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**APPENDIX A - DATA COLLECTION TOOLS**

**I. *CAREGIVER QUESTIONNAIRE***

**This questionnaire is administered by the Community Health Worker (CHW) at the first and third home visits. The caregiver is also asked to respond to this questionnaire during the six-month follow-up phone call.**

**Administration of this questionnaire is described in more detail** in **Section VI. A. of the RFP.**

What is your relationship to this child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your child’s gender?

* Male
* Female

How old is your child? \_\_\_\_\_\_\_\_\_\_ years

Is your child Hispanic or Latino?

* Yes
* No
* I don’t know

What is your child’s race? (*check all that apply*)

* White
* Black or African American
* Alaska Native or American Indian
* Asian
* Native Hawaiian or other Pacific Islander
* Other (*please specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Decline

What is the highest grade or level of school YOU have finished?

* I didn’t go to school
* 8th grade or less
* Some high school but did not graduate
* High School graduate or GED
* Some college / vocational or technical school
* Graduated from college, graduate school
* Other: (*please specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What language do you speak most at home?

* English
* Spanish
* Cape Verdean Creole
* Haitian Creole
* Portuguese
* Mandarin
* Cantonese
* Arabic
* Urdu
* Other: (*please specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your zip code? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), on how many days did your child have any asthma symptoms, such as wheezing, coughing, tightness in the chest, shortness of breath, waking up at night because of asthma symptoms, or slowing down of usual activities because of asthma?

\_\_\_\_\_\_\_\_\_\_\_\_days

During the daytime in the past 14 days, how many days did your child have asthma symptoms such as wheezing, shortness of breath, or tightness in the chest, or cough?

\_\_\_\_\_\_\_\_\_\_\_\_days

During the nighttime in the past 14 days, how many nights did your child wake up because of asthma symptoms such as wheezing, shortness of breath, or tightness in the chest, or cough?

\_\_\_\_\_\_\_\_\_\_\_\_nights

During the past 14 days, how many times did your child have to slow down or stop his/her play or usual activities or missed school because of asthma, wheezing or tightness in the chest, or cough?

\_\_\_\_\_\_\_\_\_\_\_\_times

During the past 14 days (that is, during the past fourteen 24 hour periods that include daytime and nighttime), about how many days did your child use asthma rescue medicine (sometimes called a quick relief medication) such as albuterol, proventil, ventolin, Xopenex?

\_\_\_\_\_\_\_\_\_\_\_\_days

During the past 14 days, about how many days did your child use asthma controller medicine (sometimes called a preventive medicine or a steroid inhaler) such as QVAR, Pulmicort, Alvesco, Flovent, Axmanex, Symbicort, Advair or Dulera?

\_\_\_\_\_\_\_\_\_\_\_\_days

Has your child’s doctor or other health professional provided you with a written plan (action plan) to help you decide how to change your child’s asthma medicine in response to changes in his/her asthma?

* Yes
* No
* I don’t know

The last time your child’s asthma got worse, did you use the written action plan to decide what medicines to use?

* Yes
* No
* I don’t know

In the past 6 months, how many work or school days have you or another adult caregiver missed because of your child’s asthma?

\_\_\_\_\_\_\_\_\_\_\_\_days

In the past 6 months, how many days of childcare or school has your child missed because of asthma?

\_\_\_\_\_\_\_\_\_\_\_\_days

* not applicable

Has your child received a flu shot or FluMistTM in the past 12 months?

* Yes
* No
* I don’t know

**II. *ENVIRONMENTAL ASSESSMENT***

**This assessment is administered by the Community Health Worker (CHW) at the first and third home visits. The caregiver is also asked to respond to the questions in this assessment during the six-month follow-up phone call. Administration of this assessment is described in more detail in Section VI. A of the RFP.**

**DATE** Interview / Home Visit Date (MM/DD/YY): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**CHW** Interviewer’s / Home Visitor’s Initials: \_\_\_\_\_\_\_\_\_

**ENV1.1** On how many of the **past 7 days** has anyone, including you, smoked anywhere inside your home?

* 1 1-2 days
* 2 3-7 days
* 3 Every day
* 4 None
* 99 Don’t know / Not sure

**ENV2.1** On how many of the **past 7 days** have you noticed/smelled tobacco smoke that comes from your neighbors’ units or other areas in your building anywhere outside your home?

