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Abandoned Infants Assistance

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In final, we dedicate this report to the Latinas and their families who are living and struggling with substance abuse, HIV or AIDS. We express our deepest gratitude for their participation in this program and for sharing their stories.

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Executive Summary

Bienvenidos Children’s Center is a private nonprofit organization located in Los Angeles, California and has provided services to families in the East Los Angeles and Southeast areas by applying culturally responsive comprehensive models that target children, adolescents, teen mothers and parents. The agency’s family home-based model funded by the Abandoned Infants Assistance Program was implemented in 1992. During the years, the AIA Project Milagro model has evolved from serving Latinas and children to providing substance abuse outpatient treatment through establishing the Institute for Women’s Health (funded by SAMSHA). Child-focused interventions and family support models provided the AIA program to target Latinas and children impacted by HIV/AIDS and substance abuse. Bienvenidos developed alliances and collaborations with over 25 local organizations focused on HIV/AIDS services and has been recognized for providing culturally sensitive services to Latinas living with HIV/AIDS. The program’s outcomes provided a framework for working with HIV families by delineating the differing and multitude of problems impacting these families. AIA Project Milagro Latinas impacted by substance abuse were more acculturated, more likely to speak and read English, had generational substance abuse and the majority were single parents. These women were more likely second and third generation Mexican American, faced with similar challenges as other women of color in this country. These women were poorly educated, lacked job skills and have dealt with the limited job training resources often found in low-income communities. In addition, they represented second or third generation alcohol/drug using families with histories of child abuse and domestic violence. Many were challenged with the limited substance abuse programs in the East Los Angeles area and that served women with children. In contrast, women affected by HIV/AIDS were minimally acculturated to the United States and many were recent immigrants. They were monolingual Spanish-speaking, and adhered to Latino cultural practices and beliefs. Women affected by HIV/AIDS were less educated and as new comers to this country, they experienced stress associated with acculturation, discrimination and poverty, and they were often isolated from their extended families that remained in their country of origin. HIV/AIDS women tended to be married, and ascribed to traditional sex-roles in the Latino culture. Project Milagro has actively provided prevention strategies to reduce the risk of HIV exposure among Latinas, particularly since the majority of Project Milagro HIV women contacted the virus through heterosexual exposure.

Under the Abandoned Infants Assistance Program, Bienvenidos implemented an innovated home-based model to prevent the abandonment of children and secure their safety by meeting the multiple needs of families impacted by substance abuse and/or HIV/AIDS. The amalgamation of sociocultural, socioeconomic and epidemiological factors defined the program’s framework and the past decade of services to high risk families. This project successfully provided culturally specific services and interventions aimed at mediating the detrimental effects of substance abuse and/or HIV/AIDS experienced by Latina women and their children. The multi-level service tracks involved family assessment and family support, case management and advocacy, child assessment and parenting, health education and medical access, child reunification and permanency planning, and alcohol/drug and mental health counseling. The efficacy of a multidisciplinary bilingual/bicultural service team comprised of a case manager, parent educator, drug counselor, family support worker, health educator, group facilitators, and clinicians proved critical in assessing and meeting the economic, social, cultural, legal, health, and psychological needs of families. The program model was expanded to Latinas from Mexico, Central and South America, immigrant women and their partners, primary caregivers and extended family members.

Introduction

Bienvenidos Children’s Center implemented the Abandoned Infants Assistance Program from 1992 to 2008. During the past 16 years, the AIA Project Milagro has chronicled relevant factors that improve the safety, permanency and well being of children living with Latina mothers, primarily of Mexican origin, whom are coping with HIV/AIDS or Substance Abuse. Equally important, historical pathways to understanding the social and familial dynamics that impede positive outcomes among Latinas have been clearly delineated by this longstanding AIA program. The gaps in knowledge for providing program polices and service designs that target the complexities of needs for Latinas and their children have led to an array of innovative AIA programs that are perceptible in the interiors of poor and disenfranchised communities. In general, AIA programs have collectively worked towards providing services to the “least of these” communities, families and children. Thus, these programs continue to contribute to improving our knowledge base by developing strategies to meet the unique needs of families coping with HIV/AIDS and Substance Abuse.
Project Milagro provided comprehensive services to Mexican and Mexican American mothers and their children residing in the East and Southeast Los Angeles area who were identified as high-risk for abandoning their infants and young children due to HIV/AIDS or chronic substance abuse. The project's target service area has a large concentration of Latinas living with HIV or AIDS and has been identified as a priority group by the Los Angeles County HIV Prevention Plan (2008). Multiple co-factors have been attributed to the disparities of HIV/AIDS among Latinas. More importantly, such co-factors continue to add to the vulnerabilities of Latinas for newly diagnosed HIV infections, living with AIDS and limited prevention strategies for acquiring HIV. The incidence rates in the United States for women living with AIDS and women at risk for HIV infection or transmission has led to re-examining emerging patterns of the epidemiological nature of HIV/AIDS (HIV Epidemiology Program, 2008). Overall, Latinas diagnosed with HIV or AIDS has not only increased but has exceeded case rates among women in general. One in seven Latinas are living with HIV/AIDS compared to white female counterparts (Los Angeles County HIV Prevention Plan, 2008). Although HIV/AIDS among African American women exceed rates for both Latina and white women, the critical factors associated with reducing HIV infections and providing preventive services have not been fully addressed when working with Latinas. Project Milagro has provided services aimed at improving the mental well-being of high-risk Latinas and their children. The model applied to these families has emerged from acquiring knowledge of HIV/AIDS trends and working with Latinas and children. The project's comprehensive model developed effective strategies to address co-factors relevant to HIV/AIDS within a cultural context.

Additionally, service mechanisms that successfully resulted in improving positive outcomes were supported by the project's evaluation findings.

The project's Substance Abuse women were primarily second and third generation Mexican Americans with chronic alcohol and drug addictions. Most of the project's Latinas were identified as "neglectful" parents, actively engaged in child welfare systems and had limited parenting knowledge. Project Milagro developed a model that targeted substance abusers with histories of prenatal drug/alcohol use; domestic violence victims; drug exposed infants; victims of child abuse; sexual trauma; depression; and chronic relapses. Although the project's Latinas were faced with these challenges, the program model was effective in reducing risks for child abuse and child abandonment. Further, strategies aimed at improving mental health, coping skills and social support were significantly effective for this group.

Program Model

Cultural Theoretical Framework

Project Milagro over the course of four years implemented a model that was effective in promoting safety, permanence, and well-being of children impacted by HIV/AIDS and substance abuse. Located in Los Angeles, California, Project Milagro concentrated its efforts towards understanding the needs of families and children in the context of their culture. Beyond providing linguistically appropriate (Spanish translations) information and education, the program provided services that were culturally relevant and sensitive to Latinas. Interventions applied by the program staff were respectful of cultural beliefs and practices (folkloric concepts and healing, celebrations, family hierarchies, and worldviews, etc.). Such services were instrumental in engaging and retaining Latino families in services that are generally not accessed. Project Milagro services were guided by respect and integration of Latino values; familismo (familialism) - high value and regard for the family, view of family as the primary unit of support and help; Simpatia - a social script emphasizing a pleasant demeanor focused on reducing conflict and promoting agreement; and Personalismo - a personal attitude valuing warmth, friendliness, and respect towards others especially towards family and those who hold positions of authority in a community (Santiago-Rivera & Azara, 2003). These cultural Latino characteristics were instrumental to program implementation and service delivery.

Family Systems and Humanistic Approach

The program's model incorporated the core elements of AIA philosophies into the program design and service delivery. Embedded in AIA's framework, Project Milagro's services focused on the concurrent needs of parents and children. The program implemented a family systems approach in which families were encouraged to define their strengths and needs in the context of their total environment. Additionally, the strength in the provider-client relationship lied in the ability of the staff to develop long-term, trusting, non-judgmental relationships with their families. Families served by the program were empowered and respected as well as supported in their decision-making practices (Templeton-McMann, Currier-Ezepechick, Bouchard, Adnopoz, Pack & Abruzzino, 2003). Services were family centered and concentrated on strengthening family connections to their communities. The program's infrastructure and flow of services were aligned to the general family tenets implemented by other AIA programs across the country. Team based interventions were
focused on stabilizing families through increased support and case management.

Project Milagro further delivered services that were family-centered, client driven and embedded in a humanistic approach to serving families. Based on Abraham Maslow’s theory of hierarchy needs, the program operated with a fundamental belief that the basic needs of food, shelter and safety must be met first and be integral to the program’s approach. In par, case plans and interventions were designed to provide basic concrete services and resources to meet such needs in order for families to evolve and achieve other goals. Services were parallel to the National Abandoned Infants Resource Center’s (2007) AIA principles: “provided developmentally informed parental guidance; individual and family counselling; taught tangible skills; assisted families in developing linkages to community resources through direct advocacy and modeling systems navigation” (p. 5). Additionally, Project Milagro continued to provide information and education in a culturally relevant manner.

**Comprehensive Home-Based Services**

In order to improve child well-being, a comprehensive families approach was utilized. The program was driven and operated under the principle that in effort to improve child well-being, the needs of the family as a unit had to be addressed and met either by the program or through community based support. Over the years, the program learned that family emergent needs or crisis must be met and resolved. Unaddressed family issues tended to persist, creating family stress and subsequently affecting children. Family and parental stabilization were key indicators to increasing child and family well-being.

The uniqueness and strength of the program was in the ability to assess and identify the needs in the families’ natural home environment. The home-based approach implemented by the program, allowed the staff to work closely with the parents and children as well as others in the home. The staff’s ability to develop individual relationships with the parents was essential to engaging families in services and conducting thorough assessments. Home-based sessions focused on promoting positive parenting strategies and enhancing parents’ relationships with their children. The providers focused on supporting; affirming; and encouraging parent-child bonding and attachment.

Furthermore, offering services in the home allowed the staff accessibility to everyone in the family and the ability to closely monitor risks, and changes in the home environment. Immediate interventions were offered to families faced with a crisis. The supportive multidisciplinary model addressed parenting concerns, psychosocial stressors, and mental health issues. Interventions concentrating on preventing out of home placement, strengthening reunification, and supporting post permanency plans were offered. Home observations of environment and family dynamics assisted in assessment and case service planning goals.

**Long Term and Intense Services**

Project Milagro’s model was shaped after years of studying the needs of families impacted by HIV/AIDS and substance abuse. Early lessons learned highlighted the importance of delivering services that were not only in the home, but long term and with high frequency. Families enrolled in the program received 12 months of services and in some cases families received services up to 18 months. Families received weekly home visits by either the Family Support Worker (for HA group) or Substance Abuse counselor (for the SA group) for the first nine months of services. Visits were reduced to twice a month if appropriate for the remaining 3 months of services. The intense approach allowed for the staff to work closely with families and identify the issues that were not disclosed. Frequent visits in the families’ homes also enhanced trust building between the provider and client. Additionally, flexibility on length of visits allowed opportunity for the clients to open up and share personal concerns. Staff reported that on an average, visits lasted from two to four hours depending on the focus of the visit. For example, the duration of a visit concentrating on case management needs was an hour, however, visits addressing crisis on an average lasted 4 hours. Furthermore, in cases where safety planning was critical, staff members would take up to the whole day to reduce the risks of detainment and secure family stability for the child and/or parent.

**Project Milagro Families**

Project Milagro served Latinas and their families who were identified “at risk” of abandoning their young children due to substance abuse and/or HIV/AIDS. Families with at least one child 0-6 years of age were eligible for services. The program targeted Latino families residing in Greater East Los Angeles and East Hollywood areas. The program developed two service tracks to assist in identifying and reducing specific factors
placing infants and children "at risk" of abandonment, abuse or neglect. A total of 163 families impacted by substance abuse and HIV/AIDS were enrolled during the grant period. The program identified multiple risks among these families and their children. Families headed by single parents (mostly mothers), two parent households, as well as single fathers and relative caregivers were enrolled.

**Characteristics of Families Served**

During the four years of funding, Project Milagro enrolled and served a total of 163 families consisting of 210 adult participants and 475 children (159 index children and 4 unborn). Of the 163 families enrolled, 44% were affected by HIV/AIDS and 52% were affected by substance abuse. Demographic characteristics for the project's families indicated that 51% of women from the substance abuse (SA) group reported being single mothers in comparison to 37% of women from HIV/AIDS (HA) group. Families from both groups were primarily Mexican and Mexican American. Among the HIV/AIDS families, 83% were foreign born and 61% were monolingual Spanish-speakers. In contrast, 94% of the families from the Substance Abuse group were Mexican-American with more than two thirds born in United States. Substance Abuse mothers were mostly English speakers (88%) with reportedly 46% as bilingual and only 12% were Spanish-speaking. Social conditions, environmental factors and life experiences placed these women at high risk for child abuse and abandonment. Overall, Latinas were impacted by past childhood victimization and adult domestic abuse. The program noted that at least half of the families experienced mental health distress and limited parenting skills. Furthermore, program entry assessments indicated that 90% of families were living in poverty, residing in unstable living conditions and lacked stable family support. Consistent with the program model, case management and providing concrete resources were primary intervention areas for families.

Children enrolled in the program were 3.6 years average age although younger children resided with Substance Abuse mothers (2.7 years) compared to HIV/AIDS children whom were 4.5 years. Children from both groups were found at high risk of abandonment and abuse at intake due to 71% lacked stable family compositions; 41% were exposed to domestic violence; and approximately 38% of the children had experienced abuse or neglect prior to intake. Additionally, the evaluation findings indicated that at least 17% of these children were identified as having behavioral problems and 13% had a chronic health problem (including 8 children living with HIV/AIDS).

Project Milagro's supportive model was effective in reducing child abandonment and abuse by targeting culturally sensitive services to high-risk families. For many families, chronic risk factors were unchanged. The project learned that situations such as generational substance abuse and trauma were recurrent. Environmental stressors such as poverty, and limited resources to the project's indigent families were lingering and at times, beyond the scope of the project's services.

**Outreach and Recruitment Strategies**

Due to the social stigmas experienced by families, the program staff was creative in their outreach efforts. Outreach efforts were conducted at HIV shelters, professional conferences targeting families living with HIV as well as commemoration events organized by the Twelve Step community for individuals in recovery. Furthermore, the program stationed staff at substance abuse centers, local hospitals and clinics where women routinely tested for HIV. In addition, the program distributed flyers at Children's Dependency Court; local Department of Public Social Services as well as other agencies that serve families affected by substance abuse and HIV/AIDS. The staff also participated in community resource fairs and events. The program developed a linguistically appropriate and culturally sensitive brochure (see Appendices) that was instrumental in engaging eligible participants.

A coordinated, seamless referral process was developed to ensure that families received prompt responses after requesting services or upon referral to the program. Following the referral, families were initially screened by the Project Coordinator to determine program eligibility. The Coordinator conducted initial intakes and assessments in the clients' home within 2-3 days after receiving referrals. The intake assessment focused on: introduction of services; assessment of the family's needs and risks as well as clients' level of motivation to receive comprehensive home-based support. Program forms such as Intake, Confidentiality and Consent to Release Information, and Service Agreement forms were completed during the initial visit. The initial visit was crucial in establishing trust and extending genuine non-threatening support. Additionally, families received information highlighting length of services, level of intensity, confidentiality guidelines, and collaborative approaches with other key providers (i.e., DCFS, courts, Drug Treatment, mental health, schools). Following the initial visit, the Project Coordinator assigned the case to either the Substance Abuse Team or the HIV Team. Families received a total of 12 months of comprehensive home-based services.
Family Retention

The program model focused on actively engaging families at the point of entry. Bilingual and bicultural staff enhanced engagement among Latinas, particularly low acculturated Mexican immigrant women living with HIV/AIDS. Families welcomed strategies that included identifying with their country of origin or displaying knowledge of regional differences. Respecting varying acculturation levels and heterogeneity of Latinos was critical to engaging and retaining families in the program. The project’s overall yearly retention rate was 79% for active cases; 74% of families remained in the program for 6 months or more; 26% of families completed the 9 months of intensive home-based services; and 20% of families were retained for more than 12 months. For this latter group, services ranged from 13 to 26 months. In these cases (7% for 20 months or more), relative caregivers were generally included in family case plans. The attrition rate was 11.6% and included families enrolled for less than 3 months.

Families Impacted by Substance Abuse

Scope of Addiction

Project Milagro responded to the needs of substance abusing women. In-depth and thorough intakes revealed that women from the substance abuse group were no strangers to addiction, violence and trauma. The majority of the women reported generational histories of addiction, and violence. In several cases, the women reported being introduced to drugs and alcohol by their family members. Childhood abuse in the form of sexual and physical assault was often disclosed. Not surprisingly, the women reported abusing drugs at a very young age. Additionally, more than half were long-term poly drug abusers. Methamphetamine and alcohol were the most commonly used drugs. Women also reported having numerous encounters with law enforcement often leading to arrest for “drug possessions.” Substance abusing women were repeatedly entangled with multiple systems. These included DCFS (Child Welfare), Criminal and Family Law Courts. The women were often faced with legal pressures to comply with DCFS court orders (parenting, counseling), drug treatment programs and restitution through volunteer community service work. Compliance with such mandates, coupled with caring for young children while attempting to seek or maintain employment was often overwhelming. It is not surprising that many of these women had a history of poor drug treatment outcomes.

This group also engaged in unhealthy relationships. Women were in relationships with men who were substance abusers themselves. Intake information indicated that partners were often involved with multiple systems as well. Such as criminal court, probation and parole. Operating under a family systems approach, Project Milagro focused efforts towards engaging the partners in services. The partners were often unwilling to engage in services at intake. Substance abuse counselors assigned to these families were patient with the process and appropriately planned inclusion of partners in home visits. Eventually, the partners responded to services and joined family sessions as well as couples counseling. A total of 22 partners were actively engaged in services. As a result, engaging partners had positive effects in reducing the prevalence of unsafe home environments. Interventions prioritized ensuring safety of the children, while developing a relationship built on trust with both of the parents. The program's non-threatening approach to engaging substance abusing women as well as their partners was instrumental in retaining these families in the program.

Child Welfare Involvement

Women from the substance abuse group were often identified as “abusive” and court ordered to comply with various mandates in order to reunify and/or to maintain custody of their children. Similar to other AIA Programs, Substance Abuse Latinas had a high incidence of DCFS involvement, current or past. Unfortunately, unresolved childhood traumas and social stigma associated with their drug use intensified feelings of guilt, shame, and inadequacy. Project Milagro counselors responded to these issues as part of their strategies to strengthening recovery and sobriety among these women. Additionally, the program staff developed collaborative relationships with DCFS (Child Protection) workers with the aim of increasing reunification of families. Others strategies applied to women with DCFS involvement included; court advocacy, monitoring of visits with children; submission of letters to the courts indicating progress and improvement on behalf of the mother, participation in TDM (Team Decision Meetings) held at DCFS. Program staff ensured that ongoing communication between the DCFS worker, family and program counselor was maintained. Overall, parents received assistance in developing healthy coping mechanisms and supports as they faced multiple demands across systems.
Families affected by substance abuse were often experiencing multiple challenges and conditions that pressed down on their lives. Culminated by poor economic and social conditions, women from the substance abuse group were often disenfranchised. Lack of stable housing, and the realities of living in disproportionately drug-exposed communities were present. Augmenting their environmental stress was the fact that the women had relatively minimal support and assistance in raising their children. Generational substance abuse, and lost families ties were frequently reported. The Child Welfare System (DCFS) and Dependency Court viewed these women as unfit and unable to protect and care for their children. Women involved in the Child Welfare System (DCFS) were faced with additional pressures. Lack of sensitivity as well as limited knowledge of addiction and sobriety process by the Child Welfare System increased the challenges faced by substance abusing women. Additionally, the Adoption and Safe Families Act (ASFA) timelines (requiring permanency planning for any child who has been in out-of-home care for 15 of the previous 22 months) do not correlate with the realities of recovery and treatment (National Abandoned Infants Assistance Resource Center, 2007). Psychosocial distress was often an ongoing threat to accomplished sobriety.

The substance abuse counselors concurrently served as advocates for their clients as well as educators to social workers that were uninformed of addiction and the recovery process. The program found that when women were empowered and treated with dignity and respect they were more receptive to services. Furthermore, women were more motivated to stay sober when they had their children under their care or had opportunities to reunify. Strategies focused on supporting women towards retaining children under their care as well as reunification was offered. Engaging and retaining substance abusing women in services was not only instrumental in promoting recovery efforts, but in increasing child reunifications and child well-being. Consequently, all efforts were exhausted towards reducing risk factors before recommendations for out-of-home care were made.

The program also concentrated on improving self-sufficiency and empowered women to become independent. Single head of households and unemployment described more than 70% of women in this project. Income stemmed from state subsidies such as Temporary Aid to Needy Families (TANF), child support, food stamps and community donations for at least 55% of families. Additionally, educational levels ranging from B to 10 years limited prospective opportunities for employment. Only 9% of women participated in formal vocational or educational activities. Interventions focusing on improving self-sufficiency skills were aimed at increasing job skills, obtaining high school diplomas, enrolling in vocational training programs or attending community college courses (within the community services department). Referrals to job development skill training was provided to 20% of mothers. Of these referrals, 97% of women obtained employment in semi-skill positions. Referrals to educational development and achievement was provided to 32% of mothers with a 92% active participation rate in GED courses, adult high school and community college non-credit courses. Program interventions that addressed increased skill sets in education and job development were implemented through careful screening, sensitivity to educational needs, identifying career interests and obtaining any work history. The majority of women lacked work experience or job skills at program entry. Women were guided through the project's three-step referral process. Referrals included providing basic information (e.g. school address or job training site) followed by assisting in completing enrollment forms or transporting to interviews and lastly, ongoing support to sustain participation or employment, such as identifying child care providers; seeking information for public transportation; requesting donations for uniforms or book stipends. Overall, self-sufficiency levels were increased by 20% among single parent Latinas during program involvement.

**Promoting Positive Mental Health**

Intake demographics revealed that women from the substance abuse group had experienced childhood trauma and adult victimization. Participants frequently reported high rates of depressive symptoms or other forms of mental health disorders. Years of experience serving substance-abusing women led to the inclusion of a mental health component to the service design. In collaboration with the substance abuse counselor, a family therapist addressed the mental health issues. Individual sessions addressed unresolved childhood trauma, grief and loss. Additionally, the therapist was instrumental in facilitating reunification by strengthening attachments and bonds between mothers and their children. Mothers openly dealt with feelings of parent inadequacy, shame and guilt. Furthermore, two parent headed households received counseling focused on couple’s issues such as rebuilding trust, respect, co-parenting, and communication.

The therapist was also instrumental in assessing and treating coexisting mental health problems. Mental health services
provided to substance abusing parents women included: assessment and counseling for physical and sexual abuse and for the possibility of post-traumatic stress disorder; counseling and training in self-esteem and image enhancement; training in interpersonal, self-sufficiency and independent living skills; and relationship development between clients and their partners. Women also accessed mental health services through drug treatment centers.

Enhancing Social Support

Similar to their counterparts, women from the substance abuse group were living in isolation. Fear of relapse as well as lack of healthy support systems led many women to isolate from others. The substance abuse counselors assessed support networks and in most cases found that they (providers) were the only healthy role models and support that that women had. Efforts concentrated on building the women's level of confidence, trust in themselves, as well as their environment. The women were equipped with relapse prevention skills such as the ability to identify people, places, and things that triggered risks for relapse. The women were encouraged to attend 12 step help groups as well as faith based supportive services. Substance abuse counselors also linked women to outpatient drug treatment centers for more intense services and support. The women often reported that their established connections to recovery networks and groups were instrumental in building their sense of belonging and acceptance. Furthermore, associations with other parenting and recovering women served as sources of support and inspiration. Women learned from others who shared their similar experiences new and successful parenting techniques. These friendships became reliable sources of support. In addition to enhancing the mothers support networks, the staff provided resources focused on enriching the parent and child relationships. Children were also linked to specialized services such as behavior modification, and counseling. The program found that reducing problematic behaviors in children directly reduced the stress and anxiety of the mothers.

Families Impacted by HIV/AIDS

Families living with HIV faced a multitude of challenges that often preceded the onset of their non-AIDS HIV condition. These challenges were multi-layered and interrelated with socio-cultural, socioeconomic, racial disparities and immigration factors. HIV families dealt with cultural differences, low acculturation, language barriers and the stigma of HIV and AIDS in Latino communities. Poverty, substandard living conditions and limited financial resources among these women mandated their attention to survival needs, such as locating emergency housing, food, and clothing for their children. Many of the project's families resided in shelters and temporary housing. The high incidence rates for non-AIDS HIV and heterosexual HIV exposure for Latinas necessitated program strategies that addressed co-factors within a cultural context. Co-factors included low acculturation, resistance to HIV testing or lack of protective sexual behaviors, misperceived understanding of HIV and AIDS, intimidation due to immigrant status and social isolation.

Chronic Instability in Environmental Conditions

Some of the greatest challenges affecting HIV/AIDS impacted families were lack of stability and environmental stressors. HIV families lived in substandard housing, shared housing environments and temporary living arrangements. The families were often referred to the program for immediate support towards stabilizing housing. Project Milagro as well as other community programs serving impoverished communities have observed a decline in housing assistance programs for low-income families. Therefore, the program experienced challenges in assisting families with obtaining suitable and permanent housing. Families were frequently placed in hotels, and emergency shelters as temporary solutions to persistent situations. Although it was beyond the scope of the program to offer housing, the program staff worked assiduously with families to access available housing resources and entitlements. The scarce funding for low-income housing, overcrowded communities and demanding rental conditions limited the program's ability to maximize housing stability for families. Nonetheless, families were provided with safe housing although temporary for their children.

As with the Substance Abuse families, HIV women had few housing options and therefore, remained in overcrowded conditions. In several cases, they lived with individuals who were unaware of their HIV status. This posed additional challenges for HIV families and the program's staff. The constant fear of HIV disclosure and impending negative eviction consequences heightened Latinas' feelings of alienation and isolation. In these situations, in-home services were hindered due to confidentiality and privacy issues. Visits with these families were provided in local parks, schools or at the Bienvenidos agency.
Enhancing Social Support and Utilization of Community Resources

The project learned that families affected by HIV/AIDS were confronted with exceedingly needs. Complicating this was the prevalence of systemic and socio-cultural barriers to accessing resources. Families from the HIV/AIDS group were often identified as isolated, unaware of community resources, and underserved. Unmet basic needs and lack of social support were commonly reported. Families appeared overwhelmed and fragmented as they dealt with their inability to meet the basic needs of their children due to extreme levels of poverty. Poor mental health and deteriorating health conditions prevented parents from obtaining and sustaining employment. Additionally, families affected by HIV/AIDS were primarily low acculturated immigrants living in isolation due to xenophobic immigrant sentiments that have intensified during the past decade. Extended family support was often not available to these families due to migration. Reliance on neighbors and friendships was frequently noted as the only form of support. Family Support Workers assigned to these families developed Case Plans to address these needs and expand social support networks.

The program learned that the common response to reducing social isolation by social service providers was to "increase linkages to agencies." The program found that this often placed additional demands on families as accessing services led to increased requirements from social service agencies. Furthermore, a high demand for HIV/AIDS resources has led to long waiting list for appointments followed by pages of intake requiring disclosure of sensitive information. Scarcity of resources has led many organizations to restrict the provision of basic needs to only the families that access some other type of support (i.e., parenting group). This in turn discouraged already strained participants from accessing supports. The program staff was extremely successful in advocating for the participants and in increasing access and utilization of services in the community. Advocacy consisted of ensuring that the families were not stretched amongst outside providers and that priority issues were addressed. Project Milagro staff frequently became the stable element and trusted source in the lives of the families. Consequently, the providers often played a lead role in communicating information about client's status and coordinating resources with other team members.

Project Milagro staff responded to these needs by developing partnerships and collaborations with community-based agencies that served families impacted by HIV/AIDS. Families were referred to agencies that shared the programs respect of cultural beliefs and that ultimately were sensitive to the needs of Latino families.

Improving Mental Health Conditions

Project Milagro served HIV families with untreated and under-diagnosed mental health conditions. Among these women, 52% experienced mental health problems that included depression and psychological distress. Compounding mental well-being were the realities of environmental and social stressors such as poverty, isolation, and marginalization due to immigrant status and their HIV. Parents were also faced with pending permanency planning issues, HIV disclosure, and guilt over their past behaviors. Not surprisingly, the participants with more stressors reported more significant psychological distress to their providers.

In few cases, neurological conditions were identified. Conditions such as AIDS-related meningitis, TB of the brain, and Toxoplasmosis caused permanent psychiatric and cognitive disorders. These disorders resulted in memory loss, motor impairments, and delays. Project Milagro incorporated services that addressed these issues. Interventions for these participants concentrated on ensuring that clients were able to protect and care for themselves and their children. Intensive and comprehensive assessments and strategies were provided in the home environments. The program ensured that parents accessed medical and mental health services. The combined approach required that parents were accompanied to medical and mental health appointments. Overall, the mental health therapist was instrumental in identifying chronic conditions and factors that were beyond the scope of the program. In these cases, the participants were referred to community mental health services. Mental health services involving couples counseling was also offered to two parent households. Unique issues specific to couples living with HIV or AIDS were addressed. Such issues were often related to: betrayal and re-building trust; sex negotiation and tradition sex role scripts. In a few cases, the couple's therapy addressed issues of past domestic violence. In general, the therapist was more successful with engaging women than male partners. The program recognized the impact of traditional Latino beliefs among men such as "family matters are to be dealt with privately." Partners reported negative past encounters with public health and community providers. Feelings of gender and cultural insensitivity were often reported. Project Milagro staff responded by implementing partner engagement strategies that focused on meeting their needs. For example, staff were flexible to meet with partners during evening hours; visited
partners at their employment sites; male providers were assigned to work with partners; and direct services aimed at job development and job referrals were offered.

The program's model addressed the holistic needs of families that included mental health conditions. During the four years of funding, 57% of the adult participants and 15% of the children accessed mental health services. Readily accessible, culturally sensitive services were instrumental in reducing depressive symptoms among HIV/AIDS Latinas. It wasn't uncommon in the early phases of therapeutic relationships for clients to express feeling less depressed, less isolated and having "someone to talk to."

**Children Impacted by Substance Abuse and HIV/AIDS**

At the core of serving high-risk families was the importance of identifying and addressing the needs of children. During the four years, the program served a total of 475 minor children, 159 of these children were the primary index child and included four unborn children. Family Support Workers and substance abuse counselors applied strategies that targeted risk factors for child abuse, neglect and abandonment. Risk factors ranging from unsafe home environments to poor parenting were identified and addressed. Poverty, lack of stable home environments as well as fragile health and mental health of parents were commonly reported as factors contributing to the "risk" of child abandonment. The program staff serving both groups of families (substance and HIV impacted) was instrumental in reducing the risk factors and increasing the parents' capacities to protect and care for their children.

**Promoting Safety and Permanency**

At the core of Project Milagro's services was promoting safety and retaining children in their natural home environments. Direct services such as child proofing homes, while promoting the parents' ability to care for their children, were provided. Non-traditional strategies such as helping the mothers' clean their homes, and taking a trip to the store with the parent to purchase locks for medicine cabinets and hazardous chemicals were provided. In addition to concentrating on child proofing homes, the mothers received fundamental basics on re-parenting their children. Mothers often reported feeling inadequate in their role as mothers and often questioned their ability to parent their children. In addition to responding to priority areas such as ensuring the provision of basic needs of children, direct services focused on re-parenting the parent. Furthermore, staff focused on the importance of re-training children in core areas such as respect, communication, trust, boundaries, and rules. Parents themselves had to re-adjust their old ways of parenting their children and adapt to new and more effective ways. Nevertheless, in order for the parents to be receptive of the new approaches, the staff had to demonstrate respect of their cultural practices and beliefs. Parents were encouraged and motivated to take pride and ownership of their families as well as their opportunity to shape the lives and future of their children. Parents responded favorably to these approaches and were willing to receive the new information.

