PROJECT MILAGRO

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

Replication Manual

Submitted to

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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 (AlA) 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 AlA 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 AlA programs that are perceptible in the interiors of poor and disenfranchised communities. In general, AlA 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:

1. Organizational Culture Shares:
   - Values?
   - Mission?
   - Philosophy?
   - Goals?
   - Objectives?
   - Services?

2. Organizational Culture Does Not Share:
   - Values?
   - Mission?
   - Philosophy?
   - Goals?
   - Objectives?
   - Services?
> believe HIV/AIDS and addictions are public health issues, not moral failings?
> Is this belief incorporated into all aspects of programs and services?
> offer programs and services to the entire family?
> believe that services are more effective when voluntary?
> attempt to involve participants in both individual and organizational decision-making processes?
> have a long term commitment to the community that it serves?

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 who 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. The program learned that building relationships took many 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.

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 ongoing 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 the 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 healthcare;
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;
5) Health education: healthy behaviors and life style, HIV/AIDS and other STIs; access to health care; drug use and impact on the body and compromised immune systems; prenatal substance abuse;

6) Recovery support: drug education, relapse prevention, coping skills, impact of substance abuse on family unit, access to drug treatment and twelve step programs;

7) Reunification services: understanding reunification process, navigating systems, advocacy, and compliance with court orders;

8) Access of community resources: knowledge and utilization of community resources; and

9) Daily living skills: household management, budgeting, scheduling and managing multiple tasks and responsibilities, self-sufficiency skills.

10) Permanency Planning: information and support to families impacted by HIV/AIDS in planning for future care of their children.

Field Safety

Home visiting provided a wealth of teachable moments as well as opportunities to conduct thorough assessments. The home-based providers were well trained in managing unpredictability and responding to crisis. The program considered personal safety and protection of the staff. Ongoing in-services and supervision addressed taking protective measures as high risk areas were served. Clinical supervision also assessed the staff's feelings and concerns to clarify if they were a result of lack of experience, or from signs of impending danger. When necessary, the Program Coordinator conducted home-visits with the providers to assess the home environment. To maximize worker safety, the program adapted the following safety measures:

- Work cell phones assigned to all home visitors;
- Supervisors cell numbers were provided to all staff;
- Supervisor on Call calendar was established when immediate supervisor was on vacation;
- Training in field safety and dealing with unpredictable home environments was offered regularly;
- Staff were encouraged to use emergency 911 numbers as appropriate;

- Staff conducted visits as a team when providing home visits in high risk areas; and
- Visits were scheduled during daylight and only in rare circumstances would staff remain late during home visits.

Service Planning and Coordination

Case Plans were implemented to ensure that culturally relevant, family and child focused services were delivered. The Plans served as the roadmaps to strengthening families and preventing child abandonment. They served as a starting point for identifying the goals of the family and to align them with the goals of the program. Staff's services and interventions were guided by quarterly Case Plans. Additionally, engaged in Case Plan development, the clients were able to take ownership and responsibility for personal improvements. Case Plans helped identify the role of the client, family, and service provider in reaching goals. Furthermore, the Plans helped identify strengths, presenting problems, and internal and external resources. Case planning was a comprehensive and coordinated process focused on strengthening families and promoting child well-being. The process led to desired outcomes and allowed for the monitoring of progress.

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 program's 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.

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 nature and focus of permanency planning process, it was presented as a choice for parents and an opportunity to learn about legal rights and options made available to parents who are terminally ill and living in California. In efforts to provide individualized permanency planning, each family was assessed as to their interest and willingness to learn about permanency planning. Areas for the provider to assess in Stage 1 include: participants level of trust; cultural and religious implications to permanency planning; family dynamics; families support system; the emotional status of the HIV positive parent; and level of urgency in initiating the planning process.

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
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.

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?
   - 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 (Goldofits & 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 parent's 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.
Section 8 provides low income housing through rent subsidies. HOPWA Section 8 provides housing assistance to people living with HIV/AIDS.

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

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.lac.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 confines 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 loved 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 Hollywood 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
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, posttest 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 AIAs 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 project administered and collected the AIAs cross-site form, PSI and SHIF required by the Children's Bureau AIAs evaluation. 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 2S 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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**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.

