 1 year of age or older.)

	0	1	2	3	4	5 or more
a) Glasses of milk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Glasses of soda or other sweetened drinks (fruit punch).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Glasses of water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Servings of fruit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Servings of vegetables.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Servings of sweets (cookies, candy, pastries).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Servings of fast food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. What is this child’s height? _____ Child’s weight: _____

Next, we ask questions about your child care and family activities.

(Continued)

11. Is there a place or person you usually take this child to be cared for during the day? If so, where?

- Head Start Child care center Other preschool program
 Family daycare center Relative/neighbor or babysitter
 My child is **not** cared for by someone else or outside of our home (**skip to Question 9**)

11b. **If this child attends preschool, or child care, please rate how you feel about its:**

	Low ☹	Average ☺	Excellent 😊
a) Convenience (hours, location)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Very expensive ☹	Average ☺	Very affordable 😊
c) Cost	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you receiving child care subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No			

12. **In a usual week, how many times does your family do these things with this child?**

	<i>Not at all</i>	<i>1-2 times</i>	<i>3 -6 times</i>	<i>Every day</i>
a) Color, draw, or paint.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Go on outings (to the playground, library, museum).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Read to or show picture books.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Tell stories or sing songs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Exercise or play sports together.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Have a bedtime routine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. **In a usual day, how often does this child...?**

	<i>Never or Not Yet</i>	<i>Sometimes</i>	<i>Often or Always</i>
a) Have a tantrum.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Let you know what he or she needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Comfort or calm him or herself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Explore new things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Get easily distracted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Play well with others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Show an interest in books.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Use gestures or words to communicate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Try to solve problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Follow rules and directions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Continued)

Finally, we ask about life as a parent and community member. There are no right or wrong answers.

14. In the past 6 months, how much have you been concerned about...?

	Not concerned ☺	A little concerned ☹	Concerned ☹
a) Having enough food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Having housing you can afford.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Having enough money or a good job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Feeling unsafe or threatened by someone in your home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Someone in your close family having a drug or alcohol problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Feeling sad or depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. In the past 6 months, how much do you agree with...?

	Strongly agree ☺	Agree	Disagree	Strongly disagree ☹
a) I feel connected to my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I have people in my community I can turn to for support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) FRC staff is friendly and welcoming.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) The FRC is clean and tidy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Most FRC staff share my background and culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I am satisfied with the services I got from the FRC.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. For the next items, rate how much you knew **BEFORE you came to the Family Resource Center (1 = Low, 3 = Average, 5 = High). Then rate how much you know **NOW** after participating in programs.**

(We know that the FRC programs may not have covered all of the topics below. If this is the case, your answers may be the same for “Now” and “Before.”)

	How much I knew BEFORE participating in FRC programs					How much I know AFTER participating in FRC programs				
	Low 1	2	Avg. 3	4	High 5	Low 1	2	Avg. 3	4	High 5
a) How to keep my child healthy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) How to guide my child’s behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) How to meet my child’s needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) How to help my child learn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) How to be a good parent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) How to read to my child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) How to engage my child in vocabulary-rich activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) How to encourage my child in positive ways.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) How to get the services my family needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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17. **In the past 6 months**, how often did you volunteer in ways to improve your community? (Such as working with religious, political, school, or community groups). (check one only)

- Never 1 or 2 times 3 to 6 times More than 6 times Don't know/Declined

18. Do any of these programs serve you or another family member? (check all that apply)

- None** of these programs Child Welfare/CPS services Differential Response program
 Mental Health services Court programs/workshops Early Start/Special Education
 Probation or parole services Alcohol and Drug services Public assistance (e.g., WIC, CalWorks)
 FIRST 5 Home Visitor Other: _____

That concludes our questions. Thank you very much for your time and participation.