Child Development education was provided to parents during individualized home visits through the distribution of brochures, books, and videos. Informational materials were provided in easy to read and linguistically relevant formats. Individualized sessions focused on topics such as safety precautions, proper medication dispensing, and importance of Well-Child visits. Mothers and caregivers caring for prenatal exposed infants received specialized information and educational sessions concentrating on pediatric HIV/AIDS. For school aged children, parents received school advocacy in the forms of support during IEP meetings. Overall, parents were encouraged to take an active role in understanding the development of their children.

The program learned that the risk for child abandonment and abuse was directly reduced as a result of increased parental knowledge of their child's medical or developmental milestones. Additionally, increased access to specialized services for children was instrumental in promoting child-well being. The providers sought the support of other services both within the organization and externally to aid in addressing areas that were outside the scope of the program (i.e., health and child development delays). Children served by the program were linked to regional centers, specialized medical care, childcare, pediatric services and school readiness services. Mental health conditions such as included behavioral/emotional problems among children represented 17% of the linkages made to child focused mental health resources.

Furthermore, the program ensured that all children had access to medical care including the 14% that were identified as having medical conditions (8 HIV/AIDS; 1 fetal alcohol syndrome; and 7% had upper respiratory conditions). Secured home environments along with enhanced access to specialized care not only increased the retention of children in the care...
of their biological parents, but also facilitated the successful reunification of a total of 85 children. The program learned that children from the substance abuse group were at a higher risk of out of home care and at least 50% of the children were previously under the supervision or care of DCFS (Child Welfare). Strategies focusing on meeting court orders as well as ensuring that the home environments were suitable for children were provided. Staff assisted staff in ensuring home environments were safe as and had basic staples such as food, and furniture.

Five Stage Permanency Planning Model

Throughout the four years of service delivery, Project Milagro responded to the permanency planning needs of parents living with HIV/AIDS. The program designed a five stage culturally responsive permanency planning model that was sensitive to the needs of families. The permanency planning model was instrumental in reducing infant abandonment as well as promoting safety. The model served both as a conceptual framework and practical tool in educating families about future care and custody planning. Additionally, the five stage model allowed for tracking families progress as well as the programs overall success in achieving permanency with children.

Although the goal of the program was that every HIV impacted family would finalize a plan, the model was implemented with a high consideration of the families' needs and their willingness to address permanency planning. The program was responsive to the fact that the families faced multiple stressors and often did not want to engage in permanency planning. Due to the nature and focus of permanency planning process, it was presented as a choice for parents and not a requirement to receive program services. Consequently, in efforts to provide individualized permanency planning each family was assessed as to their interest and willingness to learn about permanency planning. All HIV affected families were introduced to the Permanency Planning Model which included the following stages: 1) Assessing the Readiness of the Family; 2) Education on Permanency Planning; 3) Identifying a Future Guardian; 4) Securing the Plan; and 5) Aftercare services.

The two core approaches that were most integrated in the permanency planning process were Joint Guardianship and California's Caregiver Authorization Affidavit (Cal. Fam. Code 6550). Effective January 1994, the California Legislature expanded the traditional concept of joint guardianship to allow custodial parents who are terminally ill to name one or more persons to act with them as joint guardians (Probate Code 2105(f)). This was a suitable option for families for it allowed the custodial parent to share with the joint guardian legal rights and responsibilities for the child.

Furthermore, through the years of exploring the area of permanency planning, the project learned that permanency could also be achieved through informal means. Due to the diverse levels in permanency plans of families, the program invested in developing and offering alternative ways to securing the future of children affected by HIV/AIDS. Therefore, in consideration of the different situations and varying constraints experienced by the families, informal approaches to permanency planning were introduced. California's Caregiver Authorization Affidavit (Cal. Fam. Code 6550) as well as Testamentary Wills was alternative methods used with families that were reluctant to engage in legal options to securing alternative caregivers for their children. Several families reported that these alternative approaches were less threatening and cumbersome.

Barriers and Challenges to Permanency Planning

The program learned that although many parents living with HIV/AIDS gave thought to what would happen if they became incapacitated or died, many refused to take steps to formalize arrangements. Cultural and religious beliefs were of the most prominent barriers to permanency planning that were encountered. Formal means of permanency planning were identified as foreign concepts to Latinos. Informal means of permanency planning were found to be more frequent as cultural and religious beliefs and practices such as baptism and "padrinos" (godparents) were automatically considered the alternative or next in line to care for a child. Literature has found that Latinos with lower levels of acculturation, (i.e., those who speak only Spanish) were less likely to disclose their HIV/AIDS status to significant others and family members (Mason, et al., 1995). Additionally, prevalent religious beliefs such as fatalism and the notion that "God's Will" would prevail played a key role in the parent's ambivalence towards formal means of permanency planning.

Furthermore, barriers tied to social conditions such as: isolation; lack of resources; and fear of the legal system also presented challenges to establishing permanency plans. Participants from the HIV/AIDS group were mostly immigrants from Mexico...
and Central America living in the United States in isolation from their extended families. Support networks were few, and often consisted of professionals rather than family members. Parents were therefore reluctant to disclose their illness for they were already faced with few supports. Fear of stigma, feelings of shame and guilt, were notable barriers to disclosing HIV status in turn to overall planning for future care of their children. Uninformed about HIV, the Latino community continues to marginalize those with HIV due to its associations with methods of infection. Additionally, parents often equated disclosure with “harming their children.” In an attempt to protect their children and loved ones form painful knowledge, parents refused to disclose their HIV status. Therefore, parents often lived in confinements of secrecy and experienced increases psychological distress. The program staff ensured that the parents at all times felt a sense of control of their decision to disclose as well the timing and to whom. As such, parents at times veiled or disguised their disclosure by reporting to have an illness other than HIV such as cancer or rare blood disorders. Parents’ decisions were respected, yet they were reminded that although an emotionally charged decision, disclosure would require support and assistance from professionals. They were encouraged to take advantage of the specialized support provided by the Project Milagro team. Overall, the program learned that the disclosure process existed in a continuum, with parents conveying varying degrees of information to their loves ones. Parents tended to disclose as their illness progressed and often to older children.

In a few cases, parents with HIV were also reluctant to engage in permanency planning due to “hopes of immortality.” Parents found to be living in stable health were less likely to explore permanency planning options. Such participants took into account the highly publicized “idea” that if they remained compliant to their medication regimen, they would live longer and that “death” was no longer an emerging threat. Program staff was respectful of the parents’ views and encouraged their hopeful perspectives. This however, was a barrier for permanency planning was often associated with “death” and “losing control.”

Others barriers were related to the painful emotions that were often triggered as permanency planning was discussed. It was often a challenge for parents to think about what would happen to their children in the event that they became unable to care for them or died. This was especially true, for the parents who cared for HIV positive children. The program served a total of 8 families in which a child was diagnosed with HIV or other serious health condition. In a few cases, the staff directly asked by the parents if they were willing to care for and assume guardianship of their children in the event that they died. Supervision and group trainings were instrumental in supporting and guiding staff as they encountered these situations. An additional challenge was that it could take months even years for some families to establish permanency plans. To facilitate and expedite permanency planning process the project relied on the legal support of Public Counsel Law Center. Public Law Center was a firm that offered free permanency planning services to HIV impacted families.

Although the program experienced several challenges to permanency planning. Findings indicated that there was noted success as a combined 46% of the families reached some form of permanency planning (formal or informal). Additionally, permanency tracking logs revealed that 57% of the families were informed of permanency planning options and as a result identified an alternative caregiver. These findings indicate that the majority of families proceed in their planning beyond Stage 1 Assessing the Readiness. Such findings reinforce the programs model and belief that comprehensive supportive services are needed to help all families through their reactions to the impending death that they face.

**Permanency Planning Survey Outcomes**

An open-ended questionnaire based on a series of items that obtained information on client readiness and challenges to developing a permanency plan. A total of 65 HIV/AIDS families completed these questionnaires. The program utilized this information to provide feedback to its developing permanency planning workbook. Clients were asked if they have identified a caregiver for their children, 71% responded yes; 59% indicated that they have verbally communicated this request directly to the intended caregiver and 55% of caregivers have provided verbal agreements. Joint guardianship was completed by 88% of these families; 11% of caregivers signed a legal consent form; 6% have initiated a court action and one family has agreed for to temporary custody. Based on the Project Milagro’s 5 Stage Model, families were categorized into the following levels: Level 1-7%, Level 2-33%, Level 3-31%, Level 4-11% and Level 5 8%. Families continued to concentrate in the second and third stages of this process. Caregiver’s knowledge of the client’s illness was 82% and 11% among parents refusing to disclose. Children were usually too young to assess if they had knowledge of their parents’ illness (63%) and 11% of parents refused to disclose their HIV to children. Obstacles to permanency plans included 43% of families who were not ready to address this topic, 23% specified disclosure in general
as problem, 17% were in denial of the outcome of HIV and 19% of families were unable to identify a suitable caregiver. Other challenges included issues with biological fathers (32%) followed by immigrant status for 34%. Eight percent (8%) of mothers were dealing with crisis and were unable to address permanency planning and there were 25% of families who tended to "miss" permanency planning appointments. Overall, this data was helpful to the project's service delivery and in developing realistic time frames for clients.

Program Evaluation

I. EVALUATION IMPLEMENTATION

The evaluation implementation activities consisted of a series of staff trainings focused on data collection protocols, data management, coding and maintaining participant files. Emphasis was placed on adhering to the project's evaluation plan and timeline. Quarterly meetings and presentations with project staff were conducted to discuss program reports, evaluation findings and data issues. The evaluation team was active in engaging staff in the data collection process and provided technical assistance for completing instruments. The evaluation followed IRB and HIPPA guidelines by securing confidentiality of participants' identifying information and data. The evaluation applied unique participant identification numbers, obtained signed consent forms for participants and the lead evaluator stored data files in locked cabinets. The evaluation team provided ongoing data logs for tracking data collection activities and to monitor attrition rates. The evaluation completed the project's data collection for the AIA Cross-site Database and the Children's Bureau protocol database. Project Milagro submitted electronic annual data for the 4 year-grant award period to the AIA Cross-site evaluation.

II. EVALUATION DESIGN

The overarching goal of the evaluation was to capture effective strategies that promote child safety, permanency and family well being. Analogous to the Project Milagro model, the evaluation examined the impact of socio-cultural factors and socio-demographic variables on a number of short and long-term outcomes among Latinas with HIV or AIDS and Substance Abuse. The evaluation provided an enriched assessment of race/ethnicity that expanded general United States Census data, by acknowledging the heterogeneous factors ascribed to Latino/as. A quasi-non-experimental pre- and post-test design was used to evaluate the efficacy of program services at different time points. Data was collected at program entry (baseline), six months (post-test) and program completion (post-test 12 months).

A. DATA COLLECTION INSTRUMENTS

The project's self-reported instruments and interviews were administered in English or Spanish, depending on participant's language preference.

Bienvenidos Intake

This assessment contained open-ended questions on demographics such as marital status, number of children, income, employment and family composition. Cultural variables were also obtained and included language spoken in the home, country of origin and years in the United States. The Intake further obtained service needs and provided comprehensive assessment of presenting problems. The intake was obtained for each family using an interview format at program entry.

Child Risk Factor/Developmental Screening Checklist

The Child Risk Factor Survey, a 20 item checklist was used to identify experiences or events occurring within the last six months (current) and more than 1 year ago (past) that identified children at "high risk." The developmental screening assessed medical, mental health, emotional and behavioral functioning based on history data, diagnosed conditions by a professional provider, parent input and the project coordinator's observations. Child risk assessments were conducted for the youngest child of each family (index child) at baseline and post-test 12 months.

Ages and Stages Questionnaire & Developmental Profile 2

Based on the number of child risk factors, developmental testing was completed for children who were identified as "high risk" for developmental delays, learning disabilities, behavioral problems and medical conditions that may potentially impede developmental functioning. The ASQ was used to test children ages 3 months to 5 years old and the DP2 tested children between 3.1 years to 6.0 years. Both of these standardized measures provided scores for five developmental areas of functioning: communication, motor skills (fine and gross), socialization, self-help skills and problem solving or cognitive development. The DP2 scores were calculated using chronological age in months to determine functioning levels.
whereas the ASQ provided "at age-appropriate level, below or above age level" (categorical).

**Parent Risk Factor Checklist**

The Parent Risk Factor Survey, a 40-item list of events, identified childhood experiences, psychosocial events and social conditions as factors placing parents "at high risk." Recent events occurring during the past 12 months and lifetime events occurring over 12 months ago were the methods used in evaluating risk factors. This assessment was completed at baseline and post-test 12 months (or program completion).

**SAS-Hispanic Scale**

The Short Acculturation Scale - Hispanic (SASH) was utilized to assess level of acculturation among participants. This short 12-item scale taps into language preference and environmental-social practices within the Hispanic (Latino) culture. The SAS-H provided a score range from 1 (low acculturated) to 5 (highly acculturated) and was evaluated with other relevant socio-cultural variables (language, country of origin and years in the U.S.).

**Health Interview Survey**

The Health Interview was developed by the project to identify health conditions for each of the group of participants impacted by HIV/AIDS or Substance Abuse. For the Substance Abuse group, Health Interviews assessed level and history of alcohol/drug addiction; past substance abuse treatment and health problems.

The HIV/AIDS Health Interview obtained information on HIV status: such as exposure to HIV or AIDS, symptoms, medication compliance, medication side effects and HIV/AIDS related illnesses including physical functioning.

**Medical Access**

This tool contained 11 items, scored 1 to 5 with 5 meaning better access to medical services, medical centers and physicians. Medical access among Latinas was assessed at program entry and program completion.

**CES-D**

The Center for Epidemiological Scale-Depression was used to assess depressive symptoms and anxiety during the past week. The score range for this measure was 0 to 60 with a score of 16 or higher indicating presence of depressive mood symptoms. The project evaluation design included baseline, post-test 6 month and post-test 12 month assessments.

**Parent Stress Index**

The Parent Stress Index (short form) was used to examine the impact of the project's home base model on reducing parenting stress levels. The PSI short form version is currently used in the AIA Cross-site evaluation and this version was incorporated in the present study. The PSI-Short form taps into various aspects of perceived stress associated with parental distress, dealing with difficult children, parent-child interactions and total life stress levels. The PSI provided 4 domains: Parental Distress (12 items), Parent-Child Dysfunction (12), Difficult Child (12), and Total Life Stress (36 items). The PSI contained a Likert response scale with item scores ranging from 1 - 5, with 5 meaning strongly agree. Scores were summed for each domain and ranged from 12 to 180. This tool was administered at baseline and post-test 12 months to biological mothers.

**Health Related Quality of Life Scale**

The evaluation assessed the quality of life at baseline, six months and at program completion using the HRQOL measure. This instrument consisted of 9 subscales and 3 composite scores. This self-reported tool yielded a score range from 1 to 100; higher numbers indicating better levels of quality of life. The subscales were: Physical Functioning (9 items), Role Functioning (2 items), Freedom from Bodily Pain (2 items), General Health Perceptions (3 items), Social Functioning (2 items), Energy-Fatigue (2 items), Positive Affect (2 items), Anxiety (2 items) and Depression (3 items). For this study, composite Mental Health and Physical Health scores were used to assess the impact of Substance Abuse and HIV/AIDS on quality of life.

**Coping**

Coping methods used to deal with HIV/AIDS and/or Substance Abuse were assessed at baseline and program completion (Post-test 12 months). This tool contained 32 items and utilized an early version of the Coping Response Inventory (Moos, 1991). This measure provided three types of coping: Active-Cognitive, Active-Behavioral and Avoidance strategies. Participants responded to a Likert type response scale to behavioral and cognitive types of actions to coping with their health condition. Avoidance type behaviors were scored as less effective than the other 2 subscales.

**Social Support**

Practical support and Emotional support were measured on a 4-point Likert scale from 1 (a little bit supportive) to 4 (completely supportive). Ratings were summed across all people the client reported to be in their circle of support. Each
V. RESULTS

Demographic Profile

Index Children

There were 78 index children in this group. 85% were living with biological mothers diagnosed with HIV or AIDS, 4 index children resided with HIV positive fathers and 1 child lived with both HIV positive grandparents. The project currently has enrolled a total of 6 HIV positive children. The mean child age was 4.5 years with 57% male and 43% female.

87% of Latinas and their partners were primarily Mexican (foreign born) and Mexican American: 17% were born in the United States, 47% migrated from Mexico, 11.3% from Honduras, 11.3% from El Salvador, 7% from Guatemala and 2.8% from Belize. Self-identified African-Americans represented 8.5% of families while 4.2% self-reported as "Other" and migrating from Africa. The average number of years Latino families resided in the United States was 14 years (non-U.S. born). Spanish as the primary language was reported for 61% of families, English was 16% and 24% stated being bilingual.

The mean education for parents was 8.8 years for mothers and 10.4 years for fathers (N=24). The mean age for HA biological mothers was 33 years and 35 years for fathers. Marital status for this group included 33% reported “married” or “living with a domestic partner”, 37% were single mothers, 21% were separated or divorced and 9% were widowed. Among HIV/AIDS Latina primary caregivers, 62% were single heads of household. Work status reported for HA families (mothers and fathers) indicated that only 9.9% were employed full-time and 12.7% had part-time employment; close to 78% were unemployed although 10% were actively seeking work.

Client Satisfaction Survey

This five-item questionnaire was used to assess satisfaction levels using a 4-point Likert scale. The questionnaire was obtained from AIA Funded programs during the last year of this project and provided data for 36 families. This tool was administered as a follow-up questionnaire after program termination.

III. SAMPLE

The sample comprised of 159 index children, 6 years old or younger and 248 minor siblings among 163 families. Of the project’s families, 85 (52%) were identified with at least one Substance Abuse parent (primarily mothers) while 71 (44%) represented at least one HIV positive or AIDS caregiver (mostly biological mothers). There were 36 partners included in the evaluation that were assessed using demographic data and identified as fully or partially engaged in the project. The sample also included 9 index children residing in families impacted by HIV/AIDS (Hai-N=7) and/or Substance Abuse/Addiction (Sai-N=2). The results presented were based on biological Latina mothers who were HIV positive or living with AIDS; and Latina mothers diagnosed as alcohol/drug dependent. Due to the small sample numbers, non-HIV (Hai) and non-Substance Abusers (Sai) were included in the statistical analyses.

IV. OUTCOME EVALUATION

Data was examined for a total of 163 families that included 198 fully or partially participating adults and 159 index children (4 unborn index children at intake). In this report, descriptive statistics were used to identify demographic and socio-cultural variables. The overall statistical analysis scheme applied to examine program effects included change T-Tests and ANOVA statistics for the HIV/AIDS and Substance Abuse groups from baseline to termination for the project’s outcome measures. Within and between group analyses were also conducted to detect further significant changes from baseline (pre-test) to post-test for the project’s sample.
SUBSTANCE ABUSE FAMILIES

Index Children
There were 85 index children impacted by Substance Abuse and 87% were residing with a substance abusing biological mother. Children were younger in this group with a mean age of 2.7 years; 41% were male and 59% were female.

Substance Abuse (SA) Latinos
The mean age for mothers was 30 years (N=82) and 32 years for fathers (N=20) with an education mean of 10.7 years.

Ethnicity for this group represented 94% Mexican American, 3% African American and 3% Anglo. More than two thirds of these families were born in the United States, 19% were from Mexico and 6% were from Central or South America. Primary language in the home was English (88%) followed by Spanish (12%) with 46% reporting being bilingual. The unemployment rate was 73%; 12% of mothers worked part time with only 7.3% reporting full-time work. Marital status for this group indicated that 26% were married or living with a domestic partner, 51% were single mothers and 21% were separated/divorced. Similar to the HA group, 76% of indexed children were residing with single mothers. Single head of households for this group were identified for 68% of Latina families.

Child Risk Factor Prevalence Rates

SUBSTANCE ABUSE AND HIV/AIDS CHILDREN

An initial baseline and post-test child risk assessment was conducted for the project's child sample. The Child Risk Factor Survey, a 20 item checklist was used to identify experiences or events occurring within the last six months (current) and more than 1 year ago (past) that placed children at "high risk" for child abuse or abandonment. Risk factors detected at baseline for the project's HIV and SA children are listed in Table 1.

At program entry, the most frequently reported risk factors for children residing in Substance Abuse or HIV/AIDS families were: lack of stable family composition (SA=73%, HA=70%) and unstable housing (HA=25.7%, SA=23%). Children in Substance Abuse families were more likely to go to higher risks at program entry due to factors associated with child well being. Specifically, 34.6% reported out of home placements (or detained from biological parent), 25.6% were exposed to substance abuse during the past six months and 24.4% were victims of neglect. These risk factors were in contrast to the HA children with lower rates reported. The majority of SA families were referred by the Department of Children and Family Services, the risk factors identified for SA children were as expected. For the total sample, 18% of families had children detained at program enrollment. In addition, 22% of families reported recent involvement with child protective services and/or current open DCFS cases.

Table 1. Baseline Child Current Risk Factors

<table>
<thead>
<tr>
<th>Risk Factor Terms</th>
<th>Sample Group</th>
<th>HA (n=70)</th>
<th>SA (n=78)</th>
<th>TOTAL (n=148)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>count</td>
<td>%</td>
<td>count</td>
<td>%</td>
</tr>
<tr>
<td>1. Lack of stable family composition</td>
<td>49</td>
<td>70.0%</td>
<td>54</td>
<td>73.1%</td>
</tr>
<tr>
<td>2. Domestic violence</td>
<td>18</td>
<td>25.7%</td>
<td>16</td>
<td>21.1%</td>
</tr>
<tr>
<td>3. Exposure to substance abuse in the household</td>
<td>6</td>
<td>13.4%</td>
<td>21</td>
<td>27.6%</td>
</tr>
<tr>
<td>4. Victims of abuse or neglect</td>
<td>9</td>
<td>12.9%</td>
<td>10</td>
<td>13.1%</td>
</tr>
<tr>
<td>5. Exposure to domestic violence</td>
<td>7</td>
<td>10.0%</td>
<td>11</td>
<td>14.1%</td>
</tr>
<tr>
<td>6. Chronic health problems</td>
<td>8</td>
<td>11.4%</td>
<td>6</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Prevalence rates for past risk factors reported as occurring prenatally and prior to 12 months ago were found for the child sample and are shown in Table 2. Among HIV/AIDS children, 37% reported exposure to domestic violence. 26.6% reported chronic unstable housing and 21.4% reported exposure to substance abuse in the household. Additionally, close to 16% of children reported victim of abuse and/or neglect and prenatal drug exposure. Children in the SA group reported higher prevalence rates for past risk factors occurring more than 12 months ago.

Table 2. Baseline Child Past Risk Factors

<table>
<thead>
<tr>
<th>Risk Factor Terms</th>
<th>Sample Group</th>
<th>HA (n=70)</th>
<th>SA (n=78)</th>
<th>TOTAL (n=148)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>count</td>
<td>%</td>
<td>count</td>
<td>%</td>
</tr>
<tr>
<td>1. Exposure to domestic violence</td>
<td>25</td>
<td>37.1%</td>
<td>35</td>
<td>44.9%</td>
</tr>
<tr>
<td>2. Victims of abuse or neglect</td>
<td>17</td>
<td>24.3%</td>
<td>50</td>
<td>61.5%</td>
</tr>
<tr>
<td>3. Exposure to substance abuse in the household</td>
<td>15</td>
<td>21.4%</td>
<td>40</td>
<td>50.6%</td>
</tr>
<tr>
<td>4. Unstable housing</td>
<td>20</td>
<td>28.6%</td>
<td>30</td>
<td>38.5%</td>
</tr>
<tr>
<td>5. Prenatal drug exposure</td>
<td>11</td>
<td>15.7%</td>
<td>25</td>
<td>32.1%</td>
</tr>
</tbody>
</table>

Children were chronically exposed to abuse or neglect (59%), substance abuse in the household (51%), prenatal drugs/ alcohol (44.9%) and domestic violence (44.9%). Also, 38.5% of SA children have been residing in unstable housing/living conditions for more than 12 months. The salient risk factors identified for the SA child sample represent the negative impact of substance abuse on children. These risk factors continue to place children at high risk for further neglect, abuse and abandonment. Chronic substance abuse exposure,
Past victimization of abuse or neglect, family violence and family instability were identified as prevalent for these children prior to program enrollment. The project’s Substance Abuse families were engaged at critical points, often at the onset of child protection services or child detention. Most importantly, the project’s services have focused on advocacy, stabilizing families, reunification plans, drug counseling and providing family counseling. A key aspect of the evaluation is the utilization of data to guide and improve program services. Project Milagro has assisted mothers in developing self-protective skills and maintaining safe environments for their children. The prevalence rates for risk factors associated with child abuse and abandonment are displayed in Figure 1. These risk factors of interest indicated that SA children experienced higher risk factors for out of home placements and detention. For this reason, the project provided intensive case management at program entry.

**Figure 1. Risk Factors for Abandonment and Abuse**

**Prevalent Risk Factors for HIV and SA Parents**

The Parent Risk Factor Survey, a 40-item list of events, childhood experiences and current situations were identified as factors placing parents “at risk.” Risk factors reported as occurring during the past year and events occurring over 12 months ago including childhood were the time points used for determining prevalence rates. At baseline, the most prevalent current risk factors for HIV/AIDS parents were poverty (91%), unemployment (73.8%), limited or poor job skills (73%) and inadequate or no health insurance (71%). Families were currently residing in substandard/temporary housing (70%) and 71% were isolated. Augmenting their poor social conditions was family discord. Poor or limited parenting skills were identified for 52% and 38% reported current marital problems. Mental health symptoms or mental health diagnosis was reported for 45% of parents. The overall past and current risk factors are summarized in Figure 2 for both groups.

Past risk factor frequencies reported as occurring more than a year ago or during childhood are listed in Table 3. For HIV/AIDS parents, past risk factors included chronic/long term medical condition, 97.6% as expected, 60.7% reported a mental health disorder (chronic); 61.9% reported homelessness or unstable living conditions (includes shelters) and 58.3% were victims of past domestic violence. Risk factors identified as occurring during childhood consisted of 60.7% reported being victims of child abuse (neglect, physical and/or sexual), 46.4% reported witnessing domestic violence and 38% grew up in substance abusing households. Baseline risk factors for the project’s HIV/AIDS sample indicated that these families were faced with additional multiple stressful situations that increased their challenges in coping with HIV or AIDS. The high prevalence rates for poverty, mental health conditions and unstable home environments underscored the need to provide support in accessing an array of services.

Baseline risk factors were identified for families impacted by Substance Abuse using the same assessment scheme as the HIV/AIDS group. The most frequent current risk factor reported was poor or limited parenting skills (91%), followed by poverty (86%) and unemployment (78%). Substandard/temporary housing was reported for 60% of mothers and 55% had inadequate or no health insurance. Marital discord continued to impact these families with 61% reporting significant conflicts with partners. Isolation was reported for 49% and 27% of women were at risk due to mental health conditions.
For this group, 35% reported substance abuse within the past 12 months. Unlike their counterparts, SA women were at risk due to past and current DCFs reports for abuse or neglect (38%) and recent child detainment (41%). The risk factors found indicated that substance abuse parents experienced financial instability, poverty and unemployment with limited access to health resources. In addition, the prevalence of poor parenting skills is not surprising due to their past history with the child welfare system. Approximately one third of women in this group reported using alcohol or drugs during the past 6 months and were in the early phases of drug treatment. Baseline risk factors reported as occurring during childhood and more than 12 months were found for 35% to past risk factors at baseline for HA women was 5.00 and 6.46 for SA women. A significant difference was found at p < .001. This finding indicated that Substance Abuse women reported significantly higher risk factor rates compared to HIV/AIDS women at intake. Baseline to termination changes within each group (HA and SA) was found significant. Pairwise t-tests results indicated that within the Substance Abuse group, risk factors decreased at termination. This was also found for the HIV/AIDS group. Number of current risk factors (within the last 12 months) among parents was examined (N=156) from baseline to termination. For the total sample, significant changes were found for decreased abusive or neglectful parenting. A 16.5% improvement was found significant after program completion (p < .008). A second positive change was identified and included a significant decrease by 28.6% in isolation (p < .020). A reduction by 37.4% was found significant for substandard living conditions (p < .001) and inadequate/no medical insurance was improved by 39.6% (significant at p < .001). Mental health symptoms were also improved by 20.9% (p < .015) and medical illness (not HIV) improved by 14.3% (p < .021). Comparisons between SA and HA Latinas on current risk factor prevalence rates yielded several significant improvements. Substance Abuse Latinas improved by 26.0% in maintaining sobriety (p < .004); this group improved by 24.0% in reducing risks for abuse and neglect (p < .030); child detainment was reduced by 24.0% suggesting reunification (p < .001); improved parenting skills for SA Latinas was 20.0% compared to 7.3% improvement among HA women (p < .016); Employment also improved and was higher for SA women, 22.0% compared to 9.8% for HA women (p < .001). HIV/AIDS Latinas significantly improved in mental health conditions, 29.3% compared to 14.0% for SA women (p < .018).

Risk factors among children were examined using nonparametric change tests. Baseline to termination changes for the project's total children (N=148). SA child group (N=78) and HA child group (N=70) were detected for only a few risk factors. For the total sample, exposure to substance abuse in the household was improved overall by 18.6% at p < .049 (slightly significant) and out-of-home placement was reduced by 17.1% at p < .035. Out-of-home placement was also significantly reduced for children in Substance Abuse families by 25.6% (p < .025) compared to HA children with only 6.5% improvement. Baseline differences were found for SA children and HA children for total number of past and current risk factors. SA children were found to report significantly more risk factors at intake than HA children although these differences were not detected at termination. However, termination
1.63 and 1.73 respectively, were more align and suggests that one group does not change significantly more than the other.

Child Developmental Screenings and Testing

Index children were screened at program enrollment and a second time, at program termination. Developmental screenings were conducted to assess medical, behavioral and developmental problems. The purpose of these screenings was to provide early detection and intervention. A total of 148 children were screened at enrollment and 116 at termination. For the total child sample, 17.6% were identified with behavioral problems that included emotional disturbances and Attention Deficit Disorder (or ADHD). Developmental delays/learning disabilities were identified for 4.8%, only one child was diagnosed with Fetal Alcohol Syndrome, one child had vision problems, 13.4% had medical conditions including asthma (7.2%) and 8 children were HIV positive. Baseline to termination changes was examined using change t-tests. Only one significant change was detected for behavioral problems (N=114). Children were found to display more behavioral problems at program completion (p <.001). As previously stated, the project’s second developmental screenings were used to identify undetected problems.

Ages and Stages Questionnaire & Developmental Profile 2

Developmental testing was completed for children who were identified as “high risk” for developmental delays, learning disabilities, mental health conditions and medical conditions that impact developmental functioning. The ASQ was used to test children ages 3 months to 5 years old and the DP2 tested index children between 5.1 years to 6.0 years. A total of 47 children were tested at baseline using the ASQ and 7 children were tested using the DP2. Both of these standardized measures provided developmental areas of functioning that included communication, motor skills (fine and gross), socialization, self-help skills and problem solving or cognitive development. The DP2 provided chronological age in months to determine functioning levels whereas the ASQ provides “at age appropriate level compared to below or above age level” (categorical).

For the 49 children tested, the following delays were detected: 24.5% in fine motor skills, 18.4% in communication, 12.2% in problem solving, 8.2% in gross motor skills and 4.1% in social functioning. Summarizing this data, most delays were detected at the first testing time. However, 4 delays were first detected during the second testing, 2 were first detected during the 3rd testing and two were not detected until the child had been tested at 18, 20, 24 and 33 months of age. The most common delay was found in fine motor skills. These motor skills included holding crayons, pencils, writing tasks, stacking blocks, turning pages in a book and/or opening doorknobs. These developmental skills are critical to school readiness and transitioning into Kindergarten. The project staff focused on assisting families in developing activities that enhanced developmental tasks. Referrals to regional centers were completed for the children identified with at least one delay. The developmental testing was conducted in either English or Spanish, depending on child’s level of comfort and command of the language. Lastly, no significant relationship was found between the developmental testing results, child risk factors and medical conditions including HIV/AIDS pediatric cases. This may have been due to in part to the small number of assessments completed and the project’s testing criteria used to identify children for follow-up testing.