* 1 1-2 days
* 2 3-7 days
* 3 Every day
* 4 None
* 99 Don’t know / Not sure

**ENV3.1** In the past 30 days has anyone seen or smelled mold or a musty odor inside your child’s home?

* + - 1 Yes
    - 2 No

**ENV4.1** Do you have furry or feathered pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents or others?

* + - 1 Yes
    - 2 No

**ENV5.1** Do you have cockroaches in your home now or in the past 3 months?

* + - 1 Yes, within the past month
    - 2 Yes, within the past 3 months but not now
    - 3 No problem within the past 3 months
    - 99 Don’t know

**ENV6.1** Do you have a problem with mice or rats in your home now or in the past 3 months?

* + - 1 Yes, within the past month
    - 2 Yes, within the past 3 months but not now
    - 3 No problem within the past 3 months
    - 99 Don’t know

**ENV7.1** Do you have any of the following chemicals in your home that have a strong odor or that irritates your child’s asthma or makes the asthma worse, such as:

* + 1 Yes, check all that apply
    - a Cleaning products that contain bleach or ammonia
    - b Paint products, solvents, glue
    - c Air fresheners, scented candles, incense
    - d Pesticides (don’t make asthma worse but are toxic)
  + 2 No
  + 99 Don’t know

**Living Room Walk Through Observations**

**LW1.1** Level of dust on surfaces in the room: (flat surfaces do not include floors)

* + - 1 None
    - 2 Slight
    - 3 Moderate
    - 4 Heavy

**LW2.1** See evidence of water damage

* + - 1 Yes
    - 2 No

**LW3.1** See evidence of water leaks/drips

* + - 1 Yes
    - 2 No

**LW4.1** See evidence of mold/mildew

* + - 1 Yes
    - 2 No

**LW5.1** Cockroaches (including eggs, feces)

* + - 1 Yes
    - 2 No

**LW6.1** Rodents (or droppings)

* + - 1 Yes
    - 2 No

**LW7.1** Cigarette butts, ashtrays with ashes

* + - 1 Yes
    - 2 No

**LW8.1** Tobacco odor

* + - 1 Yes
    - 2 No

**LW9.1**  Other (odors)

* + - 1 Yes
    - 2 No

**Child’s Bedroom Walk Through Observations (Repeated for other bedrooms in the home)**

**CBR1.1** Level of dust on surfaces in the room: (flat surfaces do not include floors)

* + - 1 None
    - 2 Slight
    - 3 Moderate
    - 4 Heavy

**CBR2.1** See evidence of water damage

* + - 1 Yes
    - 2 No

**CBR3.1** See evidence of water leaks/drips

* + - 1 Yes
    - 2 No

**CBR4.1** See evidence of mold/mildew

* + - 1 Yes
    - 2 No

**CBR5.1** Cockroaches (including eggs, feces)

* + - 1 Yes
    - 2 No

**CBR6.1** Rodents (or droppings)

* + - 1 Yes
    - 2 No

**CBR7.1** Cigarette butts, ashtrays with ashes

* + - 1 Yes
    - 2 No

**CBR8.1** Tobacco odor

* + - 1 Yes
    - 2 No

**CBR9.1** Other (odors)

* + - 1 Yes
    - 2 No

**Kitchen Walk Through Observations**

**K1.1** Level of dust on surfaces in the room: (flat surfaces do not include floors)

* + - 1 None
    - 2 Slight
    - 3 Moderate
    - 4 Heavy

**K2.1** See evidence of water damage

* + - 1 Yes
    - 2 No

**K3.1** See evidence of water leaks/drips

* + - 1 Yes
    - 2 No

**K4.1** See evidence of mold/mildew

* + - 1 Yes
    - 2 No

**K5.1** Cockroaches (including eggs, feces)

* + - 1 Yes
    - 2 No

**K6.1** Rodents (or droppings)

* + - 1 Yes
    - 2 No

**K7.1** Cigarette butts, ashtrays with ashes

* + - 1 Yes
    - 2 No

**K8.1** Tobacco odor

* + - 1 Yes
    - 2 No

**K9.1**  Other (odors)

* + - 1 Yes
    - 2 No

**Bathroom Walk Through Observations (Repeated for Other Bathrooms in the Home)**

**BTH1.1** Level of dust on surfaces in the room: (flat surfaces do not include floors)

* + - 1 None
    - 2 Slight
    - 3 Moderate
    - 4 Heavy

**BTH2.1** See evidence of water damage

* + - 1 Yes
    - 2 No

**BTH3.1** See evidence of water leaks/drips

* + - 1 Yes
    - 2 No

**BTH4.1** See evidence of mold/mildew

* + - 1 Yes
    - 2 No

**BTH5.1** Cockroaches (including eggs, feces)

* + - 1 Yes
    - 2 No

**BTH6.1** Rodents (or droppings)

* + - 1 Yes
    - 2 No

**BTH7.1** Cigarette butts, ashtrays with ashes

* + - 1 Yes
    - 2 No

**BTH8.1** Tobacco odor

* + - 1 Yes
    - 2 No

**BTH9.1** Other (odors)

* + - 1 Yes
    - 2 No