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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 AIA 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**
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**

**City/State/ZIP**

**Phone:**

**Message Phone**

**Marital status code**

**Ethnic Code**

**Years in US**

**Country of Origin**

**Primary language in home** 1-English 2-Spanish 3-other 4-Bilingual S.S.# (optional)

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<th>Work/Employment status</th>
<th>Health Insurance Status</th>
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<td>01 Does not work 02 Seeking employment 03 Working part-time 04 Working full-time</td>
<td>01 MEDI-CAL 02 HMO 03 Healthy Families 04 No Insurance Other</td>
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In School 1-Full-time 2-Part-time 3-No Source of Income ($) TANF/GR Food Stamps Employment SSI Spouse

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

**Biological Mother**

(Complete below only if applicable)

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**DOB**

Resides in the home Yes No

**Mother’s Name**

**Comments:**

**Biological Father**

(Complete below only if applicable)

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**DOB**

Resides in the home Yes No

**Father’s Name**

**Comments:**

**Program Assignment**

1-AA
2-1733
3-WH (Substance Abuse)
4-Family Preservation 9
5-Clarity
6-HEAL
7-CEBG
8-Project Escuela
9-Family Support 9 ELA 9 Covina
10-Project Comitize 9BFS 9HSA
11-Case Worker
12-CLAWorks
13-Joven Noble 9 FED 9 STATE
14-Fatherhood 9 Test 9 CLP
15-Health Center
16-Other

Assigned to:

1-Coordinator
2-Case Worker

Opening date

Closing date
## 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 ____________________________

CSW ____________________________ Phone# ____________________________

Date of Initial Involvement ____________________________ Date of Initial Placement ____________________________

Placement History ____________________________

Attorney's name ____________________________ Phone# ____________________________

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

### CHILDREN

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<th>Placement Code</th>
<th>Date of Reunification</th>
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### CHILDREN'S RISK FACTORS

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<td>Genetic deprivation</td>
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<td>Motor impairment</td>
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<tr>
<td>Cardiac anomalies</td>
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<td>Neonatal drugs or alcohol</td>
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<tr>
<td>Is placed out of the home</td>
<td>None</td>
<td>No prenatal care</td>
<td>None</td>
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<tr>
<td>Developmental delays</td>
<td>None</td>
<td>Prematurity</td>
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<tr>
<td>Down's Syndrome</td>
<td>None</td>
<td>Seizures</td>
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<td>Failure-to-thrive</td>
<td>None</td>
<td>Severe emotional disturbance</td>
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</tr>
<tr>
<td>Hearing impairment</td>
<td>None</td>
<td>Sleep apnea syndrome</td>
<td>None</td>
</tr>
<tr>
<td>History of placements</td>
<td>None</td>
<td>Vision impairment</td>
<td>None</td>
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<tr>
<td>Learning disability</td>
<td>None</td>
<td>Other</td>
<td>None</td>
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</tbody>
</table>
**PARENT/CAREGIVER RISK FACTORS**

- **Teen Parent**: 1-Yes 2-No
- **Pregnant Teen (Due Date)**: 1-Yes 2-No
- **Current Substance Abuse**: 1-Yes 2-No
- **History of Substance Abuse (Drug of choice)**: 1-Yes 2-No
- **History of Substance Abuse During Pregnancy**: 1-Yes 2-No
- **Domestic Abuse - Emotional or Physical**: 1-Yes 2-No
- **Victim: Childhood Physical, Emotional, Sexual Abuse**: 1-Yes 2-No
- **History of Being Identified as Abusive**: 1-Yes 2-No
- **Court Identified as Abusive**: 1-Yes 2-No
- **Court Identified As Neglectful**: 1-Yes 2-No
- **Poor Parenting Skills**: 1-Yes 2-No
- **History of Mental Illness**: 1-Yes 2-No
- **Poor Job Skills**: 1-Yes 2-No
- **Other**: 1-Yes 2-No

---

**Services Request and Linkages**

<table>
<thead>
<tr>
<th>SERVICES REQUESTED</th>
<th>REFERRED TO:</th>
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<td>☐ Advocacy</td>
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</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>
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<td>☐ Concrete Services</td>
<td>☐ Domestic Violence</td>
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<tr>
<td>☐ Court Services</td>
<td>☐ E.S.L.</td>
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<tr>
<td>☐ Crisis Intervention</td>
<td>☐ Educational Evaluation</td>
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<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>☐ English, ☐ Spanish</td>
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<tr>
<td>☐ Parent Education</td>
<td>☐ Housing Assistance</td>
</tr>
<tr>
<td>☐ Respite Services</td>
<td>☐ Independent Living Program</td>
</tr>
<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>
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<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>
</tr>
<tr>
<td>☐ Other (Specify)</td>
<td>☐ Parent Education</td>
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</table>
### In Case of Emergency Contacts