Cultural Competency

The project provided services that were culturally and linguistically appropriate for Latino families. The Short Acculturation Scale – Hispanic (SASH) assessed level of Acculturation to determine language preference, cultural practices and belief systems utilized by the project’s Latino families. The SAS-H provides a score range from 1 (low acculturated) to 5 (highly acculturated). Significant group differences using ANOVA statistical analysis were found for the project’s sample. The results are shown Figure 3. The SAS-H findings indicate that families with HIV/AIDS were significantly less acculturated than Substance Abuse families. Number of years in the United States was also obtained for HA and SA groups. The mean number of years for the HA group was 14.1 years compared to 24.8 years for the SA group. HIV/AIDS families were more likely to be first generation Latinos, monolingual Spanish-speaking whom maintained Latino
Fifty-four percent (54%) of participants were rated at Stage 1, 22% at Stage 2 and 6% at Stage 3. Participants taking HIV/AIDS medications were 92% (and 8% were not). Compliance to medication protocols was 89% among this group and 67% reported experiencing illnesses secondary to HIV and/or medication side effects. Medication side effects commonly reported were fatigue/weakness (42%), loss of appetite/weight loss (39%), headaches (14%) and mood disorders (21%). Overall percentages for number of side effects reported were 34% for 3 or less; 16% for 4; and 16% for 6 to 7 symptoms.

Figure 3. Baseline SAS-H for HIV/AIDS and Substance Abuse Groups

Health Conditions

The Health Interview was developed by the project to identify health status and medical needs for participants impacted by HIV/AIDS or Substance Abuse. For the Substance Abuse group, Health Interviews assessed level and history of drug addiction; drug treatment needs; drug related health problems; and medical needs. Service plans targeting improved health outcomes are based on this assessment. For the HIV/AIDS group, HIV status, symptoms, medication side effects and associated HIV/AIDS related illnesses were used to monitor and assess health service needs and medical conditions that impact quality of life and levels of physical functioning. For the total sample, this data was used to establish case plans and service goals for each of the families.

HIV/AIDS Sample Twenty-three percent of participants have been diagnosed with AIDS and 69% are +HIV symptomatic. Among these participants, 8% were asymptomatic. The average time participants have been living with HIV/AIDS was 5.3 years (range = 1 month to 10.7 years). Physicians primarily informed participants of their diagnosis (86%) (see Figure 4). Partners only informed three women their HIV status prior to testing. Retesting to confirm their diagnosis was reported by 85% of Latinas. Figure 6 shows that this group self reported that they contacted HIV by heterosexual exposure (contact) with a partner or husband. Karnofsky Scale ratings, ranging from Stage 1 (a-symptomatic/few symptoms) to Stage 4 (AIDS-severe).

Figure 4. Informed Client of HIV Status

Fifty-four percent (54%) of participants were rated at Stage 1, 22% at Stage 2 and 6% at Stage 3. Participants taking HIV/AIDS medications were 92% (and 8% were not). Compliance to medication protocols was 89% among this group and 67% reported experiencing illnesses secondary to HIV and/or medication side effects. Medication side effects commonly reported were fatigue/weakness (42%), loss of appetite/weight loss (39%), headaches (14%) and mood disorders (21%). Overall percentages for number of side effects reported were 34% for 3 or less; 16% for 4; and 16% for 6 to 7 symptoms.

Figure 5. Exposure to HIV Infection Among Latinas
Drug/alcohol histories revealed that 17% of the sample reported using drugs or alcohol during the past six months; the most frequently abused substances are presented in Figure 6. Methamphetamines (37%) and alcohol (36%) were the most common substances used by this group. Drug dependent history indicated that 68% of women were long-term drug users (more than 5 years), 24% used drugs/alcohol between 1 year to 5 years and 4% reported using for less than one year. Self-report duration of sobriety for this group indicated that 54% were sober for more than six months, 36% were sober between two to six months and 8% were sober for less than one month. The mean age of onset of drug use was 17.1 years old and 8 years old was the youngest age reported. Half of the sample reported using alcohol/drugs during pregnancy. These included alcohol, amphetamines or tobacco (most prevalent). Drug treatment status for this sample indicated that most women utilized self-help groups (64%) followed by outpatient treatment (51%) and residential treatment (19%).

Medical conditions including mental health issues are presented in Figure 7. Half of the substance abuse women reported having poor health. The most frequent condition was mental health (31%) and abnormal PAP results (7%). A total of 34 different health conditions were reported for the SA sample. Medical treatment sought and received for these conditions was reported by only 63% of participants. Eleven percent (11%) of women reported that these medical conditions were related to their drug or alcohol abuse. A high percentage of women, 59%, reported having surgeries during the past year.

Figure 7. SA Medical Conditions Present During Program

Accessing Medical Services

Access to medical services was assessed using the Medical Access form. As previously identified, the project's sample was at high risk due to inadequate or no medical insurance. The project's services focused on assisting families in identifying health care providers, accessing health care services and obtaining medical treatment (45%). Baseline data for this form indicated that women with HIV/AIDS were accessing health services significantly more than the women impacted by Substance Abuse. This difference was found significant using ANOVA analysis (p.<.000). The means for SA and HA samples were 3.43 and 4.04, respectively. For this measure, higher scores indicated increased medical access with a score range of 1 to 5. Women in the SA group were found to have less access to health care and may be due to part to health care neglect while actively using alcohol and/or drugs. In contrast, women living with HIV were more likely to be receiving medical treatment for their HIV/AIDS. The health information obtained has guided program services to provide SA women with health care linkages and treatment for routine medical exams, STD including HIV testing and medical treatment for specific health issues (e.g. Hepatitis). For the HIV/AIDS group, services have emphasized health education on HIV symptoms, medication protocols and medication side effects. For the total sample, the project has focused on linking families to state funded medical coverage. Statistical analyses were conducted using ANOVA statistics and a series of paired t-tests for changes from baseline to 12-month post-tests (termination) for medical access outcomes. Significant changes were detected for the project's SA and HA groups. Medical access was found to significantly increase at termination for HIV/AIDS women compared to
The Parent Stress Index (short form) was used to examine the impact of the project's home base model on reducing parenting stress levels. The PSI short form version is also currently used in the AIA Cross-site evaluation. The PSI-Short form taps into various aspects of stress associated with parental distress, dealing with difficult children, parent and child bonding, and total life stress levels. Specifically, four domains...
comprised the total PSI score: Parental Distress, Parent-Child Dysfunction, Difficult Child, and Total Life Stress. Statistical analyses were used to evaluate changes from baseline to program completion. In addition, between and within group differences for the HIV/AIDS and Substance Abuse families were examined. Statistical analysis of this measure did not detect any significant results for the total project sample, SA and HA subgroups. However, a decrease was found for both groups at termination. More importantly, stress levels resulting from parenting such as dealing with childcare or a difficult child were found to be higher than the normative sample. As shown in Figure 10, means at baseline and termination for both groups were relatively higher.

**Figure 10. Non-significant Baseline to Termination Change: Higher Mean Scores for SA and HIV/AIDS Women than Normative Sample.**

The mean number of supportive people for the project's sample was 3.83 at baseline and 3.62 at termination. The majority of families indicated that they could rely on their primary supports to provide practical support (mean = 10.25) and emotional support (mean = 12.52). More than 50% had at least 2 supportive persons in their Circle of Support. Baseline to termination comparisons for the project's sample did not provide any significant differences for this analysis. Overall degree of knowledge or “disclosure” was 12.50 at baseline and 12.10 at termination. No significant changes were found for “disclosure” of HIV/AIDS and Substance Abuse to persons in participant’s circle of support.

Group comparisons on social support yielded significant results and are shown in Table 5. At baseline and termination, the SA clients reported significantly more people in their circles of support, higher levels of both practical and emotional support and greater degree of knowledge of their diagnosis among people in their circles of support. In contrast, HA clients had fewer people in their circle of support (average was close to 3) and received less practical and emotional support. Social support did not improve at termination for HA families. In addition, degree of knowledge of Substance Abuse or HIV/AIDS among supportive persons was high for both groups. The majority of Substance Abuse clients indicated that they disclosed past substance abuse problems. Among the HA group, 18% indicated that supportive persons did not know about their HIV status while 72% reported self-disclosure.
### Table 5. Social Support Group Comparisons

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<td><strong>Baseline</strong></td>
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There were several limitations to the quantitative scheme and content validity applied by the evaluation to assessing social support. This tool was developed to capture the process of permanency planning among HIV/AIDS families. For this purpose, social support items closely identified persons in clients' circle of support and attempted to measure the quality of supportive persons from highest to lowest. In general, this tool was difficult for staff and clients to complete. Clients were further asked whether they knew if supportive persons were knowledgeable of their HIV status. Only one item clearly stated, “Clients were certain they knew because they told them.” This latter item better assesses “self-disclosure” compared to the other three choices. HIV clients identified formal persons as supportive such as the project's staff, nurses and doctors followed by siblings. This pattern was also detected at termination. It is important to note that only 2 to 3 persons were identified as in the “circle of support” among HIV women. This small supportive network may be due to this group's isolation, mental health problems and limited networks if they are newcomers to the United States. It is not surprising that this group did not demonstrate any changes or increase in social support at program termination. As previously discussed, the majority of HIV women in this project have maintained supportive relationships with staff at shelters or other temporary housing facilities, hospitals, clinics and community based organizations similar to Bienvenidos.

### Environmental Safety

The evaluation assessed environmental and home safety for children using the Family Assessment Form - Safety Domain. This domain captures safety practices in the home such as child proofing; items taping into maintaining child safety include providing adequate childcare. This scale used a 1 to 5 score range with 5 indicating less safety (poor functioning). Families were evaluated at baseline and termination in their homes. Change tests statistical analysis indicated that families in both groups did not significantly improve their homes, however significant changes were found for between group comparisons. As shown in Figure 11, significant changes from baseline to termination were found for the Substance Abuse group and not the HIV/AIDS families.

#### Figure 11. Child Safety

![Child Safety Graph](image)

*groups are different at the .05 level of significance*

### Coping Strategies

Coping methods used to deal with HIV/AIDS and/or Substance Abuse were assessed at baseline and program completion (Post-test 12 months). The 32 item earlier version of the Coping Response Inventory (Moos, 1991) was used to measure three types of coping: Active-Cognitive, Active-Behavioral and Avoidance. Coping strategies were evaluated for the project's adult participants who were asked to identify how they have coped with one of the following situations: (1) their own HIV positive or AIDS diagnosis and (2) their own Substance Abuse. Statistical analysis using ANOVA's revealed significant changes from baseline to termination among the Substance Abuse women. This finding indicated that these women utilized Active-cognitive coping strategies which includes cognitive attempts to understand the problem and identify positive ways to deal with the stress (arising from Substance Abuse). The other two strategies, Active-behavioral coping and Avoidance coping were non-significant. The results are displayed in
Poor health and multiple health/medication consequences; the high number of risk factors found for this group at program entry and, moreover, the cultural barriers they face. Most of these families were low acculturated Latinas, monolingual Spanish-speaking single parents residing in shelters or temporary housing.

**Health Related Quality of Life**

The evaluation assessed the quality of life at baseline, 6 months and at program completion using the HROQL measure. This instrument consists of 7 domains that measured physical and emotional well-being. Each domain or subscale provides a score from 1 to 100; higher numbers indicate higher levels of quality of life and positive well-being. The evaluation examined the baseline to termination changes for the domains and the total sample. Additional within/between group comparisons for the SA and HA women were completed using statistical change t-tests. Non-significant results were obtained for the families evaluated. Latinas in this study however, demonstrated two significant and noteworthy differences. Overall, at baseline, Substance Abuse women reported higher levels of social functioning at program entry. In addition, health related quality of life was rated higher for SA than HIV/AIDS women, as expected. Figures 13 & 14, respectively, illustrate these significant group differences.

**Client Satisfaction**

Overall, families expressed satisfaction with program services. Specifically, 91% indicated that services were very helpful, 74% agreed strongly with receiving services promptly and 85% stated that they felt staff was sensitive to their culture. General satisfaction with Bienvenidos (agency) ranged from excellent (74%) to good (18%). There were a few families who indicated some dissatisfaction with services and the agency (13%). Among the 38 families surveyed, 85% reported that they received the services they were promised at program entry. Comments provided by respondents mainly described the supportive relationships they established with staff members (my counselor) and feelings of less isolation (I had someone to share my problems with). Interestingly, 63% of clients stated that staff "helped them cope" with their difficulties (e.g. food, entitlements, childcare).
Discussion of Findings

Project Milagro provided evidence that underscored the multitude and complex risk factors for child abandonment, abuse and neglect among Latinas and their children living with HIV/AIDS or Substance Abuse. The evaluation findings of this project provided support to the family systems framework and cultural-specific services implemented during the four years of funding. The vulnerabilities of children residing with Latina mothers with current and past substance abuse stemmed from chronic substance abuse exposure, past victimization of abuse or neglect, out of home placements, family violence and prenatal drug exposure. These findings have been delineated among national among Abandoned Infant's Assistance grantee programs (AlA Cross-Site Evaluation, 2008). Latinas in this program were more likely enrolled at the onset of child protection services or child detention. The project’s services targeted these families by providing advocacy, family stabilization, reunification plans, drug counseling and family counseling. The program was successful in reducing out of home placements for 24% of children and improving sobriety among 26% of Latinas. Closed cases or reduced involvement with child welfare agencies was achieved for 79% of Substance Abuse families after completing programs services. The risk for abandonment among children living with HIV Latina mothers was due to their mothers’ impeding health and mental health conditions. Poverty, unsafe and unstable home environments, and exposure to domestic violence increased risks for abuse and neglect among these children. The underlying sociocultural challenges and barriers associated with immigrant status and low acculturation further augmented their social conditions. Permanency plans; case management and family stabilization was key to providing meaningful services to these families. Significant improvement in stable housing and environmental conditions was detected at program completion for the HIV/AIDS families.

Heterogeneity among Latinas was reflected between the project’s two groups. Substance Abuse women were second and third generation Mexican Americans, English speaking and more acculturated. In contrast, HIV/AIDS Latinas migrated primarily from Mexico, monolingual Spanish-speaking, less acculturated and were affected by their immigrant status. Similarities between these groups were found in the socioeconomic factors that interfere with positive outcomes. Latinas were faced with poverty, unemployment or underemployment, inadequate health insurance, poor housing, low education levels and limited job skills. Psychosocial factors shared among these women included childhood abuse, trauma and chronic domestic violence. The program’s interventions were significant in reducing depressive symptoms at program completion. The findings also revealed that parenting stress was extremely high for both groups and particularly for Substance Abuse women. Latinas in this program were chronic alcohol and drug users, often using multiple substances. Many were in the early stages of recovery and faced self-blame and guilt. Significantly improved parenting strategies were identified for these women after completion of program services.

Health outcomes for families varied significantly between the HIV/AIDS and Substance Abuse Latina groups. Co-factors ascribed to Latinas living with HIV or AIDS in the project were similar to the profiles outlined by the HIV Epidemiology Program Surveillance Summary (2008); impoverished, uninsured, high incidence of HIV exposure, heterosexual contact, ineffective HIV risk reduction strategies and culturally isolated due to their immigrant status. The program effects on medical access and improved health related quality of life were unexpected. HIV women in this project were more likely to have health insurance funded by county or state programs; accessed medical services at teaching university based county or state health facilities and demonstrated high compliance rates with medication treatment protocols. Noteworthy, the project’s staff observed frequent changes in medications and participation in multiple clinical trials that included rigorous protocols. For many of the HA women, receiving medical treatment is important. In contrast, Substance Abuse women had less access to medical services at program entry and the majority lacked health insurance at program entry. While there were slight improvements in these areas, HIV women had more significant gains. One reason for this finding may be risky lifestyles often associated with drug use may have contributed to under utilization of medical services and general health neglect. The project’s culturally specific interventions to improve health outcomes were significant and were aligned with the need to adhere to culturally sensitive strategies directed towards improving Latina health outcomes with similar demographic samples (Cervantes, R., Kappos, B., Duenas, N. & Arellano, D., 2003).

Coping and social support outcomes were found significant at program completion for Substance Abuse women although less likely for HIV/AIDS women. The program effects of improving active cognitive coping skills to deal with substance abuse were significant for SA women. However, HIV women had increased avoidance coping strategies...
at program completion. This unexpected finding may be due to the limitations inherent in conducting community-based evaluations. The low follow-up post test assessments represented less than 30% of this group. Social support was significantly improved for families overall, although Substance Abuse Latinas fared better at program completion. This group had significantly higher levels of supportive networks than their counterparts.

The most significant finding was the decrease in mental health conditions including depressive symptoms between both groups of Latinas. Mental health conditions were reduced by 21% and more likely represented the HIV Latinas. This group was at higher risk at program entry compared to Substance Abuse women, accessed more mental health services and participated in the home-based therapy.

Lesson Learned

Inter-disciplinary Team Approach

Project Milagro recruited and employed staff based on the program's theoretical model, the needs of the target community, and the resources available. Additionally, the experience of the program serving families impacted by substance abuse and HIV/AIDS led to the implementation of an inter-disciplinary team approach. The small number of project staff combined with the commitment of project management to a team approach, was the key to a successful and effective service model. Culturally sensitive bilingual staff representing multiple disciplines were employed by the program and made the team. The home visits as well as the team approach was instrumental in the following areas: identifying factors that placed children “at risk;” engaging both primary and secondary caregivers (partners); engaging difficult to reach populations (families with multiple barriers); serving the entire family including extended family members; and offering services otherwise not available to families (permanency planning, substance abuse counseling). Additionally, staff offered parents opportunities to model new positive parenting and communication techniques in their own home setting. Each team member had a unique and recognized set of professional skills. Likewise, the clarity of the roles and the arrangement of one person per role such as having the substance abuse counselor address drug dependency and recovery while the mental health therapist addressed depression symptoms was instrumental.

The program learned that it was imperative to employ skilled professionals in the area of addiction and recovery. Consequently, substance abuse counselors that were CADAC certified were the primary providers to families impacted by substance abuse.

The counselors were instrumental in identifying and reducing risk factors commonly reported in the substance abuse group. Factors such as: chronic relapse; prenatal drug use; poor access to healthcare; limited education; and poor parenting were addressed. Home-based interventions focused on recovery support and one-on-one lessons on relapse prevention were implemented. Additionally, sessions concentrating on drug education, and implications of drug use while pregnant were provided. Focused on strengthening reunification process, sessions on bonding, attachment, what to expect during reunification process, and stress reducing tips were offered. Basic skills to enhance bonding and attachment as well as, reading child's cues and signals were provided during weekly home visits. The substance abuse counselors also served as educators, case managers, and advocates.

Service Planning for families was also an integral part of the service model. Consequently, flexibility in Case Planning allowed for the team to re-evaluate and integrate appropriate interventions as needed. Quarterly Case Plans as well as weekly team Case Reviews provided a road map to service delivery and maintained the team abreast of the length of services left for the family. Case Plans approaching the end of service addressed final goals identified by the family and team. Additionally, individualized Case Plans completed alongside the family often identified the need to extend services beyond twelve months. Several families were serviced beyond twelve months due to: family was near reunification or was recently reunified; and to ensure family stabilization during changes in family composition.

Overall, the program was very successful in strengthening sobriety for only 9% of the total substance abuse participants relapsed during active participation in the program. This demonstrates the high success of the program as well as the approach utilized in serving substance abuse populations. The program attributes the success to the highly sensitive approach that emphasizes on: meeting the client at their level; providing individualized home-based interventions; frequent and consistent contacts; inclusion of the family in services; and lastly utilizing a humanistic and culturally sensitive approach. Additionally, the emphasis on relapse prevention, drug education, coping and self-esteem skills were instrumental in achieving the success. Furthermore, women were also
supported with their reunification process. This tended to increase the mothers motivation to complete the program and maintain their sobriety. The women also reported that the projects approach reinforced to them that "they were not alone" as they often felt.

References


Appendices

Appendix A Improving Child Well-Being in Latina-Headed Families Faced with Substance Abuse and HIV/AIDS: Moving Theory into Practice with Outcomes

Appendix B Thank You Letters from AIA Participants

Appendix C Project Milagro Trainings and Presentations

Appendix D Project Milagro Replication Manual
Appendix A:

Improving Child Well-Being in Latina-Headed Families Faced with Substance Abuse and HIV/AIDS: Moving Theory into Practice with Outcomes

Project Milagro at Bienvenidos, Inc. provides comprehensive, culturally sensitive, family-based services to families residing in a large Latino community in Southern California. Family-centered, client-driven services are embedded in a humanistic approach guided by Maslow's hierarchy of needs (Maslow, 1959). Contextual factors that are culturally specific to Latinos and that extend beyond linguistic correctness are well-integrated into the project's conceptual framework.

Family-Centered Humanistic Approach

Families receive comprehensive home-based services once weekly over 12 months. Services follow Maslow's hierarchy of needs, first fulfilling basic physiological and safety needs in the early stages of service delivery, then moving on to the enhancement of social networks and eventually strengthened self-esteem. Because the high incidence of child abuse and neglect is likely due to parental drug and/or alcohol dependence, the program provides interventions that target substance abuse and parenting skills: recovery-focused counseling, parent education, and case management services linking parents to substance abuse treatment. While the family is addressed as a whole, services are also offered specifically to children, including linkages to medical care, the Regional Centers, and child-focused therapy, and assistance with enrollment in school, day care, and school readiness programs.

Family violence, family and home environmental instability, and medical risks involving prenatal drug exposure and poor prenatal health care are challenges faced by parents and children impacted by HIV/AIDS and/or substance abuse (Schuster et al., 2000; Kim & Krahl, 2006). Project Milagro serves Latino families who are living with a myriad of these challenges and more: generational poverty, language barriers, marginal education, unemployment, and physical and mental illness. To improve child well-being, a comprehensive family approach that aims at stabilizing families while increasing overall support has been effectively applied. The project's underlying principle is that in order to improve child outcomes, primary interventions must meet the needs of the family as a unit. The project has learned over the years that family and parental stabilization are key indicators for improving child functioning.

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Culturally Specific Services

The heterogeneity among Latino families, particularly Latinas and their children, continues to be defined as pertinent in developing culturally sensitive interventions for this ethnic group (Alvarez et al., 2004). Project Milagro delivers services, literature, program documents, and educational materials in Spanish. Bilingual staff is knowledgeable about the culture and cognizant of acculturation factors.

Identifying family acculturation levels ensures culturally sensitive services beyond Spanish translations. A linear assessment of acculturation (Marin, 1987) distinguished two groups: 50% of Latinas who were identified as less acculturated and represent HIV/AIDS families; and 50% of Latinas who were identified as more acculturated and as bicultural (Mexican and American cultures) and represent the substance abuse families. Acculturation differences were significant (p < .001) and served as a culture-specific guide for service delivery strategies, case plans, and family services.

Evaluation Plan: Methods for Assessing Child Well-Being

Like the Project Milagro service model, the evaluation plan was linguistically and culturally appropriate for Latino families. Child outcomes for 125 children, ages three months to eight years old, were examined using a pre- and post-test six-month assessment. Measures included a 20-item child risk factor and developmental screening tool developed by the Bienvenidos agency, the Developmental Profile II (DPII; Alpern et al., 2006), and the Ages and Stages Questionnaires (ASQ; Squires et al., 1999). Parents were engaged during the assessment process and provided prenatal histories for the children.

Child Risk Factors and Developmental Screenings

Risk factors identified at program entry for children delineated the problems faced by project families. At program entry, “lack of stable family composition,” the most prevalent risk factor for 71% of HIV children and 73% of substance abuse children. Prevalent risk factors during the past 12 months were also high for both groups: exposure to domestic violence and victimization by abuse or neglect (42%), exposure to substance abuse (40%), and residing in unstable housing (36%). Among substance abuse children, 53% were prenatally drug-exposed and 24% lacked prenatal or well baby care, compared to 18% and 13%, respectively, for HIV children. For the total sample, premature births were reported for 19% of children, and 13% of children had low birth weight (under six pounds).

Child risk factor outcomes suggest pronounced differences between substance abuse and HIV children. Substance abuse children experienced more risk factors for longer periods than their HIV counterparts but had significantly less risk factors at termination. Baseline and post-test comparisons showed positive significant changes (p < .05): Drug and/or alcohol exposure in the home significantly decreased for substance abuse children during program engagement. Overall, child abuse and neglect and out-of-home placements decreased significantly for all children, particularly for substance abuse children. Exposure to domestic violence, stable family relationships, and stable housing also improved for these children. The reduction in risk factors for HIV children was minimal, suggesting that these children continue to experience multiple risks. At termination, “lack of stable family composition” (53%), “unstable housing” (36%), and “exposure to domestic violence” (19%) were reported for them.
Developmental screenings assessed medical, mental health, and behavioral problems based on child history, diagnosed conditions, staff observations, and parent input. At baseline, approximately 18% of children were detected with behavioral problems, and 5% with developmental language delays/learning disabilities. Medical screenings identified 15% of children with health conditions. Post-test changes were detected only for children with behavioral problems, indicating an improvement of 15% (p<0.001).

In addition, developmental language delays had a small improvement of 8% among substance abuse children. However, these results are limited and interpreted with caution due to small samples. Overall, developmental screening outcomes at termination did not identify additional or new conditions; rather, child screenings provided early detection for supplemental testing and appropriate program interventions.

**CHILD RISK FOR DEVELOPMENTAL DELAYS**

Supplementary testing was conducted for approximately 20% of the program's children identified as "high risk" for developmental delays. The ASQ was used to test children ages three months to five years old, and the DP2 tested children between 5.1 years to 8.3 years. These standardized measures provide developmental functioning scores for communication/language, motor skills (fine and gross), socialization, self-help skills, and problem-solving/cognitive development. Baseline data indicated that 27% of children had one or more delays. The most common delay for 17% of children was communication/verbal skills (in their native language), followed by delays in fine motor skills (19%). Overall, these skills are critical to school readiness and transitioning into kindergarten. The project staff focused on assisting families in developing activities that enhanced developmental tasks. Most importantly, referrals to Regional Centers were completed for 100% of children identified with at least one delay. Post-test assessments were non-significant.

**Summary**

Improving child well-being can be achieved via various interventions. Project Milagro's interventions are family focused, strongly culturally influenced, and based on Maslow's hierarchy of needs. Evaluation outcomes show that family-focused interventions, while not child specific, have effectively resulted in improved overall child well-being. Especially, program interventions that target parental substance abuse and parenting skills have contributed to the positive outcomes reported for children.

Child risk factors, due to the lack of family and housing stability, reflect the social conditions and environmental stressors experienced by these families. Project services have focused on stabilizing families and providing family counseling. Additionally, advocacy and entitlement assistance have been effective in increasing family and housing stability, as well as reducing environmental stressors.

Latinas living with HIV/AIDS and their families continue to reside in shelters and subsidized housing and experience homelessness and isolation. The cultural stigma of HIV/AIDS, language barriers, and limited financial, emotional, and family support contribute to the continuing challenges faced by these mothers and their children.

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**REFERENCES**


Yo Cristina... Mondragon escribo estas líneas agradeciendo al programa de Bien Bbvidos por el apoyo que me han brindado ami y mi familia antes de tenerlos a ello me sentia sola deprimida pero con su ayuda me sentí mejor yo quisiera que el programa sigiera adelante por que ami me a quedado mucho cuando ami me detectaron el VIH ellos fueron un apollo muy grande para mi yo quisiera agradecer les atrodes las personas que fundaron esta organización porque la verdad es que es de gran apollo para muchas personas.

At. Cristina Mondragon
September 23, 2008

My name is Laura Valdez the mother of 4 wonderful children. I became a client of the program “Project Milagro” about one year ago. As a client of the program I have learned so much in how to deal with everyday obstacles that occur in my life today. I have learned to be a better parent, cope with stress, and I have learned many other tools that I can use today all thanks to the support, encouragement and service your program has provided to me and my family. So my family and I want to thank “Project Milagro” so much for their services and most of all I want to thank my support worker Lynda Evans for her support and encouragement through my struggle with DCFS. Again thank you.

Sincerely,

Laura Valdez
Sept 24, 08
To whom it may concern:

This is to inform you that Linda Evans was the best worker I ever had. She helped me get through the hardest times this past year. I think if it wouldn’t of been for her I wouldn’t of been where I am now.

Sincerely,
Cecilia
I wanted to thank the AIA program for all the help that they gave me. I want to thank Linda Evans for being there for me for getting me to my appointment. Helped me when I had no food with the food vouchers. I love Linda & the AIA program for listening to me when no one else would I don't know where I would be without this program. Thank Linda for teaching me how to parent my kids and for teaching me how to deal with stress and how to deal with my life. I really appreciate everything that the AIA and my wonderful worker Linda Evans did for me.

Thank you
Ana Cuind

9-24-08
JESSICA RENGIFO

3608 Bell Ave
Bell, California 90201

September 24, 2008

To whom it may concern:

I have been with AIA "Project Milagro" for a year, and have had Mrs. Lynda Evans as my in home counselor. I want to inform you that due to her concerns, assistance, suggestions, and support I have become the responsible person I am today.

Mrs. Evans helped me to process personal issues, helped me learn some parenting skills, how to build on my self-esteem, and to dream of a healthier life. I would like to mention a couple of my successes. I have regained custody of my daughter; I have my Driver License, but the most important is that I feel strong enough today to be independent, and to work hard to reach all my dreams and goals for my daughter, my family, and me.

Mrs. Lynda Evans has spent many hours in court with me encouraging me to stay positive, she helped me study for hours to pass my driver's license test, and has always show concern and respect towards me and my family. I am glad to have been introduced to the program, and hope it will continue for others who are in need as I was. I will always appreciate all that Mrs. Evans did for me.

Sincerely,

Jessica Rengifo.
Miercoles 24 de septiembre 08

pues yo le agradezco alas personas que apoyan el programa que me sirvio de mucho amia y amia Familia tanto economica como fisicamente pues me ayudaron y por eso les doy gracias por apoyar el programa y apoyar alas personas como Luz y las personas que trabajan con ella y por el apoyo a tan tas Familias como la mia con necesidades y angustias gracias al programa nos ayudo a resolverse los problemas de todos los que necesitamos y espero que siga el programa porque amia en lo particular me sirvio de mucho ya que me ayudaron Con Ropa Zapatos Comida y tarjetas de tarjeta para Comprar pamper y tambien me ayudaron a pagar Recibos de Luz y Gas. Gracias a todos los participantes del programa gracias a portodo y que Dios les de mucho mas a todos gracias y que Dios los bendiga ato Aurelia

linare y familia
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PROJECT

MILAGRO

A Comprehensive Model to Serving Latino Families Affected by Substance Abuse and HIV/AIDS

Replication Manual

Submitted to

U.S. Department of Health
and Human Services

Administration for
Children and Families,
Children's Bureau
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Contributors
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We dedicate this replication manual to all persons affected by substance abuse and HIV/AIDS. Of course, our deepest gratitude and respect to the families for sharing their stories and participating in the program. Further, we thank the leadership of Bienvenidos, who consistently supported the development and implementation of culturally sensitive and innovative models. In addition, we thank all the staff who extended valuable support, wisdom, and expertise to our effort of promoting safety, permanence and well-being of children affected by substance abuse and HIV/AIDS.
Introduction

Bienvenidos Children's Center implemented the Abandoned Infants Assistance (AIA) Program, Project Milagro, from 1992 to 2008. Project Milagro chronicled relevant factors that improve the safety, permanency and well being of children living with Latina mothers, primarily of Mexican origin, who are coping with HIV/AIDS or Substance Abuse. Equally important, historical pathways to understanding the social and familial dynamics that impede positive outcomes among Latinas have been clearly delineated by this longstanding AIA program. The gaps in knowledge for providing program policies and service designs that target the complexities of needs for Latinas and their children have led to an array of innovative AIA programs that are perceptible in the interiors of poor and disenfranchised communities. In general, AIA programs have collectively worked towards providing services to the “least of these” communities, families and children. Thus, these programs continue to contribute to improving our knowledge base by developing strategies to meet the unique needs of HIV/AIDS and Substance Abuse families.