<table>
<thead>
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<th>Phone</th>
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<tbody>
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<td>Relationship</td>
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<tr>
<td>Name</td>
<td>Phone</td>
</tr>
<tr>
<td>Relationship</td>
<td>Address</td>
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### Medical Problems

<table>
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<tr>
<th>Special Medical Problems</th>
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<tbody>
<tr>
<td>Family Doctor:</td>
</tr>
<tr>
<td>Name of Clinic/Hospital:</td>
</tr>
<tr>
<td>Phone</td>
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</table>

### Child/Children to be released to:

<table>
<thead>
<tr>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Relationship</td>
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<td>Name</td>
<td>Phone</td>
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<td>Relationship</td>
<td>Address</td>
</tr>
<tr>
<td>Signature</td>
<td>Date of release</td>
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</table>
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>

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

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>Name</td>
<td>Relationship to child</td>
</tr>
</tbody>
</table>

- Witnessed domestic abuse as a child (specify type: physical___ emotional___) ..........................................  □  □
- Victim of domestic abuse (specify type: physical___ emotional___) ..........................................................  □  □
- Grew up in a household with substance abuser(s) (specify drug(s): __________________) .................................  □  □
- Substance abuse (specify drug(s): __________________) ......................................................................................  □  □
- Substance abuse during pregnancy (specify drug(s): __________________) ..........................................................  □  □
- Victim of childhood abuse (specify type: physical___ sexual___ emotional___ neglect___) ......................................  □  □
- Court identified as abusive/neglectful ...........................................................................................................  □  □
- Homelessness/shelter/unstable living situation ...............................................................................................  □  □
- Developmental delays/learning disability .......................................................................................................  □  □
- Physical disability (specify: __________________) ..............................................................................................  □  □
- Mental disorder (specify: __________________) ....................................................................................................  □  □
- Chronic/long term medical illness (specify: __________________) .........................................................................  □  □
- Multiple incarcerations ..................................................................................................................................  □  □

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### Completion Parent/Caregiver Risk Factors

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

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<tr>
<th>Risk Factor</th>
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<tbody>
<tr>
<td>14. Victim of domestic abuse (specify type: physical _ emotional _)</td>
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<td></td>
</tr>
<tr>
<td>15. Marital/Partner discord</td>
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<tr>
<td>39. Caring for a medically fragile child or child with special needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Experienced a traumatic event (specify: ______________________)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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)**

1. Lack of prenatal care or “well baby” pediatric care (date of last physical exam __/__/__). ...... [Yes/No]
2. Preterm birth .................................................................................................................. [Yes/No]
3. Low birth weight ........................................................................................................... [Yes/No]
4. Prenatal drug exposure (specify drug(s): ________________________) ......................... [Yes/No]
5. Exposure to substance abuse in the household (specify drug(s): ________________________) ................................. [Yes/No]
6. Exposure to domestic violence ........................................................................................ [Yes/No]
7. Victim of abuse or neglect (specify type: ________________________) .......................... [Yes/No]
8. Out-of-home placement(s) ............................................................................................ [Yes/No]
9. Unstable housing (homelessness, shelters, more than 2 moves in a year) ..................... [Yes/No]

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

10. Lack of “well child” pediatric care/immunization (date of last physical exam __/__/__). ....... [Yes/No]
11. Inadequate nutrition, caloric deprivation or anemia (specify: ________________________) .... [Yes/No]
12. Chronic health problem (specify: ________________________) ........................................ [Yes/No]
13. Exposure to substance abuse in the household (specify drug(s): ________________________) ................................. [Yes/No]
14. Exposure to domestic violence ........................................................................................ [Yes/No]
15. Victim of abuse or neglect (specify type: ________________________) .......................... [Yes/No]
16. Death of a parent or other member of household with significant relationship to child ........................ [Yes/No]
17. Other significant traumatic event (specify: ________________________) .......................... [Yes/No]
18. Lack of stable family composition (absentee parent, changing caregivers) ....................... [Yes/No]
19. Out-of-home placement ................................................................................................. [Yes/No]
20. Unstable housing (homelessness, shelters, more than 1 move in past 6 months) ............ [Yes/No]
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</th>
<th>Observed / Suspected by:</th>
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</thead>
<tbody>
<tr>
<td>1. Cardiac anomaly</td>
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</tr>
<tr>
<td>2. Motor/physical impairment (specify: )</td>
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<td>3. Asthma/respiratory problem</td>
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<td>4. Hearing impairment</td>
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</tr>
<tr>
<td>5. Vision impairment</td>
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<td></td>
</tr>
<tr>
<td>6. Failure-to-thrive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Fetal Alcohol Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Cerebral palsy</td>
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<td></td>
</tr>
<tr>
<td>10. Other neurological disorder (specify: )</td>
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<td></td>
</tr>
<tr>
<td>11. Congenital HIV – asymptomatic</td>
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<td></td>
</tr>
<tr>
<td>12. Symptomatic HIV infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Other chronic medical condition (specify: )</td>
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<td></td>
</tr>
</tbody>
</table>