Project Milagro provided comprehensive services to Mexican and Mexican American mothers and their children residing in the East and southeast Los Angeles area who were identified as high-risk for abandoning their infants and young children due to HIV/AIDS or chronic substance abuse. The project’s target service area has a large concentration of Latinas living with HIV or AIDS and has been identified as a priority group by the Los Angeles County HIV Prevention Plan (2008). Multiple co-factors have been attributed to the disparities of HIV/AIDS among Latinas. More importantly, such co-factors continue to add to the vulnerabilities of Latinas for newly diagnosed HIV infections, living with AIDS and limited prevention strategies for acquiring HIV. The incidence rates in the United States for women living with AIDS and women at risk for HIV infection or transmission has led to re-examining emerging patterns of the epidemiological nature of HIV/AIDS. Overall, the number of Latinas diagnosed with HIV or AIDS has not only increased but has exceeded case rates among women in general. One in seven Latinas are living with HIV/AIDS compared to white female counterparts. Although HIV/AIDS among African American women exceed rates for both Latina and white women, the critical factors associated with reducing HIV infections and providing preventive services have not been fully addressed when working with Latinas. Project Milagro provided services aimed at improving the quality of life among high-risk Latinas and their children. The model applied to these families emerged from acquiring knowledge of HIV/AIDS trends and working with Latinas and children. The project’s comprehensive model developed effective strategies to address co-factors relevant to HIV/AIDS within a cultural context. Additionally, service mechanisms that successfully resulted in positive outcomes were supported by the project’s evaluation findings.

The project’s Substance Abuse women were primarily second and third generation Mexican Americans with chronic alcohol and drug addictions. Most of the project’s Latinas were identified as “neglectful” parents, actively engaged in child welfare systems and had limited parenting knowledge. Project Milagro developed a model that targeted substance abusers with histories of prenatal drug/alcohol use; domestic violence victims; drug exposed infants; victims of child abuse; sexual trauma; depression; and chronic relapses. Although the project’s Latinas were faced with these challenges, the program model was effective in reducing risks for child abuse and child abandonment. Further, strategies aimed at improving mental health, coping skills and quality of life were significantly effective for this group.

Purpose of this Replication Manual

The primary purpose of this manual is to provide community based programs, policy decision makers and special entities that focus on developing programs for Latinas and their children a guide to implementing the Project Milagro model, its’ framework and the underlying factors that contributed to its effectiveness. The unique aspect of this model has been attributed to the implementation of culturally specific services that recognizes the heterogeneity of Latinas. The Project Milagro model incorporated its history of services to provide a framework that illuminated the understanding of the mechanisms and pathways for successfully providing services that address contextual factors (poverty, unemployment, low wages) cultural sensitivity (immigrants, acculturation, sex roles, language barriers), regional applications (migration patterns, urban environments) and community influences (disparities in services, discrimination, single head of households).

This replication manual outlines the program’s services, staffing patterns, recruitment strategies, referral process, community collaborations and the evaluation design, including the project’s instruments and assessment forms. The intent of this manual is to guide communities working with and evaluating Latinas faced with multiple challenges and living with HIV/AIDS or Substance Abuse. Particularly, family based in home services are described in the context of reducing the abandonment and abuse of children, and increase permanency and positive well-being.
The Philosophical Framework of Project Milagro

Over the course of four years, Project Milagro implemented a model that was highly effective in promoting safety, permanence, and well-being of children affected by HIV/AIDS and substance abuse. The program's model incorporated AIA philosophies and core elements into the program design and service delivery. Embedded in AIA's framework, Project Milagro's services focused on the concurrent needs of parents and children. Project Milagro implemented a family systems approach, which encouraged families to define their strengths and needs. Additionally, the strength in the provider client relationship lay in the ability of the staff to develop long-term, trusting, non-judgmental relationship with their families. Families served by the program were empowered and respected as well as supported in their decision making (Templeton-McMann et al, 2003). Services delivered were family centered and concentrated on strengthening both family and community relationships.

Located in Los Angeles, California, Project Milagro concentrated its efforts towards understanding the needs of families and children in the context of their culture. Beyond providing informational and educational material in Spanish, the program provided services that were culturally relevant and sensitive to Latinos. Interventions applied by the program staff were respectful of cultural beliefs and practices (folkloric concepts and healing, celebrations, family hierarchies, and worldviews, etc.). Such services were instrumental in engaging and retaining Latino families in services that are historically not accessed.

Culturally Responsive Services

Project Milagro incorporated a culturally responsive approach to serving Latino families affected by substance abuse and HIV/AIDS. The families served by Project Milagro found themselves dealing with a host of psychosocial stressors as well as unfamiliar governmental and social institutions. In particular, the families affected by HIV/AIDS were confronted with language barriers that prevented them from accessing services. To compound their problems, Latino families were forced to cope with the values and expectations of two very distinct cultures as they navigated their way through the multifaceted social/governmental institutions with which that had to interface. The program's model allowed for the implementation of clinically, linguistically, and culturally appropriate services. Services were guided by respect and integration of Latino values: familismo (familism)—high value and regard for the family, view of family as the primary unit of support and help; Simpatia—a social script emphasizing a pleasant demeanor focused on reducing conflict and promoting agreement; and Personalismo—a personal attitude valuing warmth, friendliness, and respect toward others, especially toward family and those who hold positions of authority in a community (Santiago-Rivera, Azara). Such cultural dimensions had important roles in the overall program development and service delivery.

Family Centered Services

Project Milagro delivered services that were family-centered, client driven and embedded in a humanistic approach to serving families. Based on the basics of Abraham Maslow’s theory of hierarchy needs, the program operated with a fundamental belief that basic needs (food, shelter, safety, etc.) of families must be met in order for families to evolve and achieve other goals (i.e., improved parenting, self-sufficiency, and increased access to community supports). Project Milagro staff delivered services aligned with AIA principles: provided developmentally informed parental guidance and individual and family counseling; addressed concrete basic needs: taught tangible skills; assisted families in developing linkages to community resources through direct advocacy and modeling systems navigation as well as provided information on community resources (AIA, Lessons Learned 2007).

Family centered services identifying family strengths, challenges, needs, limitations, and gaps of services were offered. In addition, the project implemented client-centered services focused on development of long-term, trusting, nonjudgmental relationship between the family and the staff. Families served were empowered, respected, and supported in their decision making and in prioritizing their multiple needs. Project Milagro integrated principles from the family preservation model, characterized by services that were time-limited, relationship-based, family and child centered. Such services were flexible and offered in the families' home.

Adopting Project Milagro’s Model: A Checklist

Use this checklist to identify the assumptions your organizational culture shares or does not share with the Project Milagro model. This can help you assess the challenges you will face when integrating the Project Milagro model into your organization’s existing service philosophy. Does your agency and staff:
forms, and started with a welcoming and warm approach to engaging families. The program employed staff that reflected the community they served (both linguistically and culturally), and who were willing to engage families and parents at their level. Investing in building relationships often meant that program implementation would take more time. Consequently, staff required time in their schedules to connect with families and to conduct extensive outreach to difficult to reach populations. Building partnerships with other community based organizations and non-traditional partners (faith-based, businesses) was crucial to engaging the target population as well as meeting the myriad of needs that they faced.

**Components of Project Milagro**

**Targeting Families Through Community Outreach**

Project Milagro targeted Latinas and their families who were identified “at risk” of abandoning their young children due to substance abuse and/or HIV/AIDS. Families residing in Greater East Los Angeles and East Hollywood areas with at least one child 0-6 years of age were eligible for services. Latinos with HIV/AIDS and long histories of addiction were typically reluctant to ask for help.

It was learned that providers who intend to assist people underserved by existing resources must aggressively seek out isolated individual and engage them. They must conduct assertive as well as creative outreach efforts to engage families in services. For example, outreach efforts held at educational conferences for families living with HIV as well as commemoration events held by the Twelve Step community for individuals in recovery were found to be successful. The program stationed staff at substance abuse centers, local hospitals and clinics where women tested for HIV. Staff also conducted outreach at Children’s Dependency Court and at local Department of Public Social Services. Program staff that participated in the community held resource fairs and disseminated a linguistically and culturally appropriate brochure (attached).

Furthermore, Project Milagro staff took pride in the development of relationships with the community as the cornerstone of their success. It was through relationships that the parents were willing to explore and accept the resources and supports available to them and their families.

**Population Served**

The program had two service tracks: one for families affected by substance abuse, one for families affected by HIV/AIDS. Families consisted of single mother, single father and two parent households and relative caregivers. Families from the substance abuse were typically headed by young, third generation Mexican-American mothers. Substance abusing women had chronic addictions to methamphetamine, and/or alcohol. The women reportedly began abusing drugs at the onset of teenage years and had experienced multiple failed drug treatment programs. Families from the substance abuse group had DCFS (Child Welfare) involvement and at least half of the sample had children placed out of home prior to enrollment in the program. Families from the substance abuse group were raised in abusive homes with substance abusing parents. Substance abusing women were in relationships with partners who were also substance abusers and often involved with gangs. Participants from the substance abuse group had limited education, criminal backgrounds, and were often unemployed. Poor parenting and mental health issues were commonly reported. Families from the HIV/AIDS group were less acculturated immigrants from Mexico and Central America. Families were isolated and disenfranchised. HIV transmission was often the result of heterosexual contact and often due to an extramarital affair. In most cases, the male partner contracted HIV through an affair and later infected his wife or female partner. Participants from the HIV group were poor, underemployed and possessed limited levels of education.

**Point of Entry and Assessments**

Program Milagro received referrals from several entry points. Substance abuse outpatient and inpatient centers, hospitals and clinics, housing shelters, as well as DCFS (Child Welfare) referred families to the program. Additionally, word of mouth...
and self-referrals were common. Referrals were initially screened by the Project Coordinator to determine whether or not the family was appropriate for services. Initial screenings were conducted in the client’s home by the Coordinator within 2-3 days after receiving the referral. The screening focused on: introduction of services; assessment of the family’s needs; parent and child risk factors; as well as the client’s level of motivation to receive comprehensive home-based support. Program forms such as Intake, Confidentiality, Consents to Release Information, and Service Agreement forms were completed during the initial visit. Thorough assessments of factors that place the children at risk for abandonment and/or abuse were conducted. Parent and Child Risk Factor forms were completed and indicated level of risks.

**Initial Visit**

The initial visit was crucial for it established trust by offering genuine non-threatening support. The families received information highlighting length of services, level of intensity of the program, confidentiality guidelines, and collaborative approaches with other key providers (i.e., DCFS, courts, drug treatment, mental health, schools).

Following the Intake, the initial visit by the assigned provider was crucial to the continued engagement of the family in services. The first visit with the assigned provider was a critical session during which the following was established: initial connection with the family; foundation for trust, rapport and positive relationship between client(s) and provider developed; follow up on the initially identified risk factors, as well as families needs, were conducted. The initial session provided a forum in which program services were outlined. Although several forms were to be completed during the initial session, the core focus of the session was assessment and listening to the client as needs was presented. The family always had an opportunity to ask questions, seek clarity, express concerns as well as decline services.

**Home-based Services**

The uniqueness and strength of the program lay in the ability to offer services in the families’ natural home environment. Families received twelve months of voluntary comprehensive prevention services and supports. Services consisted of: home-based counseling; case management; parenting education; and center-based services. Home-visits were offered on a weekly basis, or as needed, and identified in the case plan. Although families for the most part closed at twelve months, exceptions were granted for those needing services beyond that time period. The need for extended services was often due to pending or recent reunifications, changes in the health status of the parent or child diagnosed with HIV/AIDS or due to an increase in risk factors.

Accessible, flexible and most importantly family centered services proved to be the most promising in engagement and retention of families. Additionally, safety, and well-being of the child and family unit were the primary goals of Project Milagro, along with strengthening the capacity of parents to care for their children. The home-based approach implemented by the program allowed the staff to work closely with the parents and children as well as others in the home. The staff’s ability to develop individual relationships with the parents was integral to engaging the families in services as well as promoting parent development and enhancing the parent’s relationship with their child. The providers focused on supporting, affirming, and promoting bonding and attachment.

The program learned that observations of the home environment and family dynamics increased the validity of assessments and case service planning. Offering services in the home allowed the staff accessibility to everyone in the family and the ability to closely monitor risks and changes in home environment. Immediate interventions were also readily offered to families in crisis. The supportive multidisciplinary model addressed parenting concerns, psychosocial stressors, substance abuse, HIV, and mental health issues. Interventions concentrating on preventing out of home placement, strengthening reunification, and supporting post permanency were offered.

Family Support Workers, Substance Abuse Counselors (In-home Counselors), and Family Therapist coordinated services aimed at reducing risk factors and improving family and child well-being. In-home sessions were designed to build on family strengths and address challenges. Weekly home visits lasting an average of two hours in length addressed the following:

1. Basic needs of the family: food, shelter, clothing, utilities and health care;
2. Child’s needs: safety, physical, proper nutrition, exercise, rest and health care;
3. Parent support and education: re-building relationships, communication with children, personal care, self-esteem, access to services;
4. Counseling: crisis intervention, conflict resolution, couples issues, child development, bonding and attachment;
Project Milagro's Expected Outcomes

• maintain at-risk infants/children in their own homes or those of their relatives;
• provide children with a safe and stable environment;
• build healthy relationships and sense of home, family and security;
• reduce parental and environmental stress;
• increase voluntary use of community resources;
• decrease use of drugs and/or alcohol;
• increase knowledge of health promoting practices, treatment protocols, and reduce risk for prenatal exposed infants;
• improve health and mental health outcomes;
• improve child developmental and health outcomes;
• increase participants' social support systems;
• strengthen family's ability to become self-sufficient; and
• increase knowledge on permanency planning by families impacted by HIV/AIDS.
Team Approach

Inter-agency, multi-disciplinary services were offered by a bilingual/bicultural team comprised of a Family Support Worker, Substance Abuse Counselor, and Mental Health Therapist. Administrative and clinical support was offered by the Director, Project Coordinator and Licensed Clinical Social Worker. The multi-level services involved family assessment, family support, case management, advocacy, child assessment, parenting, health education, medical access, child reunification, permanency planning, drug/alcohol recovery support and mental health services.

Project Milagro's team approach was developed after a careful assessment of the needs of the target population. Careful consideration was placed on ensuring that the program employed qualified and culturally responsive staff. Consequently, education levels, ethnic and gender considerations were made. Nevertheless, given budget constraints the program had to compromise staffing patterns. Staffing a mental health provider versus a child development specialist was a trade off decision that was made early in the program design phase. Sessions carefully assessed the needs of the target population as well as available resources. The program emphasized resources to ensure that the right staff was employed. Careful consideration was placed on hiring staff with the right personality. Beyond hiring skilled staff, the program employed staff who were genuine and invested in serving disenfranchised communities. Other qualities and attributes that the program staff had were: responsible, reliable, flexible, worked well under pressure, and overall had a positive outlook on life. Additionally, the hired staff had diverse training and educational backgrounds in HIV/AIDS, substance abuse, child development, and mental health issues. Staff members were matched with program participants. This was crucial to meeting the proposed goals of the program and ensuring overall program success. Furthermore, the program set priority and funds towards staff development, supervision, and provision of technical equipment.

Staff Patterns and Role Definitions

Program Coordinator was responsible for day-to-day operations of the program. Program Coordinator supervised direct line staff through individual, and group supervision. Responsibilities of the Program Coordinator included: ensuring the program operated at optimum level and meeting proposed program goals and objectives; conducting intakes for the program; oversight of case load management of staff; coordination of services; oversight of program evaluation; implementation of program design and documents; provide quality assurance (file reviews); prepare program reports; promote collaborative relationships with other community based providers; and attend Community Collaborative and Networking Meetings.

Family Therapist provided individual, family, couples counseling to participants identified as having a need and receptive to mental health services. Mental Health Services were offered in the home environment and addressed issues related to substance abuse, HIV/AIDS and dual disorders.

Family Support Worker concentrated on engagement of family into the program. The Family Support Workers (FSW) acted as case managers, counselors, teachers and sources of support for the family. The FSW modeled appropriate parenting, household management, and coping skills. The FSW identified the needs of the family by implementing Quarterly Case Plans and presented cases on a monthly basis during Case Reviews. Additionally, FSW were responsible for completing program documentation (Progress Notes, evaluation assessments) and ensure files were organized.

In-Home Counselor (CAADAC) offered recovery focused supportive services. Services consisted of counseling, relapse prevention, parenting skills, reunification services, education on caring for drug exposed infants, health education, case management, resources and referrals. Additional responsibilities were: development and implementation of Quarterly Case Plans; participation in monthly Case Reviews; completion of program documentation as required by the FSW.

Clinical Supervisor (LCSW) provided clinical supervision both in individual (for Family Therapist) and group (Case Reviews/Conference) settings. The Clinical Supervisor reviewed and approved Case Plans and Case Review forms.

Case Reviews and Staff Supervision

Program staff received cross-disciplinary training through participation in Case Reviews (a.k.a. Case Conferences). Case Reviews were scheduled a month in advance by the Project Coordinator. All cases were reviewed once a month unless risk factors increased requiring immediate case presentation. Case presentations were conducted weekly allowing for the latest information on family to be shared. Case Reviews as well as one-on-one clinical supervision was offered by the Clinical Supervisor who acted as a guide and provided support to the team.
Additionally, the Clinical Supervisor ensured proper supports and interventions to assure the safety of the children.

New enrollments were presented within a week following intake. Assessment information gathered during the initial intake was presented during the initial Case Review. The initial case presentation served to initiate an introductory plan of action addressing any high risk issues. Ongoing monthly Case Reviews allow for ongoing group supervision and consultation to take place.

Case Reviews were integral to effective service delivery for it ensured the following:
- delivery of culturally relevant, family and child focused services;
- interventions were aligned with the goals of the family and the program;
- guided service delivery;
- examination of family strengths, needs, and presenting problems;
- identifying progress and steps towards family stabilization;
- support to staff dealing with critical issues (i.e., high risk cases, child safety, DCFS and court timeliness, challenging clients, lack of resources); and
- coordination of services across disciplines.

The program emphasized the importance of allowing families to define their needs and engage in the case planning process. The program’s team focused case planning approach assisted in building the trust necessary to engage families at a deeper level. This process required enormous patience and flexibility for the needs of the families were often being identified by multiple parties: multiple family members, program team, and outside providers. Often, those at the table identified needs ranging from basic to more complex needs, which were beyond the scope of the program. In cases where multiple professionals were engaged in service delivery, careful planning and prioritizing was taken into account in efforts to prevent adding additional stress to the family.

**Case Closing**

A team agreement on closing cases was important. Project Milagro’s policy was to serve families for a period of twelve months. When the families reached twelve months of services, and completed the objectives delineated in the initial and follow up Case Plans, it was time to close the case. Prior to closing cases, families were prepared and informed of the tentative closing date. Additionally, partnering agencies and providers were notified of the programs plans to close the case (i.e., DCFS Social Workers). Prior to closing cases, the program ensured that families had a safety net of services and, when possible, kinship supports (relative). Families requiring an extension of services beyond twelve months were granted “carry-over” status. Extended services were applicable in cases such as: children were identified to be “at-risk” of child abandonment or abuse at the twelve month mark; unstable home environment; recent reunification; or recent disruption in care and custody of children. Infrequently, cases closed prematurely (prior to 12 months) due to: families’ whereabouts became unknown; parent refused services; parent was non-compliant to services (missing appointments); or family moved out of the service area. Standard program policy was to close cases after 30 days of inactivity.

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**Five Stage Model of Permanency Planning**

Project Milagro responded to the permanency planning needs of parents living with HIV/AIDS. The program designed a five stage culturally responsive permanency planning model that was sensitive and critical to meeting the needs of families affected by HIV/AIDS. The model served both as a conceptual framework and practical tool in educating families about future care and custody planning. The Permanency Planning Model included the following stages:

**Stage 1:** Assessing the Readiness of the Family;

**Stage 2:** Education on Permanency Planning;

**Stage 3:** Identifying a Future Guardian;

**Stage 4:** Securing the Plan; and

**Stage 5:** Aftercare services.

**STAGE 1: Assessing the Readiness of the Family**

The goal of the program was that every HIV impacted family would finalize a custody plan for their children in the event that they became incapacitated or died. The model was developed and implemented with a consideration of the families' needs and their willingness to address permanency planning. The model's approach was responsive to the multiple constraints..
and stressors that HIV impacted families faced. Due to the
time constraints; current drug use; fear of the legal system;
fear of stigma due to HIV/AIDS diagnosis; and
poverty, isolation, limited resources, immigration factors,
domestic abuse; fear of stigma due to HIV/AIDS diagnosis;
custody disagreements between biological parents; and
fear of the legal system.

Psychological
- Response to grief, fear of death, denial of diagnosis;
- Parents equated disclosure with “harming their children;
- Current drug use;
- Mental disorders (depression, anxiety); and
- Impaired cognitive function (AIDS related dementia or memory loss).

Cultural and Religious
- Fatalism—belief that God’s will will prevail; therefore,
parents refuse to take an active role in planning for the future; and
- Baptism—religious and cultural practices that informally imply alternative caregivers (godparents) for the child.

PROJECT MILAGRO encountered several challenges to implementing the permanency planning model. Challenges were for the most part client related, yet a few provider challenges were also reported. The following barriers were encountered:

CLIENT CHALLENGES

Psychosocial
- Poverty, isolation, limited resources, immigration factors, domestic abuse;
- Fear of stigma due to HIV/AIDS diagnosis;
- Custody disagreements between biological parents; and
- Fear of the legal system.

Psychological
- Response to grief, fear of death, denial of diagnosis;
- Parents equated disclosure with “harming their children;
- Current drug use;
- Mental disorders (depression, anxiety); and
- Impaired cognitive function (AIDS related dementia or memory loss).

Cultural and Religious
- Fatalism—belief that God’s will will prevail; therefore,
parents refuse to take an active role in planning for the future; and
- Baptism—religious and cultural practices that informally imply alternative caregivers (godparents) for the child.

PROVIDER CHALLENGES
- Time constraints;
- Limited knowledge and awareness in permanency planning options; and
- Counter transference—the provider’s own thoughts and fears of death.

STAGE 2: Education on Permanency Planning

There are several options for the parent or family wishing to plan for the future care of their children. As a provider, it is important for you to identify what the best option is for the family based on their unique circumstances. There are various options that exist in California, both formal (legal) and informal (not filed in a court). Each option has benefits and drawbacks.

In order for you to determine what option is best for the family, consider answering the following questions:

- Does the parent have concerns about disclosing their HIV diagnosis?
- Does the parent want to secure their decision by making a legal plan (filing in court)?
- Has the parent identified an alternative caregiver?
- Is the alternative caregiver interested in assuming legal responsibility should it ever be necessary?

These are all very important areas to assess for they guide in choosing the best suitable permanency plan option. Below are the options available to parents living in California diagnosed with a terminal illness:

TESTAMENTARY GUARDIANSHIP

Testamentary Guardianship is a guardianship preference stated in a Will or other written document, which goes into effect after the custodial parent's death and following court approval. The custodial parent initiates Testamentary Guardianship and has nominated an alternative caregiver guardian in a Will. However, initiation of a future guardianship through a Will does not, in and of itself, ensure that a court will appoint the person named in the Will. Disadvantages to Testamentary Guardianships are that nominations through Wills can be contested and do not assist during temporary incapacitation of custodial parents.

CAREGIVER’S AUTHORIZATION AFFIDAVIT

California Law recognizes a category of adults who have informally assumed responsibility for the care of minors residing with them. Through the Caregiver’s Authorization Affidavit, a caregiver may enroll a minor in school and make
school-related medical decisions. In some circumstances, a caregiver may authorize most types of medical care for the child. Completing this affidavit does not affect the rights of a custodial parent or legal guardian regarding the care, custody, and control of the minor, and does not mean that the designated caregiver has legal custody of the minor. The affidavit is not filed in a court and not valid for more than a year after the date on which it is executed.

JOINT GUARDIANSHIP

Joint Guardianship Law allows for the parent who suffers from a terminal illness to designate someone who will participate in the care of the child if and when the parent is no longer able to provide for the child’s daily needs. One of the most important aspects of this law is that it allows the custodial biological parent the opportunity to share child custody with the nominated caregiver. Further, custodial parents are permitted to retain custody and care for their children even after the joint guardianship has been granted. In most cases, this is the preferred option for parents filing for a caregiver guardianship. Joint Guardianship can also be applied in cases where two parties other than the parent, petition the court for shared custody. In this situation, the primary caregiver may request assignment of a joint caregiver guardian for additional support in raising the child. In order to file for Joint Guardianship, two conditions must be met: first, the non-custodial parent must be in agreement with the nomination of the caregiver guardian, and second, the non-custodial parent does not contest the petition submitted by the custodial parent. In addition, if the court finds it in the “best interest” of the child to agree with the petition of the custodial parent, the joint guardianship will be approved. Courts require for all non-custodial parents, grandparents, and siblings of the child to be notified of joint guardianship requests.

Guardians are permitted by law to obtain medical treatment, and they are required to ensure the safety and educational needs of the child. Guardians are also eligible to apply for public benefits on behalf of the child. Upon the death of the custodial parent, the Joint Guardian caregiver becomes the sole legal guardian of the child without any further court proceedings. Joint Guardianship appointments can be revoked by the caregiver, minor who is of 14 years or older, the parent or the court.

TEMPORARY GUARDIANSHIP

A petition filed to the court requesting an urgent appointment of a guardian. This appointment is temporary, usually 30 days until a regular guardianship hearing is scheduled. A temporary guardian can be nominated by the parent, the guardian or the child 14 years of age or older. The temporary guardian is provided with immediate authorization for the child’s care.

ADOPTION

Adoption is a permanent legal option. Adoption is most often an order filed by the Department of Children and Family Services as a procedure to implement a permanency plan for children who have suffered abuse by their biological parents. In these cases, foster care parents or relative caregivers adopt children. In adoptions, the rights of both parents must either be relinquished (voluntarily given up) or terminated by a court order. Adoptive parents assume all legal rights of adopted children, including but not limited to religion, education, and medical care. The majority of terminally ill parents are not ready to relinquish their rights as parents and therefore often do not chose adoption as a plan for the future care of their children. In cases where a parent is deceased, the alternative caregiver (if not the other parent) can chose to file for adoption of the child.

STAGE 3: Identifying a Future Guardian

Careful consideration needs to be given to choosing an alternative caregiver. Unfortunately, it is common for parents to wait until an urgent need arises to identify either a temporary or permanent caregiver. Making choices in times of urgency does not lend to careful considerations or thoughts as to whom would best care for their children. Likewise, the nominated caregiver may feel compromised to accept due to the urgency and not really consider the extent of their commitment. In such situations, parents run the risk of securing only a temporary placement followed by disruptions and at times multiple unsuccessful placements. The process of identifying an alternative caregiver can be challenging; nevertheless, it is a crucial step in the parent’s planning process.

The following questions assist in the process of selecting an alternative caregiver:

1. Has the parent experienced past hospitalizations?
   - O Yes; O No

2. If yes, who cared for their children during the hospitalization?

3. Would this person care for their children long term or permanently?
There are other important considerations in choosing the alternative caregiver. We recommend that as a provider you help the parent explore the following:

- Is the potential caregiver of age (18 years or older) and in good health?

- Is the potential caregiver aware of the parent's health condition? If not, how will he/she respond if they found out?

- Is the potential caregiver interested in assuming the responsibility permanently?

- Do the children have a relationship with him or her?

- Would the other parent object to the nomination of the potential caregiver?

- Is there anyone who the parent absolutely would not want to care for their children?

As the parent selects the future caregiver, it is important for them to know the court process for approving a nominated guardian. Although there are no hard rules as to who is most appropriate to be a guardian, it is up to the discretion of the court to approve a nomination. The court will weigh many factors in making a decision to appoint a guardian. Judges in California follow guidelines provided by law in appointment of guardians. Factors used to give guardianship preference include: to one or both parents; to the person whom the child has been living in a stable environment; and to any person determined suitable and able to provide adequate and proper care and guidance to the child (Goldoftas & Brown, 2000). Ultimately, the most important consideration in naming a guardian is the "best interest of the child."

Other important things to know before filing a legal guardianship:

1. The nominated guardian does not:
   a. have to be a legal resident or citizen.
   b. have to be married or be a parent.
   c. have to be a relative of the child.

2. The nominated guardian does have to:
   a. have a basic ability to "parent" the child.
   b. have an ability to provide the child with food, shelter, clothing, and medical care.
   c. be in fair health.

3. Reasons why a court might find a nomination improper:
   a. a person who has been charged with neglecting or abusing a minor.
   b. a person who has been convicted of a felony.
   c. other run-ins with the law depending on the crime, how long ago it was committed and the current lifestyle of the person.

4. The minor and appointed guardian will be interviewed before the court proceeding by an investigator who will give the judge a recommendation.

5. Non-custodial parents, grandparents, and siblings will be notified of the petition.

6. If the child is 14 years old or older, the child must consent to the guardianship.

7. After appointment of a guardian, the child's parents remain legally responsible for supporting the child. While not a requirement, many guardians volunteer to accept this responsibility.

8. At the request of the parent, the diagnosis of the parent can be kept confidential during the hearing.

**INvolving the children in the process**

One of the many challenging decisions faced by parents living with a terminal illness is whether or not to disclose their health status to their children as well as finding the best time to disclose. Disclosure of a terminal illness to a child is one that requires thought and preparation as well as support and guidance from professionals. Professional help can assist by reducing the parent's worries and fears. Parents commonly experience worries related to disclosure such as: Is the child old enough to understand? Will the child keep the illness and information confidential? Additionally, parents often fear that disclosing their illness to their child will intensify acting out behavior or emotional problems such as depression. The following areas should be considered in determining the appropriateness of disclosing the parents diagnosis to their children:

- The age of the child(ren);
- The emotional status of the child(ren);
- The child's ability to keep the health status confidential if asked to.
- The level of support available to the parent and family.
• The child's past response to death (if applicable) or fears about dying.

Based on our experience, we found the following tips have been extremely helpful to parents as they continue in the process:

• avoid secretive talk around the children;
• avoid disclosure of health or plans in a moment of anger or frustration;
• ensure the children receive information from the parent for this will maintain a level of trust and security;
• open and honest communication with children, especially if they are of age to understand; and
• maintain a consistent level of communication with those who support the parent.

It was learned that traditional and religious beliefs and practices often provide valuable insights to parents who are planning to discuss life and death issues to their loved ones. Tapping into alternative forms of support (i.e., spiritual) and guidance as well as to the past traditional practices that have been effective in facing and processing grief, death, and future.

STAGE 4: Securing the Plan

Securing the parent's wishes and plan is one of the most important steps in permanency planning.

STEPS TO SECURING A PLAN

1. The parent decides on the approach they will take toward securing the appointment of a guardian (legal or an informal appointment through a will or Caregivers Affidavit).
2. In urgent cases (parent is in the end stages of life), filing for a Temporary Guardianship appointment is strongly suggested.
3. Contact the local Probate Court and request procedures for filing Guardianship. Most courts offer assistance either through the clerk or in-house legal clinic.
4. Find out if there is an organization that assists with filing legal Guardianship.
5. Set up an appointment with the legal clinic or walk in during walk in hours.
6. Prior to the appointment ensure that the parent has all the necessary documents required to file a guardianship (birth certificates, social security numbers, addresses etc.). This will reduce unnecessary trips to the court and a prolonging of the court date.
7. If eligible the parent may qualify for a fee waiver for filing the petition.

STAGE 5: Aftercare Services

Aftercare support is crucial for a family that has completed a permanency plan. In cases where the transition of children to the new caregiver has occurred, it is important that comprehensive support is provided to assist in the adaptation process. Counseling, assistance with accessing resources, and obtaining entitlements is important. Additional assistance such as enrollment of children to new schools and identifying medical resources are also important. The following is a list of resources available to parents or caregivers and the minors:

FINANCIAL SUPPORT

**CalWORKs** Government benefits that provide financial support to parents or guardians and dependent children. Apply in person at the local Department of Public Social Services (DPSS) or call (866) 613-3777. Contact can also be made via the internet at www.ladpss.org.

**Social Security Benefits** Call the Social Security office at (800) 772-1213 or contact via the internet at www.ssa.gov.

Social Security Disability (SSDI) pays monthly cash benefits to disabled workers under age 65 and their dependents.

Supplemental Security Income (SSI) pays monthly benefits to people with low incomes and limited assets who are age 65 or older, or individuals of any age who are blind or disabled.

Social Security Survivors Benefits pays monthly benefits to family members of a deceased person if he/she earned enough "work credits."

**Food Stamps** Monthly benefits for low income individuals to purchase food through an electronic benefits transfer (EBT) card. Apply in person at the local Department of Public Social Services (DPSS) or call (866) 613-3777. Contact can also be made via the internet at www.ladpss.org.

**WIC** Food and nutritional education programs for at-risk, low-income pregnant women, infants, and children under the age of five. Call (888) 942-9675 or contact via the internet at www.fns.usda.gov.

**Housing** Call L.A. County Housing Authority at (800) 731-4663 or contact via the internet at www.lacd.org.
LESSONS LEARNED - PROFESSIONAL TO PROFESSIONAL

Shelter Plus Care provides rental assistance and support assistance to low income individuals with disabilities.

HALSA
Free legal advocacy and services for HIV/AIDS impacted families. Call (323) 993-1640.

Legal Aid Foundation of Los Angeles
Legal advocacy, representation and education for low income individuals. Call (800) 399-4529 or contact via the internet at www.lafla.org.

Healthy Families
Low cost insurance program for children and teens that do not have insurance and do not qualify for free Medi-Cal. Call (800) 880-5305 or contact via the internet at www.healthyfamilies.gov.

LEGAL ASSISTANCE

Public Counsel Children's Rights Project
Legal assistance in filling guardianships, adoptions and legal advocacy for minors with unmet educational needs. Call (213) 385-2977 or (800) 870-8090.

HALSA
Free legal advocacy and services for HIV/AIDS impacted families. Call (323) 993-1640.

Legal Aid Foundation of Los Angeles
Legal advocacy, representation and education for low income individuals. Call (800) 399-4529 or contact via the internet at www.lafla.org.

Special Immigrant Juvenile Status
Legal residency for children under the age of 21 (must not be married). Children must be dependent of the juvenile court or abandoned by their parents to be eligible. Call Pro Per Clinic at (213) 893-1030 or Dependency Court’s Special Immigrant Status Unit at (323) 725-4667.

LESSONS LEARNED - PROFESSIONAL TO PROFESSIONAL

Several lessons were learned in the years of implementing the permanency planning model. The most important lesson was the importance of honoring the parents’ wishes and control of their future. Additionally, it was important to respect the parents desire to maintain their illness confidential. The program staff ensured the parents at all times felt a sense of control of their decision to disclose as well the timing and to whom. Unfortunately, parents often lived in confinements of secrecy and experienced increases psychological distress as a result of their reluctance to disclose. Parents at times veiled or disguised their disclosure by reporting to have an illness other than HIV such as cancer or rare blood disorders. In a few cases, parents with HIV were also reluctant to engage in permanency planning due to “hopes of immortality.” Parents found to be living in stable health were less likely to explore permanency planning options. Such participants took into account the highly publicized “idea” that if they remained compliant to their medication regimen, they would live longer and that “death” was no longer an emerging threat. Program staff was respectful of the parents’ views and encouraged their hopeful perspectives. Nevertheless, parents were encouraged to take advantage of the specialized support provided by the Project Milagro team. Overall, the program learned that the disclosure process existed in a continuum, with parents conveying varying degrees of information to their loves ones. Parents tended to disclose as their illness progressed and often to older children.

To facilitate and expedite permanency planning process the project relied on the legal support of Public Counsel Law Center, a firm that offered free permanency planning services to HIV impacted families. Additionally, a workbook (attached) was developed to assist and guide parents through the process of planning for the future care of their children. Planning for the Future Care of My Children workbook was made available to participants in English and Spanish.

Building Bridges Through Community Partnerships

Project Milagro placed an emphasis on building community partnerships that were responsive to the needs of families affected by substance abuse and HIV/AIDS. The development of this web of support required investment by the front line providers as well as the Coordinator. This was instrumental in ensuring the families served were linked to services and resources. Collaborations were developed with organizations that concentrated on the following areas: parent education; Early Care and Education; maternal and child health; mental health; child welfare; legal clinics; children with disabilities; alcohol and substance abuse prevention and treatment programs. Specific partnerships were developed with LA County USC Medical Center HIV Unit; Women and Children’s Maternal Health Clinic; housing entities such as Salvation Army Alegria and Hollywoy Housing; HUD; Section 8; Institute of Women’s Health substance abuse out patient program;
Public Council Law Firm; and non-traditional partners (Faith Community Church). The primary goal of Project Milagro was preventing child abandonment through direct strategies emphasizing strengthening the families' protective capacity. Nevertheless, the program realized the need to provide direct care services to the children as well as the adult parents. Limitations due to staffing patterns, and a model that emphasized on family stabilization led to engagement of community resources that focused on the needs of the children. Linkages to Early Care and Education, local Regional Centers offering specialized services to children with disabilities, and child care centers were established.

Project Evaluation

The evaluation assessed process and outcome variables related to the achievement of the project's service goals and strategies. The evaluation captured the program model's strengths and weaknesses; successful and unsuccessful strategies; and culturally competent practices for evaluating Latino families. In this project, the lead evaluator worked closely with project staff to assess progress; identify barriers and challenges; and assist with data collection protocols and assessment tools.

Qualitative and Quantitative Data Collection

The evaluation implemented data collection procedures that were practical for participants and project staff. The overarching goal of the evaluation was to capture effective strategies that promoted child safety, permanency, and family and child well being. Parallel to this framework, the evaluation examined the culture-specific practices using measures that provide assessed outcomes for children, parents and families. Descriptive data was obtained for the sample's socio-characteristics, demographic variables, socio-cultural variables such as ethnicity, country of origin, primary language and number of years in the U.S., family composition and housing status. The evaluation provided an enriched assessment of race/ethnicity that moved beyond general United States Census data, by acknowledging the heterogeneous elements when studying Latinos.

Process variables included types and nature of the ongoing service needs and services provided to meet the program needs of children and their families; service utilization rates; and project capacity building activities (e.g. staff trainings). The project's collaboration process with other culturally competent community providers (resources) was further examined by the evaluation. Tracking logs were used to collect process data. Health status and substance abuse usage, including prenatal drug exposure and generational substance abuse, was collected using the Health survey. The Parent/Child Risk Factor Survey examined risk factor prevalence rates for children and parents and/or primary caregivers. Child well being outcomes assessed safety, permanency, child development, behavioral, emotional and health status using risk factor assessments, developmental screenings and child-focused testing. Family well being outcome indicators included assessment of parenting stress using the Parent Stress Index-Short Form; mental health conditions were evaluated by the Health Related Quality of Life and CES-D depressive symptom scale; health status was obtained by the project's Health Forms for HIV and Substance Abuse; acculturation levels were determined using the Short Acculturation Scale-Hispanic; and psychological distress factors were evaluated as subsections from the HRQoL measure. The evaluation additionally captured data on permanency outcomes for children. These were: child placement, child abuse report history, and current DCFS case status (voluntary maintenance plan, open-case).

Evaluation Methods and Procedures

Project Milagro, through the evaluation effort, tested the efficacy of a culturally specific evidence based home based model for preventing infant and child abandonment among Latina women of child bearing age impacted by HIV/AIDS and Substance Abuse. The evaluation was based on past data collection and outcome analyses to examine the project's services and strategies.

Evaluation Design

The project's comprehensive methodology utilized a quasi-experimental design with a series of measures to effectively assess the project's goals and objectives. Project Milagro's home based model provided comprehensive services and interventions with a number of expected short-term and long-term outcomes. The evaluation design incorporated measurements of the multiple outcomes. The quasi-experimental design applied to the current project was feasible and most appropriate for community-based organizations. Despite the need for experimental control groups to determine causal effects, the current trend in evaluating community programs is to utilize and apply a more realistic and useful design. In this design, participants were assessed as their own control using baseline measurements. The study used a pre and
A post-test design with baseline, six month and twelve month data collection time points.

Sample

Participants comprised substance abusing Latinas and their affected children and Latinas living with HIV/AIDS and their children. The participants consisted of two groups: HIV/AIDS and Substance Abuse. Data was obtained from biological mothers, children and in some cases, fathers and caregivers.

Process evaluation Process evaluation provided information on project planning, patterns of service needs and utilization, and implementation. This level of evaluation yielded information on the various aspects of the project's strategies utilized. Information collected for process variables included: outreach efforts, staff trainings, participant service utilization rates, participant completion and attrition rates, participant satisfaction with program services, referrals and linkages, and the program's ability of the project to meet the cultural and linguistic needs of the participants.

Outcome evaluation The outcome evaluation measured the attainment of measurable project goals. Participants were assessed at baseline, 6 months (posttest 1) and 12 months (posttest 2). Measurements were evaluated at each point and patterns of change over time were examined. Participants comprising the project's two groups: HIV/AIDS and Substance Abuse were assessed for within group and between group changes the project's outcomes.

Data collection procedure The evaluation team worked closely with project staff to provide hands-on training on administering and completing the evaluation forms. The project staff was bilingual and bicultural, and administered the instruments in English or Spanish. Prior to data collection, each participant was asked to sign a consent form for the evaluation component (see Appendix B). Consent forms were available in Spanish and English. The evaluation utilized a repeated measurement design for collecting the project's data. Data was collected at baseline, 6 months (posttest 1) and 12 months-program completion (posttest 2). Because the target population is transient, homeless, migrate to different counties or impacted by HIV related health difficulties, post-test 1 provided termination data for those clients receiving less services.

Data collection instruments Selecting measures that adequately assess project goals, objectives, process and outcome variables' must take into account the cultural and linguistic needs of the target population and the usefulness of the instrument to project staff. The instruments were in part, consistent with the AIA Cross-site data collection plan, and can be used for case planning and screening tools for children and families. For some measures, normative data for Latino women with children and/or Hispanics is limited; however, the project has established a database with respective referent means.

The following instruments were used for the evaluation of this project:

Data Collection Instruments

Bienvenidos Intake Agency form used to enroll clients and identify service needs. Form provides demographics.

Safety | Family Assessment Form (FAF) The form provides a standardized assessment of family functioning and service planning for families. The project utilized the "safety" domain to assess child safety in the environment and family's stability and functioning to meet child's safety needs.

Parent/Child Risk Factor Survey This is a 25 item checklist that identifies parent risk factors and child risk factors based on current stressors, problems and past experiences, incidents.

Developmental Screening Form This questionnaire was developed by the evaluator to identify and screen developmental risks and age appropriate functioning.

Parent Stress Index-SF (PSI) This survey assesses life stress, parenting efficacy, parenting stress, parent-child bond and child behaviors. This measure is used in the AIA Cross-Site Evaluation. The PSI long form and short form have been used in the AIA Project Milagro evaluation. This standardized tool has a reliability of .87 for current sample. The PSI Short Form was used in the project and has a published Spanish version.

CES-D This 20 item self-report measure assesses at risk levels of Depression and has been used with Latinas for the past 2 decades. This screening tool is currently used in the project and obtained a reliability of .86.

Developmental Profile II - This is a child development measure that examines physical, self-help, cognitive, language and social development for children ages 3 months to 10 years old. The DPII was used to assess child participants aged 5 years and older.

Ages and Stages Questionnaire This is a child development measure that examines physical, self-help, cognitive, language
and social development for children ages 3 months to 5 years old. The ASQ was used to assess children up to 5 years old.

**Health Related Quality of Life** This self-report tool provides perceived level of quality of life using 9 indicators of physical, emotional, psychological and mental well-being for individuals dealing with a health condition. The HRQOL (Rand, 1999) was developed primarily for HIV/AIDS males although the current project used this measure. Reliabilities for both the long version (15 domains) and short form for our current sample were .79 to .89.

**Short Acculturation Scale for Hispanics** This measure identifies cultural and linguistic practices in the home and socially. It provides a continuum from low acculturation to high acculturation among Hispanics.

**Client Satisfaction Survey** This survey will be administered at termination and will assess participant's satisfaction with specific services and linkages provided by the program.

**Changes in Home/Environment Form** This tracking tool will identify changes in service needs and/or family composition that impact child and family well being.

**Linkages/Referrals Form** This form is an ongoing tracking form used to identify needs, referrals and linkages.

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**Appendices**

**Appendix A: Job descriptions for positions**
1. Family Support Worker
2. In-home Counselor
3. Therapist

**Appendix B: Evaluation instruments**
1. Bienvenidos Intake Form
2. Parent/Caregiver Risk Factor Survey: I + ii
3. Child Risk Factor Survey: i + ii
4. CES-D
5. Short Acculturation Scale for Hispanics (SASH)
6. Social Support
7. Medical Access Form [English and Spanish]
8. Family Assessment Form (FAF Safety scale)
9. Health Related Quality of Life Survey
10. Coping Survey [English and Spanish]
11. Health Interview Survey for HIV/AIDS
12. Substance Abuse Health Interview
13. Changes in Home/Environment / Family Log
14. Client Satisfaction Survey for ALA Family Programs
15. Copyright Instruments
16. Informed Consent Form for Treatment and Evaluation

**Appendix C: Program Documents**
1. In-home Visit Progress Report
2. Case Plan

**Appendix D: Program Brochure**

**Appendix E: Planning for the Future Care of My Children Workbook**

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**References**


The project’s instruments appear in Appendix B. Spanish versions used are also included. Instruments with copyright rules are not provided in this manual.

**Health Survey Interview** A short health survey developed by the evaluation was used to assess HIV women and Substance Abuse women. Different versions applicable to HIV or Substance abuse were developed.
Appendix A: Job Descriptions

1. JOB DESCRIPTION: Family Support Worker

Organization Mission Statement: Bienvenidos Children's Center, Inc., (B.C.C.) is a state licensed private non-profit, nonsectarian, child/family welfare agency offering services throughout Los Angeles County. B.C.C's mission is to strengthen vulnerable families and to support and encourage the healthy development of their children.

Job Title: Family Support Worker, Full Time Position

Supervised by: Program Coordinator

Classification: Salary/Exempt

Duties and Responsibilities:

- Conduct home visits, comprehensive assessments assessing risk of child abuse and/or child abandonment.
- Provide counseling and case management services to children, youth and families impacted by HIV/AIDS.
- Provide linkages and referrals to families (transportation and advocacy in the community).
- Meet with identified families in their home environment as prescribed by the family support plan.
- Complete all necessary documentation according to project protocol (monthly documentation, intake and evaluation documents).
- Actively participate in regularly scheduled interdisciplinary case conferences with Project Support Team and individual supervision with Program Coordinator.
- Meet with Program Supervisor for supervision.
- Conduct outreach activities (participate in outreach events, and community presentations).
- Participate in program and BFS meetings.
- Other activities as required to conduct program and agency objectives.

Qualifications:

- Bachelor's Degree in Social Work, Psychology or related discipline and a minimum of two years of practical experience in the field of social services.
- Bilingual/Bicultural (Spanish Speaking): Class 3 Drivers License.

2. JOB DESCRIPTION: In-Home Counselor

Organization Mission Statement: Bienvenidos Children's Center, Inc., (B.C.C.) is a state licensed private non-profit, nonsectarian, child/family welfare agency offering services throughout Los Angeles County. B.C.C's mission is to strengthen vulnerable families and to support and encourage the healthy development of their children.

Job Title: In-Home Counselor, Full Time Position

Supervised by: Program Coordinator

Classification: Salary/Exempt

Duties and Responsibilities:

- Conduct home visits, comprehensive assessments assessing risk of child abuse and/or child abandonment.
- Provide counseling and case management services to children, youth and families impacted by HIV/AIDS and/or Substance Abuse.
- Provide Parenting Education, and information on Child Development.
- Meet with identified families in their home environment as prescribed by the family support plan.
- Coordinate transportation services to clients and their families.
- Complete all necessary documentation according to project protocol.
- Actively participate in regularly scheduled interdisciplinary case conferences with Project Support Team and individual supervision with Program Coordinator.
- Conduct outreach activities in the community (presentations, distribution of program material).
- Other activities as required to conduct program and agency objectives.

Qualifications:

- Bachelor's Degree in Social Work, Psychology or related discipline and/or CAADAC.
- A minimum of one year of practical experience in the field of HIV/AIDS, Substance Abuse and Child Welfare.
- Bilingual/Bicultural (Spanish Speaking): Class 3 Drivers License.
3. **JOB DESCRIPTION: Family Therapist**

*Organization Mission Statement:* Bienvenidos Children's Center, Inc. (B.C.C.) is a state licensed private non-profit, nonsectarian, child/family welfare agency offering services throughout Los Angeles County. B.C.C.'s mission is to strengthen vulnerable families and to support and encourage the healthy development of their children.

*Job Title:* Family Therapist, Full Time Position

*Supervised by:* Program Coordinator

*Classification:* Salary/Exempt

*Duties and Responsibilities:*

- Conduct thorough psycho-social assessments for children, youth and participating project families that are impacted by substance abuse and/or HIV/AIDS.

- Provide intensive home-based counseling and therapy to adults and families.

- Meet with identified families in their home environment as prescribed by the family support plan.

- Complete all necessary documentation according to project protocol.

- Participate in regularly scheduled interdisciplinary case conferences with Project Support Team.

- Meet with Project Coordinator and Clinical Supervisor for direct supervision.

- Other duties as assigned (i.e., facilitate groups for families impacted by HIV/AIDS, conduct presentations in the community).

**Qualifications:**

- Master's Degree in Social Work, Psychology or related discipline, and;

- A minimum of two years of clinical experience in the field of HIV/AIDS, Substance Abuse and Child Welfare.

- Bilingual/Bicultural (Spanish Speaking); Class 3 Drivers License
Bienvenidos Family Services

Date of Initial Intake
ID#
SPA#
District#

Name:

Relation to Child _______________ DOB _______________

Address

Cti/State/ZIP

Phone: _______________ Message Phone

Health Insurance Status
01 MEDI-CAL
02 HMO
03 Healthy Families
04 No Insurance
Other _______________________

Country of Origin

Primary language in home
1-English
2-Spanish
3-other
4-Bilingual

S.S.# (optional) _______________________

Educational status
00 Elementary Education only
01 Number of years of Education completed
02 GED

Work/Employment status
01 Does not work
02 Seeking employment
03 Working part-time
04 Working full-time

Other _______________________

In School 1-Full-time 2-Part-time 3-No Source of Income ($) TANF/GR Food Stamps Employment

Number of household families to be served: Adults ______ Children ______

Biological Mother
(Complete below only if applicable)
Martial Status Code ______ Ed. Code ______ Work Code ______
DOB ______________ Resides in the home Yes____ No____

Mother's Name
Comments:

Biological Father
(Complete below only if applicable)
Martial Status Code ______ Ed. Code ______ Work Code ______
DOB ______________ Resides in the home Yes____ No____

Father's Name
Comments:

Program Assignment
1-AIA
2-1733
9-WH (Substance Abuse)
4-Family Preservation
5-Clarity
6-HEAL
7-FED
8-Project Escuelita
9-Family Support 9 ELA 9 Covina
10-Project Corazon 96FS 9 HSA
11-Wraparound
12-CALWORKS
13-Joven Noble 9 FED 9 STATE
14-Fatherhood 9 Teen 9 CLP
15-Health Center
16-Other

Assigned to:
1-Coordinator
2-Case Worker

Opening date _______ / _______ / _______
Closing date _______ / _______ / _______

Message Phone
**Previous BFS Services:** Yes/No  Which program: ____________________________

**STATUS OF DCFS/DPSS CASE:**  
1-None 2-Family Preservation 3-Permanency Planning 4-Emergency Response 5-Adoptions 6-Closed case 7-Reunification 8-Maintenance

DCFS Case # ____________________________ Office ____________________________

(CSWS) Optional) Phone# ____________________________

**Date of Initial Involvement** ____________________________  **Date of Initial Placement** ____________________________

**Placement History** ____________________________

**Attorney's name** ____________________________ Phone# ____________________________

**DPSS-Case Worker** ____________________________ Case # ____________________________ Tel. # ____________________________

---

### CHILDREN

<table>
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<tr>
<th>#</th>
<th>Name</th>
<th>Ethnic Code</th>
<th>F/M</th>
<th>DOB/Age</th>
<th>Parent</th>
<th>Placement Code</th>
<th>Date of Reunification</th>
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<td>F/M</td>
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### CHILDREN'S RISK FACTORS

<table>
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<tr>
<th>Risk Factor</th>
<th>Child #</th>
<th>Risk Factor</th>
<th>Child #</th>
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</thead>
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<tr>
<td>Behavior problems: None</td>
<td>1 2 3 4</td>
<td>Low birth weight: None</td>
<td>7 8 9 10</td>
</tr>
<tr>
<td>Caloric deprivation: None</td>
<td>1 2 3 4</td>
<td>Motor impairment: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>Cardiac anomalies: None</td>
<td>1 2 3 4</td>
<td>Neonatal drugs or alcohol: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>No placed out of the home: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>No prenatal care: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>Developmental delays: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>Premature: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>Down's Syndrome: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>Seizures: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
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<tr>
<td>Failure-to-drive: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>Severe emotional disturbance: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>Hearing impairment: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>Sleep apnea syndrome: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
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<tr>
<td>History of placements: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>Vision impairment: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>Learning disability: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>Other: None</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
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**PARENT/CAREGIVER RISK FACTORS**

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<th>2-No</th>
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<tr>
<td>Pregnant Teen (Due Date)</td>
<td>1-Yes</td>
<td>2-No</td>
</tr>
<tr>
<td>Current Substance abuse</td>
<td>1-Yes</td>
<td>2-No</td>
</tr>
<tr>
<td>History of substance abuse (drug of choice)</td>
<td>1-Yes</td>
<td>2-No</td>
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</tbody>
</table>

**Services Request and Linkages**

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<tr>
<th>SERVICES REQUESTED</th>
<th>REFERRED TO:</th>
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<tr>
<td>Advocacy</td>
<td>After school Program</td>
</tr>
<tr>
<td>Anger Management</td>
<td>Case Management</td>
</tr>
<tr>
<td>Case Management</td>
<td>Childcare/Day Care</td>
</tr>
<tr>
<td>Counseling</td>
<td>Concrete Services</td>
</tr>
<tr>
<td>Concrete Services</td>
<td>Domestic Violence</td>
</tr>
<tr>
<td>Court Services</td>
<td>E.S.L.</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Educational Evaluation</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Family Counseling</td>
</tr>
<tr>
<td>Employment Counseling</td>
<td>Financial Assistance</td>
</tr>
<tr>
<td>Fatherhood Classes</td>
<td>Food Assistance</td>
</tr>
<tr>
<td>In-Home Services</td>
<td>Health Services</td>
</tr>
<tr>
<td>Self-Help Groups</td>
<td>HIV/AIDS Services</td>
</tr>
<tr>
<td>Parenting Classes</td>
<td>Housing Assistance</td>
</tr>
<tr>
<td>Respite Services</td>
<td>Independent Living Program</td>
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<tr>
<td>Substance Abuse: Education Recovery</td>
<td>Individual Counseling</td>
</tr>
<tr>
<td>Teen's Girl's Group</td>
<td>In-Home Support</td>
</tr>
<tr>
<td>Teen Male Group</td>
<td>Job Readiness</td>
</tr>
<tr>
<td>Transportation</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Workshops</td>
<td>Mommy &amp; Me</td>
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<tr>
<td>Other (Specify)</td>
<td>Parent Education</td>
</tr>
</tbody>
</table>
**NARRATIVE**

[Blank NARRATIVE space for client's information]

**FOLLOW-UP**

[Blank FOLLOW-UP space for notes or assessment]

<table>
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<tr>
<th>Code Box</th>
<th>Marsital Status</th>
<th>Resides w/Current Placement List</th>
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<tbody>
<tr>
<td>Ethnic Code</td>
<td>1-Married</td>
<td>1-Home w/parent, no CPS involvement</td>
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<td>2-Hispanic</td>
<td>2-Divorced</td>
<td>2-Home w/parent CPS involvement</td>
</tr>
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<td>3-African/American</td>
<td>3-Separated</td>
<td>3-Adoptive home parent</td>
</tr>
<tr>
<td>4-Asian</td>
<td>4-Widowed</td>
<td>4-Relative, informal placement</td>
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<td>5-Pacific Islander</td>
<td>5-Domestic Partner</td>
<td>5-Relative, foster care</td>
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<td>6-American Indian</td>
<td>6-Single</td>
<td>6-Non-relative, informal placement</td>
</tr>
<tr>
<td>7-Other</td>
<td>9-N/A</td>
<td>7-Foster Family Care</td>
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<tr>
<td>9-N/A</td>
<td>11-Hospital</td>
<td>8-Group home/shelter</td>
</tr>
<tr>
<td>13-W/relative - Legal Guardianship</td>
<td>12-Homeless shelter w/parent</td>
<td>10-Residential treatment w/o parent</td>
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</tbody>
</table>

Referring agency: ___________________________  Contact: ___________________________

Referred by: 1-Hospital  2-Substance abuse program  3-DCFS  4-Self/friend/relative  5-Mental Health  
6-Shelter  7-Judicial  8-Regional Center  9-BFFA  10-Other

Code Box

Client's Signature__________________________ Date__________________________

Intake taken by: ____________________________

Date__________
### In Case of Emergency Contacts

<table>
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<th>Name</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Relationship</td>
<td>Address</td>
</tr>
<tr>
<td>Name</td>
<td>Phone</td>
</tr>
<tr>
<td>Relationship</td>
<td>Address</td>
</tr>
</tbody>
</table>

### Medical Problems

<table>
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<td>Family Doctor:</td>
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<tr>
<td>Name of Clinic/Hospital:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
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### Child/Children to be released to:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Relationship</td>
<td>Address</td>
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<tr>
<td>Signature</td>
<td>Date of release:</td>
</tr>
<tr>
<td>Name</td>
<td>Phone</td>
</tr>
<tr>
<td>Relationship</td>
<td>Address</td>
</tr>
<tr>
<td>Signature</td>
<td>Date of release:</td>
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</tbody>
</table>
Appendix B2-i  Project Milagro Evaluation – Parent/Caregiver Risk Factors

Baseline Parent/Caregiver Risk Factors

*Please complete during the Initial Intake/Referral for those parents/primary caregivers who are currently residing with child(ren) participating in Project Milagro.*

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver 1:</td>
<td></td>
</tr>
<tr>
<td>Caregiver 2:</td>
<td></td>
</tr>
</tbody>
</table>

*Please check the following items that place parents/caregivers at risk and thereby potentially limit the child(ren)’s ability to develop normally (within the social, emotional, physical, cognitive and adaptive domains)*

**Section 1: Past Risk Factors (occurring during caregivers’ childhood or longer than 6 months ago)**

<table>
<thead>
<tr>
<th>Caregiver</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Witnessed domestic abuse as a child (specify type: physical, emotional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Victim of domestic abuse (specify type: physical, emotional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Grew up in a household with substance abuser(s) (specify drug(s): )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Substance abuse (specify drug(s): )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Substance abuse during pregnancy (specify drug(s): )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Victim of childhood abuse (specify type: physical, sexual, emotional, neglect)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Court identified as abusive, neglectful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Homelessness/shelter/unstable living situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Developmental delays/learning disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Physical disability (specify: )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Mental disorder (specify: )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Chronic/long term medical illness (specify: )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Multiple incarcerations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

continued on next page

*Note: Requests to duplicate this instrument/form can be forward to Lourdes Carranza, Project Manager at Bienvenidos, address*
### Section 2: Current Risk Factors (occurring within last 6 months)

<table>
<thead>
<tr>
<th></th>
<th>Risk Factor</th>
<th>Caregiver 1</th>
<th>Caregiver 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Victim of domestic abuse (specify type: physical, emotional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Marital/Partner discord</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Pregnant (Date due: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Substance abuse (specify drug(s): ____________)</td>
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<tr>
<td>18</td>
<td>Court identified as abusive/neglectful</td>
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<tr>
<td>19</td>
<td>Children detained by DCFS (during the past year)</td>
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<tr>
<td>20</td>
<td>Poor/limited parenting skills</td>
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<tr>
<td>21</td>
<td>Poor/limited job skills</td>
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<td></td>
</tr>
<tr>
<td>22</td>
<td>Poverty</td>
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<tr>
<td>23</td>
<td>Isolation</td>
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<td>24</td>
<td>Presently homeless</td>
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<td></td>
</tr>
<tr>
<td>25</td>
<td>Substandard living/temporary housing</td>
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<tr>
<td>26</td>
<td>Unemployed for most or all of the past year</td>
<td></td>
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<tr>
<td>27</td>
<td>Inadequate or no health insurance</td>
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</tr>
<tr>
<td>28</td>
<td>Developmental delays/learning disability</td>
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<td></td>
</tr>
<tr>
<td>29</td>
<td>Physical disability (specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Mental disorder, asymptomatic (specify: ____________)</td>
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<tr>
<td>31</td>
<td>Symptomatic mental illness (specify: ____________)</td>
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<tr>
<td>32</td>
<td>Medical illness, expected to improve (specify: ____________)</td>
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<tr>
<td>33</td>
<td>Taking medication for medical or psychological condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Incarcerated during the past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Probation/parole during the past 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Illiteracy: unable to read</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Illiteracy: unable to write</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Caring for a disabled/ill person in the same household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Caring for a medically fragile child or child with special needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Experienced a traumatic event (specify: ____________)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Completion Parent/Caregiver Risk Factors

Please complete during the initial intake/referral for those parents/primary caregivers who are currently residing with child(ren) participating in Project Milagro.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver 1:</td>
<td></td>
</tr>
<tr>
<td>Caregiver 2:</td>
<td></td>
</tr>
</tbody>
</table>

Please check the following items that place parents/caregivers at risk and thereby potentially limit the child(ren)'s ability to develop normally (within the social, emotional, physical, cognitive and adaptive domains).

**Section 1: Past Risk Factors (occurring during caregivers' childhood or longer than 6 months ago)**

<table>
<thead>
<tr>
<th>Caregiver 1</th>
<th>Caregiver 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Witnessed domestic abuse as a child (specify type: physical___ emotional___)</td>
<td>□ □</td>
</tr>
<tr>
<td>2. Victim of domestic abuse (specify type: physical___ emotional___)</td>
<td>□ □</td>
</tr>
<tr>
<td>3. Grew up in a household with substance abuser(s) (specify drug(s): __________________)</td>
<td>□ □</td>
</tr>
<tr>
<td>4. Substance abuse (specify drug(s): __________________)</td>
<td>□ □</td>
</tr>
<tr>
<td>5. Substance abuse during pregnancy (specify drug(s): __________________)</td>
<td>□ □</td>
</tr>
<tr>
<td>6. Victim of childhood abuse (specify type: physical___ sexual___ emotional___ neglect___)</td>
<td>□ □</td>
</tr>
<tr>
<td>7. Court identified as abusive/neglectful</td>
<td>□ □</td>
</tr>
<tr>
<td>8. Homelessness/shelter/unstable living situation</td>
<td>□ □</td>
</tr>
<tr>
<td>9. Developmental delays/learning disability</td>
<td>□ □</td>
</tr>
<tr>
<td>10. Physical disability (specify: __________________)</td>
<td>□ □</td>
</tr>
<tr>
<td>11. Mental disorder (specify: __________________)</td>
<td>□ □</td>
</tr>
<tr>
<td>12. Chronic/long term medical illness (specify: __________________)</td>
<td>□ □</td>
</tr>
<tr>
<td>13. Multiple incarcerations</td>
<td>□ □</td>
</tr>
</tbody>
</table>

continued on next page
### Completion Parent/Caregiver Risk Factors

**Section 2: Current Risk Factors (occurring within last 6 months)**

| 14. Victim of domestic abuse (specify type: physical, emotional) | 15. Marital/Partner discord |
| 16. Pregnant (Date due: ) | 17. Substance abuse (specify drug(s): ) |
| 18. Court identified as abusive/neglectful | 19. Children detained by DCFS (during the past year) |
| 20. Poor/limited parenting skills | 21. Poor/limited job skills |
| 22. Poverty | 23. Isolation |
| 24. Presently homeless | 25. Substandard living/temporary housing |
| 26. Unemployed for most or all of the past year | 27. Inadequate or no health insurance |
| 30. Mental disorder, asymptomatic (specify: ) | 31. Symptomatic mental illness (specify: ) |
| 32. Medical illness, expected to improve (specify: ) | 33. Taking medication for medical or psychological condition |
| 34. Incarcerated during the past year | 35. Probation/parole during the past 12 months |
| 36. Illiteracy, unable to read | 37. Illiteracy, unable to write |
| 38. Caring for a disabled/ill person in the same household | 39. Caring for a medically fragile child or child with special needs |
| 40. Experienced a traumatic event (specify: ) |  |
Baseline Child Risk Factors/Developmental Screening

Please complete this assessment during the Initial Intake/Referral for index child participating in Project Milagro.