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

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

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10.</strong> Lack of “well child” pediatric care/immunization (date of last physical exam <em>/</em>)</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>11.</strong> Inadequate nutrition, caloric deprivation or anemia (specify: _____________)</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>12.</strong> Chronic health problem (specify: _____________)</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>13.</strong> Exposure to substance abuse in the household (specify drug(s): _____________)</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>14.</strong> Exposure to domestic violence</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>15.</strong> Victim of abuse or neglect (specify type: _____________)</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>16.</strong> Death of a parent or other member of household with significant relationship to child</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>17.</strong> Other significant traumatic event (specify: _____________)</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>18.</strong> Lack of stable family composition (absentee parent, changing caregivers)</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>19.</strong> Out-of-home placement</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>20.</strong> Unstable housing (homelessness, shelters, more than 1 move in past 6 months)</td>
<td>Yes No</td>
</tr>
</tbody>
</table>
Completion 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 by:</th>
<th>Suspected by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiac anomaly</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>2. Motor/physical impairment (specify: ..................................................)</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>3. Asthma/respiratory problem</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>4. Hearing impairment</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>5. Vision impairment</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>6. Failure-to-thrive</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>7. Fetal Alcohol Syndrome</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>8. Seizures</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>9. Cerebral palsy</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>10. Other neurological disorder (specify: ..................................................)</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>11. Congenital HIV – asymptomatic</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>12. Symptomatic HIV infection</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>13. Other chronic medical condition (specify: ..................................................)</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental and Emotional/Behavioral conditions:</th>
<th>Formally Diagnosed</th>
<th>Observed by:</th>
<th>Suspected by:</th>
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<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>16. Other developmental delay (specify: ..................................................)</td>
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<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>17. Severe emotional disturbance (specify: ..................................................)</td>
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<td>Examiner</td>
<td>Caregiver</td>
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<td>Examiner</td>
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</tr>
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<td>19. Other learning disability (specify: ..................................................)</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>20. Behavioral problem (specify: ............... .................................)</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</td>
</tr>
<tr>
<td>21. Other mental health disorder (specify: ..................................................)</td>
<td></td>
<td>Examiner</td>
<td>Caregiver</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.</td>
<td>I was bothered by things that usually don't bother me</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>I did not feel like eating; my appetite was poor</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>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>
</tr>
<tr>
<td>4.</td>
<td>I felt that I was just as good as other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>I had trouble keeping my mind on what I was doing</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>I felt depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>I felt that everything I did was an effort</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>I felt hopeful about the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>I thought my life had been a failure</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>I felt fearful</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>My sleep was restless</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12.</td>
<td>I was happy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>I talked less than usual</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>I felt lonely</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>People were unfriendly</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16.</td>
<td>I enjoyed life</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.</td>
<td>I had crying spells</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18.</td>
<td>I felt sad</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19.</td>
<td>I felt that people disliked me</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20.</td>
<td>I could not get &quot;going&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*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.*
A. English

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<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>

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th>3</th>
<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>
6. In what language(s) are the TV programs you usually watch?

1  2  3  4  5
☐ ☐ ☐ ☐ ☐

Only Spanish  Spanish better than English  Both Equally  English better than Spanish  only English

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

1  2  3  4  5
☐ ☐ ☐ ☐ ☐

Only Spanish  Spanish better than English  Both Equally  English better than Spanish  only English

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

1  2  3  4  5
☐ ☐ ☐ ☐ ☐

Only Spanish  Spanish better than English  Both Equally  English better than Spanish  only English

9. Your close friends are:

1  2  3  4  5
☐ ☐ ☐ ☐ ☐

Only Latinos  More Latinos than Americans  About half and half  More Americans than Latinos  All Americans

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

1  2  3  4  5
☐ ☐ ☐ ☐ ☐

Only Latinos  More Latinos than Americans  About half and half  More Americans than Latinos  All Americans

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

1  2  3  4  5
☐ ☐ ☐ ☐ ☐

Only Latinos  More Latinos than Americans  About half and half  More Americans than Latinos  All Americans

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

1  2  3  4  5
☐ ☐ ☐ ☐ ☐

Only Latinos  More Latinos than Americans  About half and half  More Americans than Latinos  All Americans
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, qué idioma(s) leé y habla usted?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>5</th>
</tr>
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<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- 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)?

<table>
<thead>
<tr>
<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>
</tr>
</tbody>
</table>

- solo Español
- Español mejor
- Ambos por igual
- Ingles mejor
- Que Español
- SoLo Ingles

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- solo Español
- Español mejor
- Ambos por igual
- Ingles mejor
- Que Español
- SoLo Ingles

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- solo Español
- Español mejor
- Ambos por igual
- Ingles mejor
- Que Español
- SoLo Ingles

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☩</td>
<td>☩</td>
<td>☩</td>
</tr>
</tbody>
</table>

- Solo Español
- Español mejor
- Ambos por igual
- Inglés mejor
- Que Español
- Que Inglés
- Que Español
- Que Inglés
- Inglés mejor
- Que Español
- Solo Español
- Solo Inglés

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☩</td>
<td>☩</td>
<td>☩</td>
</tr>
</tbody>
</table>

- Solo Español
- Español mejor
- Ambos por igual
- Inglés mejor
- Que Español
- Que Inglés
- Que Español
- Que Inglés
- Inglés mejor
- Que Español
- Solo Español
- Solo Inglés

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

<table>
<thead>
<tr>
<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>
</tr>
</tbody>
</table>

- Solo Español
- Español mejor
- Ambos por igual
- Inglés mejor
- Que Español
- Que Inglés
- Que Español
- Que Inglés
- Inglés mejor
- Que Español
- Solo Español
- Solo Inglés

9. Sus amigos y amigas más cercanos son?

<table>
<thead>
<tr>
<th>1</th>
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</tbody>
</table>

- Solo Latinos
- Mas Latinos que Americanos
- Ambos por igual
- Mas Americanos que Latinos
- Mas Americanos que Latinos
- Solo Americanos

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

<table>
<thead>
<tr>
<th>1</th>
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</tr>
</tbody>
</table>

- Solo Latinos
- Mas Latinos que Americanos
- Ambos por igual
- Mas Americanos que Latinos
- Mas Americanos que Latinos
- Solo Americanos

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>5</th>
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</tr>
</tbody>
</table>

- Solo Latinos
- Mas Latinos que Americanos
- Ambos por igual
- Mas Americanos que Latinos
- Mas Americanos que Latinos
- Solo Americanos

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
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</tr>
</tbody>
</table>

- Solo Latinos
- Mas Latinos que Americanos
- Ambos por igual
- Mas Americanos que Latinos
- 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.

Supportive Person # 1:

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?

Supportive Person # 2:

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?

Supportive Person # 3:

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?
Supportive Person # 4:

What relationship do you have with this person?

<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>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Completely</th>
<th>Very Much</th>
<th>Somewhat</th>
<th>A little bit</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Completely</th>
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<tbody>
<tr>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>I am certain he/she knows</th>
<th>I think he/she knows</th>
<th>I'm sure he/she does not know</th>
<th>Yes, I told him/her</th>
</tr>
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</tr>
</tbody>
</table>

Supportive Person # 5:

What relationship do you have with this person?

<table>
<thead>
<tr>
<th>Completely</th>
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<th>Somewhat</th>
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</thead>
<tbody>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
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<th>Somewhat</th>
<th>A little bit</th>
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<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
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</table>

Supportive Person # 6:

What relationship do you have with this person?

<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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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Completely</th>
<th>Very Much</th>
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<tbody>
<tr>
<td></td>
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</table>

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

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</tr>
</tbody>
</table>
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.):

<table>
<thead>
<tr>
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<th>Very Much</th>
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</tr>
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</table>

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

<table>
<thead>
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3. Does this person know about your HIV/AIDS or Substance Abuse?