Please check any of the following factors which may impact age-appropriate development in the areas of social (behavioral), emotional, physical (motor), cognitive (learning, language) and independent (self-help skills) functioning.

Section 1: Past Risk Factors (occurring prior to birth or longer than 6 months ago)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of prenatal care or &quot;well baby&quot; pediatric care (date of last physical exam <strong>/</strong>_)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Preterm birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Low birth weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Prenatal drug exposure (specify drug(s): ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Exposure to substance abuse in the household (specify drug(s): ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Exposure to domestic violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Victim of abuse or neglect (specify type: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Out-of-home placement(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Unstable housing (homelessness, shelters, more than 2 moves in a year)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 2: Current Risk Factors (occurring within last 6 months)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Lack of &quot;well child&quot; pediatric care/immunization (date of last physical exam <strong>/</strong>_)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Inadequate nutrition, caloric deprivation or anemia (specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Chronic health problem (specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Exposure to substance abuse in the household (specify drug(s): ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Exposure to domestic violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Victim of abuse or neglect (specify type: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Death of a parent or other member of household with significant relationship to child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Other significant traumatic event (specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Lack of stable family composition (absentee parent, changing caregivers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Out-of-home placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Unstable housing (homelessness, shelters, more than 1 move in past 6 months)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Baseline Child Risk Factors/Developmental Screening

Section 3: Developmental Screening

Please indicate any of the following conditions that have been formally diagnosed by a medical or other professional, or which have been observed or suspected by either the intake examiner or the child's caregiver. For undiagnosed conditions, check only if the problem is expected to have a significant impact on the child's normal development.

<table>
<thead>
<tr>
<th>Physical conditions:</th>
<th>Formally Diagnosed</th>
<th>Observed / Suspected by:</th>
<th>Examiner</th>
<th>Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiac anomaly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Motor/physical impairment (specify: ____ )</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Asthma/respiratory problem</td>
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<tr>
<td>4. Hearing impairment</td>
<td></td>
<td></td>
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<tr>
<td>5. Vision impairment</td>
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<td></td>
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<tr>
<td>6. Failure-to-thrive</td>
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<td>7. Fetal Alcohol Syndrome</td>
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<tr>
<td>8. Seizures</td>
<td></td>
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</tr>
<tr>
<td>9. Cerebral palsy</td>
<td></td>
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</tr>
<tr>
<td>10. Other neurological disorder (specify: ____ )</td>
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<td></td>
</tr>
<tr>
<td>11. Congenital HIV - asymptomatic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Symptomatic HIV infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Other chronic medical condition (specify: ____ )</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Mental and Emotional/Behavioral conditions:</th>
<th>Formally Diagnosed</th>
<th>Observed / Suspected by:</th>
<th>Examiner</th>
<th>Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Down syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Pervasive Developmental Disorder/Autism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Other developmental delay (specify: ____ )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Severe emotional disturbance (specify: ____ )</td>
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<tr>
<td>18. Attention Deficit Disorder (or ADHD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Other learning disability (specify: ____ )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Behavioral problem (specify: ____ )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Other mental health disorder (specify: ____ )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the examiner or child's caregiver suspects that the child has special needs based on a condition not listed above, please provide a detailed description below:
Completion Child Risk Factors/Developmental Screening

Please complete this assessment at termination for index child participating in Project Milagro.

Please check any of the following factors which may impact age-appropriate development in the areas of social (behavioral, relationship), emotional, physical (motor), cognitive (learning, language) and independent (self-help skills) functioning.

**Section 1: Past Risk Factors (occurring prior to birth or longer than 6 months ago)**

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<tbody>
<tr>
<td>1.</td>
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<tr>
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<td>Exposure to substance abuse in the household (specify drug(s): ____________)</td>
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<tr>
<td>6.</td>
<td>Exposure to domestic violence</td>
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<td>7.</td>
<td>Victim of abuse or neglect (specify type: ________________)</td>
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<td>9.</td>
<td>Unstable housing (homelessness, shelters, more than 2 moves in a year)</td>
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</table>

**Section 2: Current Risk Factors (occurring within last 6 months)**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>10.</td>
<td>Lack of “well child” pediatric care/immunization (date of last physical exam: ___ / ___)</td>
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<td>14.</td>
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Completion Child Risk Factors/Developmental Screening

Section 3: Developmental Screening

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<td></td>
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<tr>
<td>13. Other chronic medical condition (specify: ____________)</td>
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<td>19. Other learning disability (specify: ____________)</td>
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<td></td>
</tr>
<tr>
<td>20. Behavioral problem (specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Other mental health disorder (specify: ____________)</td>
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<td></td>
</tr>
</tbody>
</table>

If the examiner or child’s caregiver suspects that the child has special needs based on a condition not listed above, please provide a detailed description below.
Below is a list of some of the ways you may have felt or behaved. Please circle how often you have felt this way during the past week.

<table>
<thead>
<tr>
<th></th>
<th>rarely or none of the time</th>
<th>some of the time</th>
<th>occasionally</th>
<th>most or all of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>under 1 day</td>
<td>1-2 days</td>
<td>3-4 days</td>
<td>5-7 days</td>
</tr>
<tr>
<td>1. I was bothered by things that usually don’t bother me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I did not feel like eating; my appetite was poor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I felt that I could not shake off the blues even with help from my family or friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I felt that I was just as good as other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I had trouble keeping my mind on what I was doing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I felt depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I felt that everything I did was an effort</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I felt hopeful about the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I thought my life had been a failure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I felt fearful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. My sleep was restless</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I was happy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I talked less than usual</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I felt lonely</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. People were unfriendly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I enjoyed life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I had crying spells</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I felt sad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I felt that people disliked me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I could not get &quot;going&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*Note: Requests to duplicate this instrument/form can be forward to Lourdes Carranza, Project Manager at Bienvenidos, 316 W. 2nd Street, Suite 800, Los Angeles, CA 90012.*
A. English

1. In general, what language(s) do you read and speak?

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<th>1</th>
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<td>☐</td>
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<td>☐</td>
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</tbody>
</table>
   Only Spanish better than English | Both Equally | English better than Spanish | only English |

2. What was the Language(s) you used as a child?

<table>
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<tr>
<th>1</th>
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</table>
   Only Spanish better than English | Both Equally | English better than Spanish | only English |

3. What language(s) do you usually speak at home?

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<tr>
<th>1</th>
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</tbody>
</table>
   Only Spanish better than English | Both Equally | English better than Spanish | only English |

4. In which language(s) do you usually think?

<table>
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<tr>
<th>1</th>
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</tr>
</tbody>
</table>
   Only Spanish better than English | Both Equally | English better than Spanish | only English |

5. What language(s) do you usually speak with your friends?

<table>
<thead>
<tr>
<th>1</th>
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</tbody>
</table>
   Only Spanish better than English | Both Equally | English better than Spanish | only English |

Total Score = _______
6. In what language(s) are the TV programs you usually watch?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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</tr>
<tr>
<td>Only Spanish</td>
<td>Spanish better than English</td>
<td>Both Equally</td>
<td>English better than Spanish</td>
<td>only English</td>
<td></td>
</tr>
</tbody>
</table>

7. In what language(s) are the radio programs you usually listen to?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<td>Only Spanish</td>
<td>Spanish better than English</td>
<td>Both Equally</td>
<td>English better than Spanish</td>
<td>only English</td>
<td></td>
</tr>
</tbody>
</table>

8. In general, in what language(s) are the movies, TV, and radio programs you prefer to watch and listen to:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th>4</th>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Only Spanish</td>
<td>Spanish better than English</td>
<td>Both Equally</td>
<td>English better than Spanish</td>
<td>only English</td>
<td></td>
</tr>
</tbody>
</table>

9. Your close friends are:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
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<td>☐</td>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Only Latinos</td>
<td>More Latinos than Americans</td>
<td>About half and half</td>
<td>More Americans than Latinos</td>
<td>All Americans</td>
<td></td>
</tr>
</tbody>
</table>

10. You prefer going to social gatherings/parties at which the people are:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Only Latinos</td>
<td>More Latinos than Americans</td>
<td>About half and half</td>
<td>More Americans than Latinos</td>
<td>All Americans</td>
<td></td>
</tr>
</tbody>
</table>

11. The persons you visit or who visit you are:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Only Latinos</td>
<td>More Latinos than Americans</td>
<td>About half and half</td>
<td>More Americans than Latinos</td>
<td>All Americans</td>
<td></td>
</tr>
</tbody>
</table>

12. If you could choose your children’s friends, you would want them to be:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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</tr>
<tr>
<td>Only Latinos</td>
<td>More Latinos than Americans</td>
<td>About half and half</td>
<td>More Americans than Latinos</td>
<td>All Americans</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B5  Project Milagro Evaluation – Short Acculturation Scale for Hispanics (Spanish)

Client ID: ___________________________  Group:  □ HA  □ SA  □ HS
Date of Intake: ___________________________
Today’s Date: ___________________________

Total Score= ________

SASH 10

A. Spanish

1. Por lo general, que idioma(s) leé y habla usted?

1  2  3  4  5

□  □  □  □  □

solo Español  Español mejor  Ambos por igual  Ingles mejor  Que Español  Solo Ingles

2. Cual fue el idioma(s) que hablo cuando era niño(a)?

1  2  3  4  5

□  □  □  □  □

solo Español  Español mejor  Ambos por igual  Ingles mejor  Que Español  Solo Ingles

3. Por lo general, en que idioma(s) habla en su casa?

1  2  3  4  5

□  □  □  □  □

solo Español  Español mejor  Ambos por igual  Ingles mejor  Que Español  Solo Ingles

4. Por lo general, en que idioma(s) habla en su casa?

1  2  3  4  5

□  □  □  □  □

solo Español  Español mejor  Ambos por igual  Ingles mejor  Que Español  Solo Ingles

5. Por lo general, en que idioma(s) habla con sus amigos(as)?

1  2  3  4  5

□  □  □  □  □

solo Español  Español mejor  Ambos por igual  Ingles mejor  Que Español  Solo Ingles
6. Por lo general, en que idioma(s) son los programas de televisión que usted ve?

   | 1 | 2 | 3 | 4 | 5 |
   |   |   |   |   |   |
   | solo Español | Español mejor Que Ingles | Ambos por igual | Ingles mejor Que Español | Solo Ingles |

7. Por lo general, en que idioma(s) son los programas de radio que escucha?

   | 1 | 2 | 3 | 4 | 5 |
   |   |   |   |   |   |
   | solo Español | Español mejor Que Ingles | Ambos por igual | Ingles mejor Que Español | Solo Ingles |

8. Por lo general, en que idioma(s) prefiere oir y ver películas, y programas de radio y televisión?

   | 1 | 2 | 3 | 4 | 5 |
   |   |   |   |   |   |
   | solo Español | Español mejor Que Ingles | Ambos por igual | Ingles mejor Que Español | Solo Ingles |

9. Sus amigos y amigas mas cercanos son?

   | 1 | 2 | 3 | 4 | 5 |
   |   |   |   |   |   |
   | solo Latinos | Mas Latinos que Americanos | Ambos por igual | Mas Americanos que Latinos | solo Americanos |

10. Usted prefiere ir a reuniones sociales fiestas en la cuales las personas son:

   | 1 | 2 | 3 | 4 | 5 |
   |   |   |   |   |   |
   | solo Latinos | Mas Latinos que Americanos | Ambos por igual | Mas Americanos que Latinos | solo Americanos |

11. Las personas que usted visita o que lo(a) visitan son?

   | 1 | 2 | 3 | 4 | 5 |
   |   |   |   |   |   |
   | solo Latinos | Mas Latinos que Americanos | Ambos por igual | Mas Americanos que Latinos | solo Americanos |

12. Si usted pudiera escoger los amigos(as) de sus hijos(as), quisiera que ellos(as) fueran:

   | 1 | 2 | 3 | 4 | 5 |
   |   |   |   |   |   |
   | solo Latinos | Mas Latinos que Americanos | Ambos por igual | Mas Americanos que Latinos | solo Americanos |
Think of the people in your life who help you cope with your HIV/AIDS or substance abuse. Using the Circle of Support diagram, list the people who you feel that you can count on and that are inside your circle of support. Please list in order of importance.

1. How much can you rely on this person for practical support? (financial, household, transportation, childcare, etc.).
2. How much can you rely on this person for emotional support?
3. Does this person know about your HIV/AIDS or Substance Abuse?
Supportive Person # 4:

What relationship do you have with this person?

1. How much can you rely on this person for *practical* support? (financial, household, transportation, childcare, etc.).

2. How much can you rely on this person for *emotional* support?

3. Does this person know about your HIV/AIDS or Substance Abuse?

   I am certain he/she knows
   I think he/she knows
   I'm sure he/she does not know
   Yes, I told him/her

Supportive Person # 5:

What relationship do you have with this person?

1. How much can you rely on this person for *practical* support? (financial, household, transportation, childcare, etc.).

2. How much can you rely on this person for *emotional* support?

3. Does this person know about your HIV/AIDS or Substance Abuse?

   I am certain he/she knows
   I think he/she knows
   I'm sure he/she does not know
   Yes, I told him/her

Supportive Person # 6:

What relationship do you have with this person?

1. How much can you rely on this person for *practical* support? (financial, household, transportation, childcare, etc.).

2. How much can you rely on this person for *emotional* support?

3. Does this person know about your HIV/AIDS or Substance Abuse?

   I am certain he/she knows
   I think he/she knows
   I'm sure he/she does not know
   Yes, I told him/her
Supportive Person #7:

What relationship do you have with this person?

1. How much can you rely on this person for *practical* support? (financial, household, transportation, childcare, etc.).

2. How much can you rely on this person for *emotional* support?

3. Does this person know about your HIV/AIDS or Substance Abuse?

<table>
<thead>
<tr>
<th>Completely</th>
<th>Very Much</th>
<th>Somewhat</th>
<th>A little bit</th>
<th>Not at all</th>
</tr>
</thead>
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</table>

Supportive Person #8:

What relationship do you have with this person?

1. How much can you rely on this person for *practical* support? (financial, household, transportation, childcare, etc.).

2. How much can you rely on this person for *emotional* support?

3. Does this person know about your HIV/AIDS or Substance Abuse?

<table>
<thead>
<tr>
<th>Completely</th>
<th>Very Much</th>
<th>Somewhat</th>
<th>A little bit</th>
<th>Not at all</th>
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</table>

Supportive Person #9:

What relationship do you have with this person?

1. How much can you rely on this person for *practical* support? (financial, household, transportation, childcare, etc.).

2. How much can you rely on this person for *emotional* support?

3. Does this person know about your HIV/AIDS or Substance Abuse?

<table>
<thead>
<tr>
<th>Completely</th>
<th>Very Much</th>
<th>Somewhat</th>
<th>A little bit</th>
<th>Not at all</th>
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Note: Requests to duplicate this instrument/form can be forwarded to Lourdes Carranza, Project Manager at Bienvenidos, 316 W. 2nd Street, Suite 800, Los Angeles, CA 90012.
Appendix B7  Project Milagro Evaluation – Medical Access

Client ID: ___________________  Group:  □ HA  □ SA  □ HS
Timeline: Baseline __________ 12 Months __________  Today’s Date: __________

Medical Access Form

1. If I need hospital care, I can get admitted without any trouble?
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

2. It is hard for me to get medical care in an emergency.
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

3. Sometimes it is a problem to cover my share of the cost for a medical visit.
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

4. Sometimes I go without the medical care I need because it is too expensive
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

5. The clinic(s) I attend should be open for more hours than it is.
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

6. I have easy access to the medical specialist I need.
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree
Medical Access form/Client ID# ________________ Timeline: □ Baseline □ 12 months

7. Places where I can get medical care are very conveniently located.
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

8. If I have a medical question, I can reach a doctor or nurse practitioner for help.
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

9. I am able to get medical care whenever I need it.
   □ strongly agree
   □ somewhat agree
   □ uncertain
   □ somewhat disagree
   □ strongly disagree

10. The medical staff understands my Hispanic (or ____________) culture.
    □ strongly agree
    □ somewhat agree
    □ uncertain
    □ somewhat disagree
    □ strongly disagree

11. The medical staff can communicate with me in my native language (Spanish /English/ other).
    □ strongly agree
    □ somewhat agree
    □ uncertain
    □ somewhat disagree
    □ strongly disagree
Client ID: ___________________________ Group: □ HA □ SA □ HS
Timeline: Baseline _____ 12 Months ________ Today’s Date: ____________

Medical Access Form

1. ¿Si necesito cuidado de hospitalización, me pueden ingresar sin ningún problema?
   □ Estoy muy de acuerdo
   □ Estoy algo de acuerdo
   □ No estoy seguro
   □ Estoy algo de desacuerdo
   □ Estoy muy en desacuerdo

2. ¿Me resulta difícil obtener cuidado médico en una emergencia?
   □ Estoy muy de acuerdo
   □ Estoy algo de acuerdo
   □ No estoy seguro
   □ Estoy algo de desacuerdo
   □ Estoy muy en desacuerdo

3. De vez en cuando es problemático cubrir mi porción del costo de una visita de cuidado médico
   □ Estoy muy de acuerdo
   □ Estoy algo de acuerdo
   □ No estoy seguro
   □ Estoy algo de desacuerdo
   □ Estoy muy en desacuerdo

4. De vez en cuando no recibo el cuidado médico que necesito porque es demasiado caro
   □ Estoy muy de acuerdo
   □ Estoy algo de acuerdo
   □ No estoy seguro
   □ Estoy algo de desacuerdo
   □ Estoy muy en desacuerdo

5. Esta clínica debería estar abierta más horas de lo que está abierta en actualidad
   □ Estoy muy de acuerdo
   □ Estoy algo de acuerdo
   □ No estoy seguro
   □ Estoy algo de desacuerdo
   □ Estoy muy en desacuerdo

6. Tengo acceso fácil a los médicos especialistas que necesito
   □ Estoy muy de acuerdo
   □ Estoy algo de acuerdo
   □ No estoy seguro
   □ Estoy algo de desacuerdo
   □ Estoy muy en desacuerdo
Medical Access Form / Client ID# ____________________  Timeline  ___________  

7. Los lugares donde puedo recibir cuidado médico están ubicados en lugares locales  
   □ Estoy muy de acuerdo  
   □ Estoy algo de acuerdo  
   □ No estoy seguro  
   □ Estoy algo de desacuerdo  
   □ Estoy muy en desacuerdo  

8. Si tengo una pregunta médica, puedo comunicarme con un médico o enfermera para que me  
   presten ayuda  
   □ Estoy muy de acuerdo  
   □ Estoy algo de acuerdo  
   □ No estoy seguro  
   □ Estoy algo de desacuerdo  
   □ Estoy muy en desacuerdo  

9. Puedo recibir cuidado médico cuando lo necesite  
   □ Estoy muy de acuerdo  
   □ Estoy algo de acuerdo  
   □ No estoy seguro  
   □ Estoy algo de desacuerdo  
   □ Estoy muy en desacuerdo  

10. El personal médico entienden mi cultura hispana(o)  
    □ Estoy muy de acuerdo  
    □ Estoy algo de acuerdo  
    □ No estoy seguro  
    □ Estoy algo de desacuerdo  
    □ Estoy muy en desacuerdo  

11. El personal médico se comunican con migo en mi idioma (Español/Inglés/otro).  
    □ Estoy muy de acuerdo  
    □ Estoy algo de acuerdo  
    □ No estoy seguro  
    □ Estoy algo de desacuerdo  
    □ Estoy muy en desacuerdo
### AIA Project Milagro
#### Safety Assessment (FAF-Section A)

<table>
<thead>
<tr>
<th>Section A: Living Conditions</th>
<th>Use scoring key</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>Baseline Score</td>
</tr>
<tr>
<td>1 Cleanliness/Orderliness - Outside Environmental Conditions</td>
<td></td>
</tr>
<tr>
<td>Refers to environmental health and hygiene factors (e.g. litter, garbage, vermin, clutter, odors around the exterior of the home) that are <em>Not within the family's control.</em></td>
<td></td>
</tr>
<tr>
<td>2 Cleanliness/Orderliness - Outside Home Maintenance</td>
<td></td>
</tr>
<tr>
<td>Refers to environmental health and hygiene factors (e.g. litter, garbage, vermin, clutter, odors around the exterior of the home) that <em>Are Within the family's ability to control.</em> Assess family's willingness and ability to maintain clean, orderly environment.</td>
<td></td>
</tr>
<tr>
<td>3 Cleanliness/Orderliness - Inside Home Maintenance</td>
<td></td>
</tr>
<tr>
<td>Refers to litter, garbage, cleanliness, feces, vermin, clutter, and odors in home. Does not refer to cleanliness of people in home. Assesses health hazards and physical neglect issues that <em>Are Within the family's control.</em></td>
<td></td>
</tr>
<tr>
<td>4 Safety – Outside Environmental Conditions</td>
<td></td>
</tr>
<tr>
<td>Refers to condition of building in terms of danger as well as functioning of utilities. If a rental, assesses conditions that are generally <em>Not Within family's control.</em></td>
<td></td>
</tr>
<tr>
<td>5 Safety - Outside Home Maintenance</td>
<td></td>
</tr>
<tr>
<td>Refers to caregiver's thoughtfulness as regards to safety precautions. Assesses conditions that <em>Are Within family's control.</em></td>
<td></td>
</tr>
<tr>
<td>6 Safety - Inside Home Maintenance</td>
<td></td>
</tr>
<tr>
<td>Refers to caregiver's thoughtfulness as regards to safety precautions in the home. Assesses conditions that <em>Are Within the family’s control.</em></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Requests to duplicate this instrument/form can be forward to Lourdes Carranza, Project Manager at Bienvenidos, 316 W. 2nd Street, Suite 800, Los Angeles, CA 90012.*
HEALTH-RELATED QUALITY OF LIFE

Client Id.# ____________________________
Today's Date: _________________________
Medical Illness: ________________________
Timeline: ☐ Baseline ☐ 12 Months
Group: ☐ HA ☐ SA ☐ HS

A1. I'm going to read you a list of activities. Please tell me if your health limited you a lot, a little or not at all in doing each of these activities in the past four weeks. IF R SAYS HE/SHE DOES NOT DO ACTIVITY FOR REASON OTHER THAN HEALTH, CODE 3 - NOT LIMITED AT ALL.

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th>Activity</th>
<th>YES, LIMITED</th>
<th>YES, LIMITED</th>
<th>NO, NOT LIMITED</th>
</tr>
</thead>
<tbody>
<tr>
<td>B08A01A</td>
<td>a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01B</td>
<td>b. Climbing one flight of stairs?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01C</td>
<td>c. Walking more than a mile?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01D</td>
<td>d. Walking one block?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01E</td>
<td>e. Bathing or dressing yourself?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01F</td>
<td>f. Preparing meals or doing laundry?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01G</td>
<td>g. Shopping?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01H</td>
<td>h. Getting around inside your home?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A01I</td>
<td>i. Feeding yourself?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

A2. During the past four weeks, has your health prevented you from (READ ACTIVITY) all of the time, some of the time, or none of the time?

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th>Activity</th>
<th>YES, FOR ALL OF THE TIME</th>
<th>YES, FOR SOME OF THE TIME</th>
<th>NONE OF THE TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>B08A02A</td>
<td>a. Working at a job, doing work around the house, or going to school?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A02B</td>
<td>b. Doing certain kinds or amounts of work, housework, or schoolwork?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B08A02C</td>
<td>c. Taking care of paperwork for health insurance or medical bills?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
A3. During the **past four weeks**, how many days did your health cause you to stay in bed for 1/2 a day or more?

B08A03

DAYS: __________

**NOTE:** FOR CAI, RESPONSE CAN'T BE >28.

A4. During the **past four weeks**, how much did pain interfere with your normal work (including work outside the house and housework)? Would you say:

B08A04

<table>
<thead>
<tr>
<th>(Circle One)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
<tr>
<td>A little bit</td>
<td>2</td>
</tr>
<tr>
<td>Moderately</td>
<td>3</td>
</tr>
<tr>
<td>Quite a bit, or</td>
<td>4</td>
</tr>
<tr>
<td>Extremely?</td>
<td>5</td>
</tr>
</tbody>
</table>

A5. During the **past four weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? Would you say:

B08A05

<table>
<thead>
<tr>
<th>(Circle One)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all,</td>
<td>1</td>
</tr>
<tr>
<td>A little bit,</td>
<td>2</td>
</tr>
<tr>
<td>Moderately,</td>
<td>3</td>
</tr>
<tr>
<td>Quite a bit, or</td>
<td>4</td>
</tr>
<tr>
<td>Extremely?</td>
<td>5</td>
</tr>
</tbody>
</table>

A6. In general, would you say your health in the **past four weeks** was:

B08A06

<table>
<thead>
<tr>
<th>(Circle One)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent,</td>
<td>1</td>
</tr>
<tr>
<td>Very Good,</td>
<td>2</td>
</tr>
<tr>
<td>Good,</td>
<td>3</td>
</tr>
<tr>
<td>Fair, or</td>
<td>4</td>
</tr>
<tr>
<td>Poor?</td>
<td>5</td>
</tr>
</tbody>
</table>
A7. (HAND R CARD #35) Please indicate the extent to which the following statements are true or false for you during the past four weeks:

<table>
<thead>
<tr>
<th>Item</th>
<th>True</th>
<th>Mostly True</th>
<th>Definitely True</th>
<th>Most True</th>
<th>False</th>
<th>Definitely False</th>
<th>Mostly False</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I seem to get sick a little easier than other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. I have been feeling bad lately</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A8. (HAND CARD #36) How much of the time during the past four weeks (READ ITEM), would you say all of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time?

<table>
<thead>
<tr>
<th>Item</th>
<th>All Of The Time</th>
<th>Most Of The Time</th>
<th>A Good Bit Of The Time</th>
<th>Some Of The Time</th>
<th>A Little Of The Time</th>
<th>None Of The Time</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Have you felt calm and peaceful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>b. Have you felt downhearted and blue?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>c. Did you feel tired?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>d. Have you been a happy person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>e. Have you been a very nervous person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>f. Did you have enough energy to do the things you wanted to do?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>g. Have you felt so down in the dumps that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>h. Have you been anxious or worried?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>i. Have you felt depressed?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>
A9. During the **past four weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? These answer choices are a little different. Would you say:

(Circle One)

<table>
<thead>
<tr>
<th>B08A09</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All of the time,</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Most of the time,</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Some of the time,</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>A little of the time,</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>None of the time?</td>
<td>5</td>
</tr>
</tbody>
</table>

A10. How much bodily pain have you had during the **past four weeks**? Would you say:

(Circle One)

<table>
<thead>
<tr>
<th>B08A10</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None,</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very mild,</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Mild,</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Moderate,</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Severe, or</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Very severe?</td>
<td>6</td>
</tr>
</tbody>
</table>
HEALTH-RELATED QUALITY OF LIFE

Client Id. # _______________________

Today’s Date: ________________

Medical Illness: ________________

Timeline: □ Baseline □ 12 Months

Group: □ HA □ SA □ HS

A1. Voy a leerle una lista de actividades. Por favor digame si su salud le ha limitado mucho, un poco o nada al hacer cada una de estas actividades en las últimas cuatro semanas. **IF R SAYS HE/SHE DOES NOT DO ACTIVITY FOR REASON OTHER THAN HEALTH, CODE 3 - NOT LIMITED AT ALL.**

<table>
<thead>
<tr>
<th>(Circle One Number on Each Line)</th>
<th>SI, LO HA LIMITADO MUCHO</th>
<th>SI, LO HA LIMITADO UN POCO</th>
<th>NO, NO LE HA LIMITADO NADA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Actividades fuertes, como correr, levantar objetos pesados, participar en deportes fuertes?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Al subir un piso de escaleras/gradas?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Al caminar más de una milla?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. Al caminar una cuadra?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. Al bañarse o vestirse?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. Al preparar comida o lavar la ropa?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. Al ir de compras?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. Al hacer cosas en su casa?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. Al alimentarse?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

A2. Durante las últimas cuatro semanas, ¿le ha impedido su salud (READ ACTIVITY) **todo el tiempo**, algunas veces, o nunca?

<table>
<thead>
<tr>
<th>(Circle One Number on Each Line)</th>
<th>SI, TODO EL TIEMPO</th>
<th>SI, ALGUNAS VECE</th>
<th>NO, NUNCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Trabajar en un empleo, trabajar en casa, ¿le ha afectado la escuela?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Hacer cierto tipo o cantidad de trabajo, quehaceres, o tareas de la escuela?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Encargarse del papeleo para el seguro médico (asegurarse) o cuentas médicas?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
A3. Durante las últimas cuatro semanas, ¿cuántos días se tuvo que quedar en la cama por 1/2 día o más a causa de su salud?

DAYS: 

NOTE: FOR CAPI, RESPONSE CAN'T BE >28.

A4. Durante las últimas cuatro semanas, ¿cuánto interrumpió el dolor con su trabajo normal (incluyendo el trabajo fuera de la casa y los quehaceres de la casa)? Diría Ud.:

(Circle One)

Para nada, .................................................. 1
Un poquito, .................................................. 2
Moderadamente, .......................................... 3
Bastante, ................................................... 4
Mucho? ....................................................... 5

A5. Durante las últimas cuatro semanas, ¿en cuánto ha interferido su salud o sus problemas emocionales con sus actividades sociales normales con su familia, amigos, vecinos, o grupos? Diría Ud.:

(Circle One)

Para nada, .................................................. 1
Un poco, .................................................... 2
Moderadamente, .......................................... 3
Bastante, ................................................... 4
Mucho? ....................................................... 5

A6. En general, diría Ud. que su salud en estas últimas cuatro semanas fue:

(Circle One)

Excelente, .................................................. 1
Muy buena, ................................................ 2
Buena, ...................................................... 3
Regular o, ............................................... 4
Mala? ........................................................ 5
**A7. (HAND R CARD #34)** Por favor dégame que tan ciertas o que tan falsas han sido las siguientes frases para Ud. durante las últimas cuatro semanas:

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th></th>
<th>DEFINITIVAMENTE CIERTO</th>
<th>MAS O MENOS CIERTO</th>
<th>NO SARE</th>
<th>MAS O MENOS FALSO</th>
<th>DEFINITIVAMENTE FALSO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Parezco enfermarme más fácilmente que otras personas...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Me he estado sintiendo mal últimamente...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**A8. (HAND CARD #35)** ¿Cuánto tiempo durante las últimas cuatro semanas (READ ITEM). Diría Ud. todo el tiempo, la mayor parte del tiempo, una buena parte del tiempo, alguna parte del tiempo, un poco de tiempo, o nunca?

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th></th>
<th>TODO EL TIEMPO</th>
<th>LA MAYOR PARTE DEL TIEMPO</th>
<th>UNA BUENA PARTE DEL TIEMPO</th>
<th>ALGUNA PARTE DEL TIEMPO</th>
<th>UN POCO DE TIEMPO</th>
<th>NUNCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Se ha sentido calmado/a y tranquilo/a?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. Se ha sentido desanimado (desconsolado/a) y triste?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>c. Se ha sentido cansado/a?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. Ha sido Ud. una persona feliz?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>e. Ha sido Ud. una persona muy nerviosa?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f. Ha tenido suficiente energía para hacer las cosas que quería hacer?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>g. Se ha sentido Ud. tan triste que nada lo/la podía alegrar?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
h. Ha estado ansioso/a o preocupado/a? .................. 1 2 3 4 5 6

i. Se ha sentido deprimido/a? 1 2 3 4 5 6

A9. Durante las últimas cuatro semanas, ¿cuánto ha interferido su salud física o sus problemas emocionales con sus actividades sociales (como visitar amigos, parientes, etc.)? Estas respuestas son un poco diferentes. Diría Ud.:

(Circle One)

Todo el tiempo, ....................................................... 1
La mayor parte del tiempo, ....................................... 2
Parte del tiempo, .................................................. 3
Un poco del tiempo, o .......................................... 4
Nunca? ..................................................................... 5

A10. ¿Cuánto dolor de cuerpo ha tenido durante las últimas cuatro semanas? Diría Ud. que:

(Circle One)

Nada, ................................................................. 1
Muy poco, ........................................................... 2
Poco, ................................................................. 3
Moderado, ......................................................... 4
Grave, o ........................................................... 5
Muy grave? ....................................................... 6
Coping (English)

Client ID: ___________________________  Group: □ HA  □ SA  □ HS

Today’s Date: _______________________  □ Baseline  □ Completion

Identified Event: ___________________________________________

Please indicate which of the following (below) you did in connection with this event:

<table>
<thead>
<tr>
<th>No</th>
<th>Yes, Once or Twice</th>
<th>Yes, sometimes</th>
<th>Yes, fairly often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Tried to find out more about the situation
2. Talked with spouse or other relative about the problem.
3. Talked with a friend
4. Talked with a professional person (e.g. doctor, lawyer, clergy)
5. Prayed for guidance and/or strength
6. Prepared for the worst
7. Didn’t worry about it figured everything would probably work out
8. Took it out on other people when I felt angry or depressed
9. Tried to see the positive side of the situation
10. Got busy with other things to keep my mind off of the problem
11. Made a plan of action and followed it
12. Considered several alternatives for handling the problem
13. Drew on my past experiences, I was in a similar situation before
14. Kept my feelings to myself

No  Yes,  Yes,  Yes,
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Once or Twice</th>
<th>sometimes</th>
<th>fairly often</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Took things a day at a time one step at a time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Tried to step back from the situation and be more objective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Went over the situation in my mind to try to understand it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Tried not to act too hastily or follow my first hunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Told myself things that helped me feel better</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Got away from things for a while</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. I know what had to be done and tried harder to make things work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Avoided being with people in general</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Made a promise to myself that things would be different next time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Refused to believe that it happened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Accepted it; nothing could be done</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Let my feelings out somehow</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Sought help from persons or groups with similar experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Bargained or compromised to get something positive from the situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 29. Tried to reduce tension by:  
   a. drinking (alcohol) more  
   b. eating more  
   c. smoking more  
   d. exercising more  
   e. taking more tranquilizers |   |   |   |   |
**Coping**  
*(Spanish)*

<table>
<thead>
<tr>
<th>No</th>
<th>Si, Una o Dos veces</th>
<th>Si, algunas veces</th>
<th>Si, frecuentemente</th>
</tr>
</thead>
</table>

1. Trató de informarme más al respecto de el problema

2. Hablé con mi esposo o otro familiar sobre el problema

3. Hablé con un amigo

4. Hablé con una persona profesional (doctor, abogado, sacerdote)

5. Resé para recibir fuerza y dirección

6. Me prepare para lo peor

7. No me preocupé; pense que todo saldria bien

8. Me desquité con otras personas cuando me sentí enojada o deprimida

9. Trató de ver el lado positivo de la situación

10. Me ocupé en otras cosas para evitar pensar en el problema

---

*Appendix B10  Project Milagro Evaluation - Coping Survey (Spanish)*
<table>
<thead>
<tr>
<th>No</th>
<th>Si, una o dos veces</th>
<th>Si, algunas veces</th>
<th>Si, frecuentemente</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Hice un plan de acción y lo seguí</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Consideré varias alternativas para tratar con el problema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Me base en mis experiencias anteriores; estuve en una situación similar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Fui muy reservado(a) sobre el problema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Tomé las cosas con calma, día a día, paso a paso</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Traté de salirme de la situación, y ser más objetivo(a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Revisé la situación en mi mente, para tratar de entenderla</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Traté de no actuar aceleradamente o de seguir mi primera intuición</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Me dije a mi mismo(a) cosas que me ayudaron a sentir mejor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Me alejé por un tiempo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Yo sabía lo que tenía que hacer y traté de hacer que las cosas trabajaran</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. En general traté de evitar a otras personas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Hice una promesa a mi mismo que las cosas serían diferentes la próxima vez</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. No creí lo que había pasado</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
25. Acepté que no podría hacer nada sobre el problema

Client ID: ___________ Group: □ HA □ SA □ HS

Today's Date: ___________ □ Baseline □ Completion

26. Descargué mis sentimientos de alguna forma

27. Busqué ayuda en personas o grupos con experiencias similares

28. Me prometí sacar algo positivo de la situación

29. Trató de reducir la tensión por medio de:
   a. Tomando alcohol más
   b. Comiendo más
   c. Fumando más
   d. Haciendo más ejercicio
   e. Tomando más tranquilizantes
HEALTH INTERVIEW SURVEY FOR HIV/AIDS

Client ID#: ___________________________  Today's Date: ___________________________

☐ Baseline   ☐ Post

**Medical Diagnosis**

1. Medical Diagnosis is:  
   ☐ AIDS  ☐ HIV Symptomatic  ☐ HIV + Asymptomatic

2. Date of Diagnosis: ___________________________  (When client was informed)

3. Transmission Category:  
   ☐ Homosexual  ☐ Bisexual  ☐ Heterosexual  ☐ I.V. Drug User  
   ☐ Blood Transfusion  ☐ Hemophiliac  ☐ Birth

4. Client was infected by (specify): ___________________________

5. Client was informed of HIV/Aids diagnosis by:  
   ☐ Partner  ☐ Physician  ☐ Lab Tests (routine)  
   ☐ During a Hospitalization  ☐ HIV/Aids Test  ☐ Parent(s)  ☐ Relative/Friend

6. Was a retest conducted to confirm the client's positive HIV results?  ☐ Yes  ☐ No

7. Did client (or child's parent) seek a "second opinion"?  ☐ Yes  ☐ No

   If yes, where?  ☐ United States  ☐ Other Country, specify if possible: ___________________________

**Present Medical Status**

8. Client's most recent laboratory results:  
   CD4  
   CD4%  
   Viral Load

9. Karnofsky Scale assessment:  
   Stage I=100-90  Stage II=70-60  Stage III=50-40  Stage IV=30-20

10. Is client presently disabled due to HIV/AIDS?  ☐ yes  ☐ no

11. Has this client been hospitalized in the past:  
   ☐ week  ☐ 30 days  ☐ 6 months  ☐ year  ☐ no

**AIDS-related Illnesses**

Please check any AIDS-related illnesses or co-existing illnesses the client is experiencing currently:

☐ PCP  ☐ meningoitis

☐ wasting syndrome  ☐ dementia (memory impairment)

☐ gynecological problems (abnormal PAP, yeast infections)  ☐ mood disorders (anxiety disorders)

☐ cervical cancer  ☐ TB

☐ Kaposi’s Sarcoma (lesions in the skin or internal organs)  ☐ Hepatitis B

☐ thrush (fungal infection)  ☐ Hepatitis C

☐ toxoplasmosis (swelling, lesions in brain)  ☐ other, specify: ___________________________

---

Note: Requests to duplicate this instrument/form can be forwarded to Lourdes Carranza, Project Manager at Bienvenidos, address.
### Medication Treatment

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>AZT</th>
<th>Yes, other</th>
<th>No</th>
<th>N/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Did client take medication for HIV/AIDS during pregnancy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, give start &amp; end months: (month began meds) to (month ended meds)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Was newborn placed on HIV/AIDS medication?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, how long was medication given to newborn?: ______ weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Did the newborn test positive for HIV?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Was the newborn breastfed by the mother?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Is client currently taking medication for HIV/AIDS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Is the client currently compliant to medication treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If no, why not? ____________________________________________

### Medication Side Effects

Please check any medication side effects the client is experiencing currently:

- [ ] lipodystrophy (redistribution of body fat)
- [ ] weight loss
- [ ] skin irritation, rash
- [ ] abdominal pain, discomfort
- [ ] peripheral neuropathy (pain, numbness in hands, feet)
- [ ] anemia
- [ ] dizziness
- [ ] low blood pressure
- [ ] headaches
- [ ] high blood pressure
- [ ] fatigue, weakness
- [ ] menstrual irregularities
- [ ] numbness around mouth
- [ ] kidney stones
- [ ] swelling around mouth
- [ ] pancreatitis
- [ ] taste perversion
- [ ] fever
- [ ] oral ulcers
- [ ] delusions
- [ ] nausea
- [ ] impaired concentration
- [ ] vomiting
- [ ] insomnia
- [ ] diarrhea
- [ ] mood disorders
- [ ] loss of appetite
- [ ] other, specify: ____________________

### Alternative Treatments

Please check any alternative treatments for HIV/AIDS the client is seeking currently:

- [ ] herbal/homeopathy
- [ ] proper nutrition/diet
- [ ] nutritional supplements
- [ ] healer/curandera
- [ ] acupuncture
- [ ] other, specify: ____________________


**SUBSTANCE ABUSE HEALTH INTERVIEW**

Client ID: ________________  
Today's Date: ________________

☐ Baseline  
☐ Post

### Medical Conditions

1. Please check any medical conditions the client is experiencing currently:

- tuberculosis  
- heart disease  
- seizures  
- blood clots  
- ulcer  
- gallstones  
- diabetes  
- thyroid irregularities  
- asthma  
- emphysema  
- chronic bronchitis  
- kidney stones  
- kidney infections  
- tuberculosis  
- bladder infections  
- STDs  
- arthritis  
- gynecological problems  
- Hepatitis A  
- Hepatitis B  
- Hepatitis C  
- HIV/AIDS  
- severe headaches  
- mental health disorder  
- cancer  
- back problems  
- other, specify: ________________

2. Has client received medical treatment for the above condition(s)?  
☐ yes  
☐ no

3. Has this client had any surgeries during the past year?  
☐ yes  
☐ no

### Drug History

1. Please check the client's primary drug of choice in the primary column. (Check more than one drug in the primary column only if the client is or was a polydrug user (i.e., client used more than two drugs on a regular basis). In the recent column, please check any drugs client has used in the past 6 months.

<table>
<thead>
<tr>
<th>primary</th>
<th>recent</th>
<th>primary</th>
<th>recent</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ alcohol</td>
<td>☐</td>
<td>☐</td>
<td>☐ methamphetamine</td>
</tr>
<tr>
<td>☐ cocaine/crack</td>
<td>☐</td>
<td>☐</td>
<td>☐ hallucinogens (LSD, mushrooms)</td>
</tr>
<tr>
<td>☐ marijuana</td>
<td>☐</td>
<td>☐</td>
<td>☐ club drugs (roofies, ecstasy, Special K, GHB)</td>
</tr>
<tr>
<td>☐ heroin</td>
<td>☐</td>
<td>☐</td>
<td>☐ inhalants (whippets, poppers, etc.)</td>
</tr>
<tr>
<td>☐ PCP</td>
<td>☐</td>
<td>☐</td>
<td>☐ prescription meds (Vicodin, Valium, etc.)</td>
</tr>
<tr>
<td>☐ amphetamines/speed</td>
<td>☐</td>
<td>☐</td>
<td>☐ other, specify: ________________</td>
</tr>
</tbody>
</table>

1. How long did the client use drugs?  
☐ less than 1 year  
☐ 1-5 years  
☐ over 5 years

2. How long has the client been drug-free?  
☐ less than 1 month  
☐ 1-6 months  
☐ over 6 months

3. At what age did client first started drinking alcohol or using drugs? ________ years
## 1st Change in Home Environment/Family Composition

<table>
<thead>
<tr>
<th>Initial Information</th>
<th>Name</th>
<th>HIV status (+/-/na)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Caregiver</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Type or Reason for change**

**Siblings Involved?**

**Date of Change**

## 2nd Change in Home Environment/Family Composition

<table>
<thead>
<tr>
<th>Change(s) that Occurred Affecting Index child and/or primary caretaker?</th>
<th>Type or Reason for change</th>
<th>Siblings Involved?</th>
<th>Date of Change</th>
</tr>
</thead>
</table>

## 3rd Change in Home Environment/Family Composition

<table>
<thead>
<tr>
<th>Change(s) that Occurred Affecting Index child and/or primary caretaker?</th>
<th>Type or Reason for change</th>
<th>Siblings Involved?</th>
<th>Date of Change</th>
</tr>
</thead>
</table>
Client Satisfaction Survey for
AIA Funded Programs

In order to better serve the clients of the AIA Project Milagro, we are requesting that you fill out the following survey. Please check the response that best describes your experience with the program. Your participation is greatly appreciated.

1. I received services promptly.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly agree

2. Agency/program staff was respectful of me and my culture.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly agree

3. I received the services my worker said I would receive.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly agree

4. The services I received were helpful.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Agree
   - [ ] Strongly agree

5. Please rate your overall satisfaction with this agency and its services.
   - [ ] Poor
   - [ ] Fair
   - [ ] Good
   - [ ] Excellent

Please include any comments that you wish to share about your experiences with this program:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
ASQ Child Measure:

Developmental Profile 2 Scale:
Alpern, G. (2002). Developmental Profile 2 User's Guide. Western Psychological Services, Los Angeles. *Note: DP3 is now available and has replaced the DP2. Contact information for this instrument: wpspublish.com

Parent Stress Index:
Web address: www.parinc.com
Bienvenidos

INFORMED CONSENT FORM FOR TREATMENT AND EVALUATION:
PROJECT MILAGRO

Purpose of Project Milagro
The Abandoned Infants Assistance Program- Project Milagro (CFDA # 93.551) is a federally funded program by Children's Bureau- DHHS designed to prevent infant abandonment, by addressing the needs of families affected by HIV/AIDS and/or substance abuse. Participants will receive home-based supportive services using a team approach. The team approach will include a Family Support Worker, Counselor, Parent Educator, Health Educator, and when needed Therapist. Center-based services offering Parenting classes, Drug Education, Health Workshops and support groups, will also be available. Project services are aimed at strengthening families, assisting parents and their children, and improving quality of life.

Procedures:
Project Milagro is a 12 month service program offering home-based support and education services. The evaluation consists of you completing questionnaires/surveys at the time of enrollment, at 6 months and again at 12 months. This process will take approximately 90 minutes and will be conducted individually. All questionnaires are available in English and Spanish. Staff members are available to assist you completing these forms if requested.

Potential Risks:
There are minimal potential risks in participating in evaluation services. Risks include the possibility that you may experience some anxiety when completing questionnaires or discussing issues related to your health, personal and family substance abuse, and legal/criminal problems. No other known physical, emotional or psychological risk is anticipated. In the event that you experience stress or anxiety in relation to completing this process, mental health professionals will be available for you to talk to.

Benefits:
It has been the experience of the staff at this program that the benefits of participation in the evaluation of this project will far outweigh the potential risks involved. The information collected from you is expected to result in a number of significant outcomes that can help the project better serve future participants and to find out if the program is effective.

Confidentiality Statement:
Maintenance of confidentiality is of paramount importance and steps will be taken to ensure that all information is handled as confidential as possible. Surveys and questionnaires will be identified with a number and information will remain in a locked cabinet. Records will be kept for three years. However, the staff is required by law to report any suspected case of child abuse or neglect or threats to harm your-self or harm others.
Participation in this evaluation is strictly voluntary. You have a right to withdraw your consent without prejudice or the termination of services or referrals. You have the right to revoke this consent at any time, or it will expire 12 months from today ___________ (Today's Date).

**Offer to answer questions:**
If you have any questions relating to Project Milagro, please feel free to call Lourdes Carranza (323) 728-9577 or Dr. Martha Cristo at (213) 968-0338 at any time. You will be given a copy of this form to keep. If you have any complaints about the project, you can call Bienvenidos Family Services at (323) 728-9577 and ask to speak to someone on the **Institutional Review Board** (the committee that helps protect people who are in evaluation projects). The review board will then investigate your complaint. We encourage you to ask questions, give us suggestions, or tell us what you do not like about the project to try to best help you.

**Agreement:**
YOUR SIGNATURE BELOW INDICATES THAT YOU AGREE TO PARTICIPATE HAVING READ THE INFORMATION ABOVE.

<table>
<thead>
<tr>
<th>Participants Printed Name</th>
<th>Date</th>
<th>Staff Printed Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of the Participant</th>
<th>Date</th>
<th>Staff's Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Approved Research Committee Chairman Date
VIDEO, PHOTOGRAPHY AND/OR INTERVIEW RELEASE:

The Abandoned Infants Assistance Bienvenidos Project Milagro would like to document the progress and promote the success of its participants. At times, staff will be taking pictures of program activities—of which you may be a part of—over the course of the next four years. On occasion, members of the media, including newspaper photographers and television cameramen, may visit the project to video tape, photograph or interview participants. We would like your permission so that you may participate in this process. This permission will cover the four years of the program unless you notify us later that you do not wish to participate.

☐ I DO give permission to be video taped, photographed and/or interviewed.

OR

☐ I DO NOT give permission to be video taped, photographed and/or interviewed.

Thank you for your cooperation.

Signature of Participant, Parent or Guardian Date

Witness Signature Date
AIA - Project Milagro  

In-Home Visit Progress Report  

**Case Name:**  
**Case Number:**  
**Session # for Month:**  
**Start Time:**  
**Stop Time:**  
**Date of Visit:**  

- Client available:  
  - Family (counseling): □ yes □ no  
  - Client (counseling): □ yes □ no  
  - Group (counseling): □ yes □ no  
□ Client’s Home  
□ Other  

<table>
<thead>
<tr>
<th>Adults Visited</th>
<th>Children Visited</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mother:</td>
<td>1.</td>
</tr>
<tr>
<td>2. Father:</td>
<td>2.</td>
</tr>
<tr>
<td>3. Caregiver</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
</tr>
<tr>
<td>6.</td>
<td>6.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Topics Discussed On Face-To Face Visit (As Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Child’s Functioning/Development</td>
</tr>
<tr>
<td>□ Family Dynamics &amp; Communication</td>
</tr>
<tr>
<td>□ Safety Factors (environmental)</td>
</tr>
<tr>
<td>□ Immediate Basic Needs</td>
</tr>
<tr>
<td>□ Anger Management/Conflict resolution</td>
</tr>
</tbody>
</table>

□ Referrals/Linkages needed:  
□ Concrete services being requested:  

Any of the above that were discussed during this visit must be summarized by:

1. **Follow Up** on task/issues discussed at previous visit.

2. **Child Safety Issues** (Discuss conditions of the home, child (ren’s) physical appearance, child (ren’s) health, changes in household).

3. **Family Functioning** (discuss relationships, parent/child interaction, strengths/challenges, changes, commitment to program. Highlight crisis intervention)

4. **Progress towards goals stated in Case Plan** (also discuss any strengths/challenges toward goal achievement)

Rev. 4/16/08
5. **Evaluation of essential Linkage Services** (discuss effectiveness of services being provided, barriers to service provisions, parent's level of participation and any other services which may benefit the family or improve family functioning, etc.)

6. **Additional Comments** (include items to follow-up with CSW, with other service providers, family member(s))

---

*Family Support Worker*

*Date*

---

*Program Coordinator Signature*

*Date*

Rev. 4/16/08
PROJECT MILAGRO Case Plan

Client Name: __________________________ Date: ______________ ID #: ______________

STRENGTHS (Enter as many) CHALLENGES/BARRIERS (Enter as many)

1. CONCERNS: __________________________ Client: __________________________

   GOAL: __________________________

   OBJECTIVES
   a. __________________________
   b. __________________________
   c. __________________________

   Follow up: __________________________

2. CONCERNS: __________________________ Client: __________________________

   GOAL: __________________________

   OBJECTIVES
   a. __________________________
   b. __________________________
   c. __________________________

   Follow up: __________________________

3. CONCERNS: __________________________ Client: __________________________

   GOAL: __________________________

Continued
OBJECTIVES

a. 

b. 

c. 

Follow up: 

4. CONCERNS: 

Client: 

GOAL: 

OBJECTIVES

a. 

b. 

c. 

Follow up: 

Agreement of Case Plan required.

Client Signature: Date: 

Client Signature: Date: 

Client (Minor if applicable): Date: 

Family Support Worker Signature: Date: 

Family Therapist Signature: Date: 

Program Coordinator Signature: Date: 

Clinical Supervisor Signature: Date: 

Case Plan Review □ Quarterly Date of review: 

Family Support Worker Signature: Date: 

Family Therapist Signature: Date: 

Program Coordinator Signature: Date: 

Clinical Supervisor: Date:
Project Milagro

A home visitation program for families affected by HIV/AIDS or substance abuse.

Un programa de apoyo que brinda servicios en su hogar enfocándose a mejorar la calidad de vida en familias afectadas por el VIH/SIDA o abuso de alcohol o drogas.
**NUESTRA MISIÓN**

Asegura la permanencia, seguridad y buen ser de niños afectados por VIH/SIDA o drogas.

---

**Proyecto Milagro** ofrece un sentido de esperanza y mejor calidad de vida a mujeres Latinas y sus niños que han sido afectados por VIH/SIDA, o consumo de alcohol y drogas. El personal es compasivo y culturalmente sensible, y su equipo ofrece servicios en el hogar que incluyen consejería, educación, abogacía y recursos en la comunidad. La meta del programa es mantener un ambiente sano y seguro para los niños y establecer la permanencia y estabilidad de los niños con miembros de la familia. Proyecto Milagro en colaboración con servicios sociales y médicos en la comunidad proveen una red de apoyo logrando reducir el nivel de estrés, depresión y desolación en las familias afectadas por VIH/SIDA, o consumo de alcohol y drogas.

---

**SERVICIOS**

- Apoyo en su Hogar
- Consejería Individual
- Consejería Familiar
- Manejo de Casos
- Educación Sobre Salud
- Clases de Padres
- Servicios de Reunificación
- Tratamiento de Alcohol o Drogas
- Recursos en la Comunidad
- Planificación Sobre Trata de Hijos
- Desarrollo Infantil

---

**SERVICIOS**

- Family Support
- Recovery Support
- Individual Counseling
- Family Counseling
- Case Management
- Parent Education
- Health Education
- Reunification Services
- Advocacy
- Child Development Services
- Resources and Referrals
- Long-term Planning for Children

---

El programa está disponible a familias con niños menores de seis años que viven en el área del Este, Sureste de Los Ángeles y en Este de Hollywood.
Planning for the Future Care of My Children
There are things that we don't want to happen but have to accept, things we don't want to know but have to learn, and people we can't live without but have to let go.

Author unknown

Contents

Introduction

Purpose of this Workbook

Section 1 Finding Courage: Are You Ready?

Section 2 What Are Your Options?

Section 3 Choosing an Alternative Caregiver

Section 4 Involving the Children in the Process

Section 5 Securing Your Plan

Section 6 Additional Information and Resources
Introduction

I admire your strength and courage in not only picking up this workbook but also proceeding to read it. Perhaps you are sitting in your living room or in a waiting area for a medical visit and wondering if this workbook has any purpose in your life. It may or may not. However, it contains valuable information for you to read, whether you find it helpful for yourself or for someone you know.

Living with a terminal illness can be a devastating reality. As a parent you may be facing multiple decisions in the midst of unpredictable physical and emotional health. Custody planning can be very difficult emotionally, especially when you are not informed of the options available to you. It is important for you to know that there is hope as well as support in planning for the future care of your children. This workbook is designed to provide support and relieve your worries about: “What will happen to my children in the event I become too ill to care for them?” There is no greater reassurance than knowing your children’s future is secure and as a parent you played a significant role in securing it.

This workbook will serve as a practical guide in planning for the future care of your children in the event that you are no longer able to care for them. We realize that this is a difficult subject to approach and to process, yet we are confident that in the end you will find “peace of mind.” It is also important that you give thought to this and if possible, plan ahead while you are able to make informed and competent decisions about your children’s future.

> Early planning prevented several children from entering the foster care system

> Planning supported the transition of children to their new caregiver and reduced unnecessary separation between siblings

> Parents wishes were honored and their children in due course resided with suitable and loving caregivers

> Parent’s who finalized their plans ultimately shared an overall sense of “peace” and faced their futures with rest and reassurance

It is important to keep in mind that this workbook is not intended to replace legal counselor advice. Laws and procedures relating to custody and visitation as well as the rights of grandparents are determined and may vary by each state. This workbook provides information for people living in California. We suggest that residents of other states consult with attorneys or knowledgeable service providers for further information and guidance.

At this point, you may find yourself debating whether to continue reading this workbook. To encourage you to continue, we would like to share what we have learned over the years of offering support to parents living with HIV/AIDS who embarked on the journey of planning the future care of their children:
SECTION 1
Finding Courage: Are You Ready?

Planning for the future care of your children may be one of the most challenging experiences you will face. Although difficult, this process will allow you as a parent to make decisions about the lives of your children. Notably, beginning the process of future care and custody planning is a personal decision. Whether you are embarking on this journey as a result of an urgent change in your health or as part of a long-term plan, it is a personal journey. You have begun a critical and often emotional process to securing the future of your children. This process neither has a timeline nor an ideal order to follow.

Over the years, we have learned that families have unique beliefs, values and life experiences that inevitably influence their plan for the future care of their children and its process. We have listened to countless anecdotes from parents who have completed their plan. Many parents have shared their capability to currently enjoy life because they found comfort in knowing who will care for their children. Parents also shared that despite their discomfort and difficulty at the onset, the planning process eventually evolved as therapeutic and healing for themselves and their children. We also learned that parents living with stigmatized illnesses such as HIV/AIDS commonly expressed struggling with decisions in disclosing the nature and extent of their illness. These parents often experienced shame and guilt, and tended to be reluctant to disclose their health status to their children as well as future caregivers.

As you begin exploring these ideas and your thoughts, you are actually beginning the process of planning. Don’t be afraid to seek guidance and support. The following questions will help process possible concerns that you may have and help determine if you are ready to take your planning to the next step.

Purpose of this Workbook
This workbook was specifically designed for parents living with a terminal illness. It provides you and your family with the information necessary to carry out your plans for the future care of your children. This can be a long-term process and requires a personal commitment. It is not easy nor is it a one-day journey. Planning, while coping with a compromised health condition and experiencing “good and not so good days,” can be challenging. It is important to know that dealing with the possibility of surrendering the care of your children can be emotionally demanding. As you embark on this journey, it is highly recommended you find a friend or professional to journey with you. The road to planning for the future care of your children can be daunting and difficult at times; however, the final steps will bring inner peace and calm to your troubled heart.

This workbook was developed after careful assessment and consideration of the needs of children living with terminally ill parents. The workbook follows a framework successfully applied to Latino/a parents living with the HIV virus or AIDS who engaged in the journey of planning for the future care of their children. This framework incorporates a sensitive approach that is further applicable and helpful to families living with other terminal illnesses. This workbook serves as an informational resource aimed at helping parents plan for their children’s future. Moreover, it provides professionals with meaningful strategies and tools to assist parents in this emotionally complex process. Germane to the workbook, a parent securing a plan is hereinafter referred to as the “custodial parent” and the individual nominated (by the parent) to provide the future care of his/her children is hereinafter referred to as “future or alternative caregiver” or “nominated guardian.”
SECTION 2
What are Your Options?

There are several options for the parent or family wishing to plan for the future care of their children. It will be important for you to identify what is the best option for you and your family, based on your unique circumstances. There are many factors to consider when deciding on a future plan for your children. For example, a factor to consider is how to ensure the future care of your children without giving up your rights and responsibilities. In this section, you will be informed of the various options that exist in California, both formal (legal) and informal (not filed in a court). Each option has benefits and drawbacks that are briefly discussed. As you move forward in the planning process, it will help if you consult with a professional or friend to help you as you process your emotions.

In order for you to determine what option is best for you and your family, consider answering the following questions:

> Do you have concerns about disclosing your illness?
> Do you want to secure your decisions by making a formal legal plan (filing in court)?
> Do you have concerns about filing a legal plan in court?
> Do you have a person in mind who is interested in assuming legal responsibility should it ever be necessary?

These are all very important questions which, if not yet present, will eventually surface. As soon as you can determine your answers, you will be better able to make a decision in choosing an option that is best for you and your family. Below are the options available to parents living in California diagnosed with a terminal illness:

**Testamentary Guardianship**

Testamentary Guardianship is a guardianship preference stated in a Will or other written document, which goes into effect after the custodial parent's death and following court approval. The custodial parent initiates Testamentary Guardianship and has nominated an alternative caregiver guardian in a Will. However, initiation of a future guardianship through a Will does not, in and of itself, ensure that a court will appoint the person named in the Will. Disadvantages to Testamentary...
Guardianships are that nominations through Wills can be contested and do not assist during temporary incapacitation of custodial parents.

Caregiver's Authorization Affidavit
California Law recognizes a category of adults who have informally assumed responsibility for the care of minors residing with them. Through the Caregiver's Authorization Affidavit, a caregiver may enroll a minor in school and make school-related medical decisions. In some circumstances, a caregiver may authorize most types of medical care for the child. Completing this affidavit does not affect the rights of a custodial parent or legal guardian regarding the care, custody and control of the minor, and does not mean that the designated caregiver has legal custody of the minor. The affidavit is not filed in a court and not valid for more than a year after the date on which it is executed.

Joint Guardianship
Joint Guardianship Law allows for the parent who suffers from a terminal illness to designate someone who will participate in the care of the child if and when the parent is no longer able to provide for the child's daily needs. One of the most important aspects of this law is that it allows the custodial biological parent the opportunity to share child custody with the nominated caregiver. Further, custodial parents are permitted to retain custody and care for their children even after the joint guardianship has been granted. In most cases, this is the preferred option for parents filing for a caregiver guardianship. Joint Guardianship can also be applied in cases where two parties other than the parent, petition the court for shared custody. In this situation, the primary caregiver may request assignment of a joint caregiver guardian for additional support in raising the child. In order to file for Joint Guardianship, two conditions must be met: first, the non-custodial parent must be in agreement with the nomination of the caregiver guardian, and second, the non-custodial parent does not contest the petition submitted by the custodial parent. In addition, if the court finds it in the "best interest" of the child to agree with the petition of the custodial parent, the joint guardianship will be approved. Courts require for all non-custodial parents, grandparents, and siblings of the child to be notified of joint guardianship requests.

Temporary Guardianship
A petition filed to the court requesting an urgent appointment of a guardian. This appointment is temporary, usually 30 days until a regular guardianship hearing is scheduled. A temporary guardian can be nominated by the parent, the guardian or the child 14 years of age or older. The temporary guardian is provided with immediate authorization for the child's care.

Adoption
Adoption is a permanent legal option. Adoption is most often an order filed by the Department of Children and Family Services as a procedure to implement a permanency plan for children who have suffered abuse by their biological parents. In these cases, foster care parents or relative caregivers adopt children. In adoptions, the rights of both parents must either be relinquished (voluntarily given up) or terminated by a court order. Adoptive parents assume all legal rights of adopted children, including but not limited to religion, education and medical care. The majority of terminally ill parents are not ready to relinquish their rights as parents and therefore often do not choose adoption as a plan for the future care of their children. In cases where a parent is deceased, the alternative caregiver (if not the other parent) can choose to file for adoption of the child.
SECTION 3
Choosing an Alternative Caregiver

Careful consideration needs to be given to choosing an alternative caregiver. Unfortunately, it is common for parents to wait until an urgent need arises to identify either a temporary or permanent caregiver. Making choices in times of urgency often does not allow for careful consideration or thought as to whom would best care for your children. Similarly, the nominated caregiver may feel compromised to accept this role, mainly due to the urgency of parents' illness. Often, the opportunity for comprehensive review and consideration of the extent of this commitment is limited. In such situations, parents run the risk of securing only a temporary placement followed by disruptions and at times multiple unsuccessful placements. We are aware that the process of identifying an alternative caregiver can be challenging. However, we also recognize that this is a critical step in your planning process.

To assist you in the process of selecting an alternative caregiver, please follow the next steps:

STEP 1: Answer the following questions:

1. Have you experienced past hospitalizations?
   Yes No

2. If yes, who cared for your children during your last hospitalization?

3. If you were to be hospitalized today, do you have someone to care for your children?
   Yes No Not sure

4. If you answered yes above, could this person care for your children long term?
   Yes No Not sure

5. Would this person be willing to care for your children permanently?
   Yes No Not sure

STEP 2: Identify who is in your circle of support.

Inside the circle, identify who are the persons closest to you and your children.

STEP 3: Circle the names of the people who are aware of your illness.

This exercise will help you identify a suitable caregiver for your children. There are other important considerations in choosing the alternative caregiver. We recommend that you spend time giving some thought to the following:

> Is the potential caregiver of age (18 years or older) and in good health?

> Is the potential caregiver aware of your health condition?
   If not, how do you think he/she will respond if they found out?

> Is the potential caregiver interested in assuming the responsibility permanently?

> Do the children have a relationship with him or her?

> Would the other parent object to your nomination of caregiver?

> Is there anyone who you absolutely would not want to care for your children?
As you begin selecting the future caregiver, it is important for you to know the court process for approving a nominated guardian. Although there are no hard rules on whom is appropriate to be a guardian, it is the sole discretion of the court to approve a nomination. The court weighs many factors in making a decision to appoint a guardian. Judges in California follow guidelines stipulated by law in the appointment of guardians. Factors used for guardianship preference include: to one or both parents; to the person whom the child has been living in a stable environment; and to any person determined suitable and able to provide adequate and proper care and guidance to the child (Goldoftas & Brown, 2000). Ultimately, the most important consideration in naming a guardian is the “best interest of the child.”

Additional important factors to know before filing a legal guardianship:

The nominated guardian does not:

> have to be a legal resident or citizen.
> have to be married or be a parent.
> have to be a relative of the child.

The nominated guardian does have to:

> have a basic ability to “parent” the child.
> have an ability to provide the child with food, shelter, clothing, and medical care.
> be in fair health.

Reasons why a court might find a nomination improper:

> a person who has been charged with neglecting or abusing a minor.
> a person who has been convicted of a felony.
> other run-ins with the law depending on the crime, how long ago it was committed and the current lifestyle of the person.

The minor and appointed guardian will be interviewed before the court proceeding by an investigator who will provide a recommendation to the judge.

> Non-custodial parents, grandparents and siblings will be notified of the petition.
> If the child is 14 years old or older, the child must consent to the guardianship.
> After appointment of a guardian, the child's parents remain legally responsible for supporting the child. While not a requirement, many guardians volunteer to accept this responsibility.
> At the request of the parent, the diagnosis of the parent can be kept confidential during the hearing.

SECTION 4
Involving the Children in the Process

One of the many challenging decisions faced by parents living with a terminal illness is whether or not to disclose their health condition to their children as well as determining the best time to do this. Disclosure of a terminal illness to a child requires thought and preparation. Parental disclosure is enhanced with support and guidance from professionals. Professional help can assist by reducing the parent's worries and fears. Common worries experienced by parents about disclosure include: Is the child old enough to understand? Will the child keep the illness and information confidential? Additionally, parents often fear that disclosing their illness to their child will intensify acting out behavior or emotional problems such as child sadness or even depression. As you determine the appropriateness of disclosing your health status to your children, we recommend you consider the following:

> The age of your child(ren);
> The emotional status and maturity of your child(ren);
> The child's ability to keep your health status confidential if asked to do so;
> The level of support you will need; and
> Your child's past response to death (if applicable) or present fears about dying.
It is important to keep in mind that children often respond better than we anticipate and, for the most part, are more resilient than adults. Additionally, all children are different and you (the parent) know your child(ren) better than anyone else. Based on our experience, the following tips have been extremely helpful to parents as they continue in the planning process:

> Avoid secretive talk around the children;
> Avoid disclosure of health or plans in a moment of anger or frustration;
> Ensure the children receive information from you (the parent) for this will maintain a level of trust and security;
> Be as open and honest with children, especially if they are of age to understand; and
> Maintain a consistent level of communication with those who support and encourage you.

Traditional and religious beliefs and practices often provide valuable insights to parents who are planning to discuss life and death issues with their loved ones. If and when appropriate, we recommend that you tap into spiritual support and guidance as well as to the past traditional practices that have been effective in facing significant life events.

SECTION 5
Securing Your Plan

Securing your wishes and determining your plan is one of the most important steps in determining your children's future. In the event the need arises to implement the plan, the challenging decisions will be done. To assist you with this we recommend the following steps to help you put your thoughts into action. If you haven’t already, consider reaching out to a professional who can help you navigate the resources you will be contacting.

Steps to securing a plan

> Decide if you will be filing your appointment of a guardian in a legal court or an informal appointment through a Will or Caregivers Affidavit.
> Determine if there is urgency and if a Temporary Guardianship appointment is necessary.
> Contact your local Probate Court and request procedures for filing Guardianship. Most courts offer assistance either through the clerk or in-house legal clinic.
> Find out if there is an organization that assists with filing legal Guardianship.
> Set up an appointment with the legal clinic or walk in during business hours.
> Prior to the appointment, make certain that you have all the necessary documents required to file a guardianship (birth certificates, social security numbers, addresses etc.). This will reduce unnecessary repeated trips to the court and a prolonging of the court date.
> Request a fee waiver. If eligible, your filing fees will be waived.
> If you do not file a legal plan, obtain a copy of a Caregiver Affidavit.
> After the guardianship is finalized, provide copies of the legal documents to the nominated caregiver guardian and trusted individuals.
HEALTH CARE

**Medi-Cal** Public health financing program that provides free medical coverage for low income families and certain groups of people (people eligible for CalWORKs and children in Foster Care). Call (800) 430-4264 or contact via the internet at www.lacd.org.

**Healthy Families** Low cost insurance program for children and teens that do not have insurance and do not qualify for free Medi-Cal. Call (800) 880-5305 or contact via the internet at www.healthyfamilies.gov.

LEGAL ASSISTANCE

**Public Counsel Children’s Rights Project** Legal assistance in filling guardianships, adoptions and legal advocacy for minors with unmet educational needs. Call (213) 385-2977 or (800) 870-8090.

**HALSA** Free legal advocacy and services for HIV/AIDS impacted families. Call (323) 993-1640.

**Legal Aid Foundation of Los Angeles** Legal advocacy, representation and education for low income individuals. Call (800) 399-4529 or contact via the internet at www.lafla.org.

**Special Immigrant Juvenile Status** Legal residency for children under the age of 21 (must not be married). Children must be dependent of the juvenile court or abandoned by their parents to be eligible. Call Pro Per Clinic at (213) 893-1030 or Dependency Court’s Special Immigrant Status Unit at (323) 725-4667.

** References**

Un Plan
para el
Futuro
Cuidado de
Mis Hijos
Hay cosas que no quisiéramos
Que sucedieran
Pero que tenemos que aceptar,
Cosas que no quisiéramos saber
Pero que tenemos que comprender,
Y personas sin las que no podemos vivir
Pero que tenemos que dejar ir.

Autor anónimo

Escrito por
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Diciembre de 2008
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Este folleto está dedicado a todos aquellos padres valientes y comprensivos que sufren una enfermedad terminal y a sus apreciados hijos.

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**Introducción**

Admiro su fortaleza y valor no solo por tomar en sus manos este folleto sino, también, por atreverse a leerlo. Quizá esté sentado en la sala de su casa o en una sala de espera de un consultorio y se pregunta si este folleto tiene algún propósito en su vida. Puede ser que lo tenga; puede ser que no. Sin embargo contiene información valiosa que debe leer, y puede ser que sea de ayuda para usted o para alguien que conoce.

Vivir con una enfermedad terminal puede ser devastador. Como padre se puede encontrar en la situación de tener que tomar múltiples decisiones en medio de imprevisibles condiciones de salud física y emocional. La planificación de una custodia puede ser muy difícil desde el punto de vista anímico, sobre todo cuando ignora las opciones que están a su disposición. Es importante que sepa que hay esperanza, así como hay apoyo en la planificación para el cuidado de sus hijos en el futuro. Este libro está diseñado para ayudarle y así aliviar sus preocupaciones acerca de: “¿Qué va a pasar con mis hijos en el caso de que esté tan enfermo como para no poder cuidar de ellos?” No hay mayor tranquilidad que saber que el futuro de sus hijos está asegurado y como padre, usted desempeña un papel importante en el logro del mismo.

Este folleto servirá como una guía práctica en la planificación para el futuro cuidado de sus hijos en el caso de que usted ya no sea capaz de poder hacerlo. Nos damos cuenta de que éste es un tema difícil de abordar y de manejar, pero estamos seguros de que al final encontrará “paz para su espíritu.” También es importante que reflexione sobre esto y si es posible, planifique el mañana ahora que usted es capaz de tomar decisiones competentes y bien informadas acerca del porvenir de sus hijos.

A estas alturas, puede ser que se encuentre debatiendo en si debe continuar o no con la lectura de este folleto. Para animarle a continuar, nos gustaría compartir que hemos aprendido en los últimos años al ofrecer apoyo a los padres que viven con el VIH/SIDA y que se embarcaron en el viaje de la planificación de la atención futura de sus hijos:

> Una planificación temprana impidió que varios niños entrarán en el sistema de hogares adoptivos
> La planificación apoyó en la transición de los niños con su nuevo tutor y hubo una reducción en la separación innecesaria entre hermanos
> Los deseos de los padres se respetaron y sus hijos, en su debido momento, residieron con el tutor adecuado
> Los padres que completaron sus planes, al final disfrutaron de una sensación general de “paz” y enfrentaron su futuro sin preocupación y tranquilidad

Es importante tener en cuenta que este folleto no está destinado a sustituir la asesoría o consejo legal. Las leyes y los procedimientos relativos a la custodia y la visitación, así como los derechos de los abuelos, son determinados por cada estado y pueden variar según éste. Aquí solo se proporciona información para las personas que viven en California. Sugerimos que los residentes de otros estados consulten con abogados o con los proveedores de servicios para obtener más información y orientación.
SECCIÓN 1

Encontrando Valor:
¿Está listo?

Planificar para el cuidado futuro de sus hijos es una de las experiencias más difíciles que pueda enfrentar. Aunque sea difícil, este proceso permitirá que usted, como padre, tome decisiones con respecto a la vida de sus hijos. Es obvio que el inicio del proceso de planificación de la futura custodia y cuidado es una decisión personal. Ya sea que desee embarcarse en este viaje como resultado de un cambio urgente en su salud o como parte de un plan a largo plazo, de todos modos es un viaje personal. Ha comenzado un proceso crucial y delicado para asegurar el futuro de sus hijos. Este proceso no tiene tiempo ni persigue un ideal.

Con el correr de los años, hemos apreciado que las familias tienen creencias, experiencias de vida y valores únicos que inevitablemente influyen en el proceso de hacer un plan para el futuro cuidado de sus niños. Hemos escuchado innumerables anécdotas de los padres que han completado su plan. Muchos de ellos han compartido su fortuna de disfrutar de la vida hoy, ya que encontraron consuelo al saber quién cuidará de sus hijos. También compartieron que, a pesar de su malestar y dificultad en el inicio, el proceso de planificación en algún momento se transformó en una terapia y les trajo alivio tanto a ellos como a sus hijos. Hemos aprendido también que los padres que viven con el estigma de enfermedades como el VIH / SIDA comúnmente expresaron tener una lucha con las decisiones de tener que revelar la naturaleza y el alcance de su enfermedad. Estos padres a menudo pasan vergüenza y se sienten culpables, además tienden a no querer revelar su estado de salud a sus hijos, así como los futuros tutores.

Desde el momento en que comienza a investigar estas ideas y a analizar qué piensa acerca de ello, ya en realidad le dio inicio al proceso de planificación. No tenga miedo de buscar orientación y apoyo. Las siguientes preguntas ayudarán a tratar las posibles preocupaciones que pueda tener y le ayudarán a determinar si está listo para llevar su plan al siguiente nivel.

Propósito de este folleto

Este folleto fue diseñado, específicamente, para los padres que padecen una enfermedad terminal. Le ofrece a usted y a su familia la información necesaria para llevar a cabo sus planes para el cuidado de sus hijos en el futuro. Esto puede ser un proceso a largo plazo y requiere un compromiso personal. No es fácil; no es cosa que se haga en un solo día. Planificar, al mismo tiempo que lucha contra una condición de salud complicada y, aun dando a eso, pasa por "días buenos y malos", puede ser muy difícil. Es importante saber que hacer frente a la posibilidad de entregar el cuidado de sus hijos a alguien más, puede ser emocionalmente devastador. Al embarcarse en este viaje, se sugiere que busque un amigo o un profesional que haga el viaje con usted. El camino hacia la planificación para el futuro cuidado de sus niños puede ser abrumador y difícil, sin embargo, todo esto último que usted haga le traerá paz interior y calma a su atribulado corazón.

Este folleto fue elaborado después de una cuidadosa evaluación y consideración de las necesidades de los niños que viven con padres que padecen una enfermedad terminal. El panfleto está estructurado de manera que se aplica con éxito a padres latinos que viven con el virus del VIH o SIDA y que se embarcan en el viaje de la planificación para el futuro cuidado de sus hijos. Dicha estructura tiene un enfoque susceptible que además es útil y se adapta a las familias que viven con otras enfermedades terminales. Esta guía sirve como un recurso de información destinado a ayudar a los padres que desean tener un plan para el futuro de sus hijos. Además, pone a su alcance a profesionales que le ayudarán con estrategias y herramientas para apoyar a los padres en este difícil proceso emocional. Relacionado al folleto, un padre que asegura un plan se denominará en lo sucesivo como la "custodia" y la persona designada (por el padre) para proporcionar el cuidado futuro de sus hijos se denominará en lo sucesivo "futuro guardián alternó" o "tutor designado."
SECCIÓN 2
¿Cuáles son sus opciones?

Hay muchas opciones para el padre o la familia que desee planear para el cuidado de sus hijos en el futuro. Es importante que identifique cuál es la mejor opción tanto para usted como para su familia, basado en su condición particular. Existen muchos factores que se deben tomar en cuenta al decidir un plan futuro para sus hijos. Por ejemplo, un factor que se debe tomar en cuenta es cómo asegurar ese cuidado sin tener que renunciar a sus derechos y responsabilidades. En esta sección se le informará de numerosas opciones que hay en California, tanto formal (legal) como informal (no llevado a la corte). Cada opción tiene ventajas e inconvenientes que se examinan brevemente. Conforme avanza en el proceso de planificación, le será de mucha ayuda si consulta con un profesional o un amigo para que lo asista en el manejo de sus emociones.

Para que pueda determinar qué opción es mejor para usted y su familia, considere la posibilidad de responder a las siguientes preguntas:

> ¿Tiene preocupaciones con respecto a la revelación de su enfermedad?
> ¿Quiere garantizar su decisión de hacer un plan jurídico formal (la presentación en el tribunal)?
> ¿Tiene preocupaciones acerca de la presentación de un plan jurídico en el tribunal?
> ¿Tiene una persona en mente que está interesada en asumir la responsabilidad jurídica en caso de que sea necesario?

Estas son preguntas muy importantes que, en caso de que aún no estén presentes, en algún momento surgirán. Tan pronto como tenga las respuestas convenientes, estará en mejores condiciones de tomar una decisión en la elección de una opción que sea mejor para usted y su familia. A continuación se muestran las opciones disponibles para los padres que han sido diagnosticados con una enfermedad terminal, que viven en California:

Declaraución jurada de autorización tutelar
La ley de California aprueba una categoría de adultos que han aceptado la responsabilidad informal de cuidar a los menores que residen con ellos. Por medio de la declaración jurada de autorización tutelar, la persona puede inscribir a un menor en la escuela y puede tomar...
decisiones médicas relacionadas con dicha escuela. En algunas circunstancias, la persona puede autorizar la mayoría de los tipos de atención médica que necesite el niño. Completar esta declaración jurada no afectará los derechos de custodia de un padre o tutor legal en relación con el cuidado, la custodia y el control del menor, y no significa que la persona designada tiene la custodia legal del menor. La declaración jurada no se presenta ante un tribunal y no es válida por más de un año después de la fecha en que se haya ejecutado.

Tutela compartida
La Ley de Tutela compartida le permite al padre, que sufre de una enfermedad terminal, designar a alguien que participará en el cuidado del niño cuando éste ya no sea capaz de proveerle con las necesidades diarias. Uno de los aspectos más importantes de esta ley es que permite a los padres biológicos la oportunidad de compartir la custodia de los hijos con el tutor designado. Además, a los padres que tienen la custodia se les permite conservarla así como el cuidado de sus hijos, incluso después de que la tutela compartida se haya concedido. En la mayoría de los casos, esta es la opción que prefieren los padres que están haciendo una petición de cuidado tutelar. La tutela conjunta también se puede aplicar en los casos donde hay involucradas dos partes distintas de los padres, esto es, petición ante el tribunal para la custodia compartida. En este caso, el tutor principal podrá solicitar la asignación de otro como apoyo complementario en la crianza del niño. Con el fin de hacer una petición para tutela conjunta, se deben cumplir dos condiciones: en primer lugar, el que no tiene la custodia debe estar de acuerdo con la propuesta de nombramiento de tutor; en segundo lugar, tampoco debe oponerse a la petición presentada por el padre que sí la tiene. Además, si el tribunal considera que es en el "mejor interés" del niño estar de acuerdo con la petición de la custodia, la tutela conjunta será aprobada. Los tribunales exigen que todos los padres que no tienen la custodia, los abuelos y hermanos del niño sean notificados de las solicitudes de tutela conjunta.

Los tutores están autorizados legalmente para recibir tratamiento médico, y se les exige que garanticen la seguridad y las necesidades educativas del niño. A los tutores también se les aprueba para solicitar beneficios públicos en nombre del niño. A la muerte del padre custodial, el conjunto tutelar se convierte en el único tutor legal del niño sin más procedimientos judiciales. La tutela conjunta asignada se puede revocar, ya sea por el tutor, el menor (de 14 años o más), el padre o el tribunal.

La tutela temporal
Es una petición presentada al tribunal solicitando un nombramiento urgente de un tutor. Este nombramiento es temporal, por lo general 30 días, hasta que se concierta una audiencia para tutela regular. Un tutor temporal puede ser designado por los padres, puede ser un tutor o un niño de 14 años de edad o más. Al tutor provisional, se le da autorización inmediata para el cuidado del niño.

Adopción
La adopción es una opción legal permanente. La adopción es en la mayoría de las veces una orden presentada por el Departamento de Niños y Servicios Familiares como un procedimiento para aplicar un plan permanente para niños que han sufrido abuso por sus padres biológicos. En estos casos, padres guardianes o familiares guardianes adoptan a los niños. En las adopciones, los derechos de ambos padres deben ser cedidos (renuncian voluntariamente) o suspendidos por una orden judicial. Los padres adoptivos tienen todos los derechos legales sobre los niños adoptados, incluyendo, pero no limitados, a la religión, la educación y la atención médica. La mayoría de padres con enfermedad terminal no están dispuestos a renunciar a sus derechos como padres y, por lo tanto, a menudo no eligen la adopción como un plan para el futuro cuidado de sus hijos. En los casos en que un padre haya fallecido, el guardián alterno (si no es el otro padre) puede presentar una petición de adopción para el niño.
SECCIÓN 3
La elección de un tutor alterno

Es necesario considerar cuidadosamente la posibilidad de escoger un tutor alterno. Lamentablemente, es común que los padres esperen hasta que una necesidad urgente surja para asignar a un guardian temporal o permanente. Hacer la elección en momentos de apremio a menudo no permite que se considere o se piense cuidadosamente en cuanto a quién sería el mejor tutor para sus hijos. Del mismo modo, el tutor designado puede sentirse comprometido a aceptar este papel, principalmente debido a la urgencia de la enfermedad del padre. A menudo, la oportunidad de revisión completa y consideración del grado de este compromiso es limitada. En tales situaciones, los padres corren el riesgo de asegurar solo una colocación temporal seguida de interrupciones y colocaciones, a veces múltiples, sin éxito. Somos conscientes de que el proceso de identificación de un cuidador alterno puede ser un reto. Sin embargo, también reconocemos que este es un paso importante en el proceso de su planificación.

Para ayudarle en el proceso de selección de un guardian alterno, por favor, siga los siguientes pasos:

PASO 1: Conteste las siguientes preguntas:

1. ¿Ha tenido que estar hospitalizado en el pasado?
   - Sí
   - No

2. Si la respuesta es Sí, ¿quién cuidó a sus hijos mientras estuvo hospitalizado la última vez?
   - Sí
   - No
   - No estoy seguro

3. ¿Si tuviera que ser hospitalizado hoy, tiene alguien que se haga cargo de sus hijos?
   - Sí
   - No
   - No estoy seguro

4. Si la respuesta es Sí, ¿podría esta persona hacerse cargo de ellos por largo tiempo?
   - Sí
   - No
   - No estoy seguro

5. ¿Estaría esta persona dispuesta a cuidarlos permanentemente?
   - Sí
   - No
   - No estoy seguro

PASO 2: Identifique quien está en su círculo de apoyo

En la parte de adentro del círculo, identifique quienes son las personas más cercanas a usted y a sus hijos.

PASO 3: Encierre en un círculo los nombres de las personas que están al tanto de su enfermedad.

Este ejercicio le ayudará a identificar al tutor correcto para sus hijos. Hay otras consideraciones importantes que hacer al elegir al guardián alterno. Le recomendamos que dedique tiempo y reflexione en lo siguiente:

- ¿El posible guardián tiene la edad requerida (18 años o más) y goza de buena salud?
- ¿El posible guardián está al tanto de su enfermedad? Sí no, ¿Cómo cree usted que ella respondería si se entera?
- ¿El posible guardián está interesado en asumir la responsabilidad permanentemente?
- ¿Los niños tienen amistad con él o ella?
- ¿Habrá objeción por parte de su pareja para la persona que asigne como guardián?
- ¿Hay alguien quien no desea que por ningún motivo cuide a sus hijos?
Al empezar la selección del futuro tutor, es importante que conozca el proceso de la corte para la aprobación de un tutor designado. Aunque no existen normas rígidas para quién podría ser el tutor apropiado, queda a discreción de la corte aprobar a quién se haya designado. El tribunal pondera muchos factores en la toma de una decisión de nombrar a un tutor. Los jueces de California se guían por las directrices estipuladas por la ley en el nombramiento de tutores. Los factores utilizados para elegir la tutela son: uno o ambos padres; la persona con quien el niño ha estado viviendo en un ambiente estable, y cualquier persona que, sea adecuada y capaz de ofrecer atención y orientación convenientes para el niño (Goldoftas & Brown, 2000). En última instancia, la consideración más importante en el nombramiento de un tutor es: en "el mejor interés" para el niño.

Otros factores importantes que se deben saber antes de la petición de una tutela legal:

El tutor designado no tiene que ser:
> residente legal o ciudadano.
> casado o ser padre.
> pariente del niño.

El tutor designado debe:
> tener habilidad básica de "paternidad".
> ser capaz de proveerle al niño: comida, un hogar, ropa y cuidado médico.
> estar en buen estado de salud.

Razones por las que la corte puede decidir que una elección es inapropiada:
> una persona que ha recibido cargos por negligencia o abuso a un menor
> una persona que ha sido condenada por un delito grave.
> tenga otros problemas con la ley dependiendo del delito, ¿cuánto tiempo hace que se cometió? y el actual estilo de vida de la persona.

Tanto el menor como el tutor elegido serán entrevistados por un investigador antes de que la corte decida. El investigador le dará una recomendación al juez.

> Los padres que no tienen la custodia, los abuelos y hermanos serán notificados de la petición.
> Si el niño tiene 14 años de edad o más, éste podrá dar su consentimiento con respecto a la tutela.
> Tras el nombramiento de un tutor, los padres del niño siguen siendo legalmente responsables de mantenerlo y apoyarlo. Aunque no sea un requisito, muchos tutores voluntariamente aceptan esta responsabilidad.
> A petición del padre, el diagnóstico de su enfermedad puede mantenerse confidencial durante la audiencia.

SECCIÓN 4
Involucrar a los niños en el proceso

Entre las muchas decisiones difíciles que enfrentan los padres diagnosticados con enfermedades terminales, está la de si deben o no revelarles su estado de salud a sus hijos, así como determinar el mejor momento para hacerlo. Para revelarle a un niño la condición de una enfermedad terminal se necesita pensarlo bien y hacer una preparación adecuada. Esta revelación tendrá mayor realce si el padre la hace con el apoyo y la orientación de profesionales. La orientación profesional puede ayudar al padre a reducir sus preocupaciones y sus temores. Las preocupaciones más comunes que un padre enfrenta en cuanto a la divulgación incluyen: ¿Tiene el niño la edad suficiente como para entender? ¿Mantendrá el niño la información de la enfermedad confidencial? Además, los padres suelen temer que la revelación de su enfermedad a su hijo le hará tener problemas de comportamiento o problemas emocionales como tristeza o incluso depresión. Mientras piensa la forma apropiada de decírselo a sus hijos de su enfermedad, le recomendamos considerar lo siguiente:

> La edad de su niño(s);
> La condición emocional y madurez de su niño(s);
> La habilidad para guardar el secreto de su estado de salud, si se le pide que lo haga;
> El grado de apoyo que va a necesitar; y
> La actitud de su hijo hacia la muerte, en el pasado (si se aplica) o temores actuales sobre la muerte,
Es importante tener en cuenta que los niños suelen responder mejor de lo que podemos anticipar y, normalmente, son más resistentes que los adultos. Además, todos los niños son diferentes y usted (el padre) conoce a su hijo (s) mejor que nadie. Sobre la base de nuestra experiencia, los siguientes consejos han sido muy útiles para los padres que siguen en el proceso de planificación:

> evite hablar en secreto delante de los niños;
> evite hablar de salud o de planes en un momento de ira o frustración;
> asegúrese que los niños reciban la información de usted (el padre) porque esto mantendrá un nivel de confianza y de seguridad;
> sea lo más abierto y honesto posible con los niños, especialmente si tienen edad suficiente para entender, y
> mantenga comunicación constante con quienes los apoyan y los animan.

Las tradiciones así como las creencias y las prácticas religiosas a menudo le dan una valiosa perspectiva a los padres que tienen necesidad de discutir cuestiones sobre la vida y la muerte a sus seres queridos. Siempre y cuando sea apropiado, le recomendamos que haga una petición de tutela legal.

Para apoyarle en esto, le recomendamos que siga estos pasos que le ayudarán a poner sus ideas en acción. Si todavía no tiene una persona capacitada que le pueda ayudar a lidiar con los recursos que están a su disposición, considere la posibilidad de buscar a uno.

Pasos a seguir para garantizar un plan:

> Decida si va a presentar la demanda de un tutor en un tribunal legal o si hará una demanda informal a través de un testamento o una declaración jurada de tutoría.
> Precise si hay una emergencia como para que sea necesario hacer una demanda de tutela temporal.
> Póngase en contacto con su tribunal de procedimientos testamentarios local y pida los requisitos para hacer una petición de tutela. La mayoría de los tribunales ofrecen ayuda por medio de un empleado del dispensario legal interno.
> Averigüe si hay una organización que preste asistencia con la petición de una tutela legal.
> Concurre una cita con la clínica legal o solo preséntese durante horas de oficina.
> Antes de la cita, asegúrese de que cuenta con todos los documentos necesarios para una petición de tutela (certificados de nacimiento, números de seguro social, direcciones, etc.) Esto le evitará viajes repetidos e innecesarios a la corte y que le prolonguen la fecha de presentarse ante el tribunal.
> Solicite una renuncia de honorarios. Si lo aprueban, se retirarán los honorarios de su petición.
> Si no presenta una demanda de un plan legal, consiga una copia de una declaración jurada de tutoría.
> Después de haber concluido el proceso de la demanda de tutoría, entregue copias de los documentos legales a quien se haya designado como guardian(tutor) y a personas de confianza.
SECCIÓN 6
Información Complementaria y Recursos Adicionales

AYUDA FINANCIERA

CalWORKs GCiWORKs: Beneficios gubernamentales que proporcionan apoyo financiero a los padres o tutores y a los hijos a su cargo. Solicítese personalmente en el Departamento de Servicios Sociales Públicos (DPSS siglas en inglés) local o llame al (866) 613-3777. También puede comunicarse vía Internet a www.ladpss.org.

Beneficios del Seguro Social Llame a la oficina del seguro social al (800) 772-1213 o vía internet a www.ssa.gov.

Incapacidad del Seguro Social (SSDI siglas en inglés) paga mensualmente en efectivo los beneficios para los trabajadores incapacitados menores de 65 años y a quienes dependen de ellos.

Ingresos Subsidiarios del Seguro (SSI siglas en inglés) les paga beneficios mensuales a personas con ingresos bajos y ventajas limitadas que tengan 65 años de edad o más, o a invidentes o incapacitados de cualquier edad.

Beneficios de Sobrevivientes del Seguro Social les paga beneficios mensuales a miembros de la familia de una persona fallecida si él/ella ganó suficientes “créditos de trabajo”.


Vivienda Llame al Instituto de la Vivienda del Condado de LA al teléfono (800) 731-4663 o comuníquese vía Internet en www.lacd.org.

La sección 8 de HOPWA le provee asistencia de vivienda a personas que padecen VIH/SIDA.

Shelter Plus Care Provee asistencia de alquiler y auxilio a personas de bajos ingresos con incapacidades.

ASISTENCIA MÉDICA

Medi-Cal Programa de financiamiento médico público que provee cobertura médica gratuita a familias de bajos recursos y a cierto grupo de personas (personas aprobadas para CalWORKS niñíos bajo cuidado adoptivo). Llame al (800) 430-4264 o comuníquese vía Internet a www.lacd.org.

Familias Saludables Programa de asistencia médica a bajo costo para niños y adolescentes que no tienen seguro y que no son aprobados para recibir Medi-Cal gratuito. Llame al (800) 880-5305 o comuníquese vía Internet a www.healthyfamilies.gov.

ASISTENCIA LEGAL

Proyecto del Consejo Público para los Derechos de los Niños Ofrece ayuda legal para presentar una demanda tutelar, adopciones y apoyo legal para menores con necesidades educativas impropias. Llame al (213) 385-2977 o al (800) 870-8090.

HALSA (Siglas en inglés) Ofrece asistencia legal gratuita a familias afectadas por VIH/SIDA. Llame al (323) 993-1640.

Fundación de Ayuda Legal de Los Ángeles Ofrece ayuda legal, representación y educación a personas de bajos recursos. Llame al (800) 399-4529 o comuníquese por Internet a www.lafla.org.

Condicción Especial de Inmigrante juvenil Ofrece residencia legal a niños menores de 21 años (no debe estar casado). Para ser aprobados en esta categoría los niños deben depender de la corte juvenil u haber sido abandonados por sus padres. Llame a la clínica Profesional al (213) 893-1030 o llame a la Unidad de Condición Especial de Inmigrante de la Dependencia de la Corte al (323) 725-4667.

Referencias