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<th>Yes, I told him/her</th>
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</thead>
</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.):

<table>
<thead>
<tr>
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<th>Somewhat</th>
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</tr>
</thead>
</table>

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

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<th>Yes, I told him/her</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.):

<table>
<thead>
<tr>
<th>Completely</th>
<th>Very Much</th>
<th>Somewhat</th>
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</thead>
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2. How much can you rely on this person for emotional support?

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

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### HEALTH-RELATED QUALITY OF LIFE

**Client Id. # __________________________**

**Timeline:** □ Baseline □ 12 Months

**Group:** □ HA □ SA □ HS

**Today’s Date: ________________________**

**Medical Illness: ______________________**

**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 ALot</th>
<th>Yes, Limited A Little</th>
<th>No, Not Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>A08AO1A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A08AO1B</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A08AO1C</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A08AO1D</td>
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<td></td>
<td></td>
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<tr>
<td>A08AO1E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A08AO1F</td>
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<td></td>
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<tr>
<td>A08AO1G</td>
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<td></td>
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<tr>
<td>A08AO1H</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A08AO1I</td>
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<td></td>
<td></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>A08AO2A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A08AO2B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A08AO2C</td>
<td></td>
<td></td>
<td></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 CAPI, 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 (Circle One)

Not at all, .................................................. 1
A little bit, .................................................. 2
Moderately, ................................................ 3
Quite a bit, or ............................................ 4
Extremely? ............................................... 5

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 (Circle One)

Not at all, .................................................. 1
A little bit, .................................................. 2
Moderately, ................................................ 3
Quite a bit, or ............................................ 4
Extremely? ............................................... 5

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

B08A06 (Circle One)

Excellent, .................................................. 1
Very Good, .................................................. 2
Good, ......................................................... 3
Fair, or ....................................................... 4
Poor? ......................................................... 5
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:

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th></th>
<th>DON'T TRUE</th>
<th>MOSTLY TRUE</th>
<th>DEFINITELY KNOW</th>
<th>FALSE</th>
<th>DEFINITELY FALSE</th>
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</thead>
<tbody>
<tr>
<td>B08A07A a.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>B08A07B b.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</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?

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>B08A08A a.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08B b.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08C c.</td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08D d.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08E e.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08F f.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08G g.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08H h.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>B08A08I i.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</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)

B08A09

- All of the time, .............................................. 1
- Most of the time, ........................................... 2
- Some of the time, .......................................... 3
- A little of the time, or.................................... 4
- None of the time? .......................................... 5

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

(Circle One)

B08A10

- None, .......................................................... 1
- Very mild, ...................................................... 2
- Mild, .......................................................... 3
- Moderate, ..................................................... 4
- Severe, or ..................................................... 5
- Very severe? ................................................ 6
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.

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th>Activity Description</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. ¿Subir un piso de escaleras/gradas? ................</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. ¿Caminar más de una milla? ................</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. ¿Caminar una cuadra? ................</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. ¿Bañarse o vestirse? ................</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. ¿Preparar comida o lavar la ropa? ................</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. ¿Ir de compras? ................</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. ¿Hacer cosas en su casa? ................</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. ¿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?

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>SI, TODO EL TIEMPO</th>
<th>SI, ALGUNAS VECES</th>
<th>NO, NUNCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ¿Trabajar en un empleo, trabajar en casa, o ir a 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 (aseguranzas) 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 CAPÍ, RESPONSE CAN'T BE >28.

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

(Circle One)

<table>
<thead>
<tr>
<th>Para nada</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Un poquito</td>
<td>2</td>
</tr>
<tr>
<td>Moderadamente</td>
<td>3</td>
</tr>
<tr>
<td>Bastante, o</td>
<td>4</td>
</tr>
<tr>
<td>Mucho?</td>
<td>5</td>
</tr>
</tbody>
</table>

A5. Durante las últimas cuatro semanas, ¿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)

<table>
<thead>
<tr>
<th>Para nada</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Un poco</td>
<td>2</td>
</tr>
<tr>
<td>Moderadamente</td>
<td>3</td>
</tr>
<tr>
<td>Bastante, o</td>
<td>4</td>
</tr>
<tr>
<td>Mucho?</td>
<td>5</td>
</tr>
</tbody>
</table>

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

(Circle One)

<table>
<thead>
<tr>
<th>Excelente</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muy buena</td>
<td>2</td>
</tr>
<tr>
<td>Buena</td>
<td>3</td>
</tr>
<tr>
<td>Regular o</td>
<td>4</td>
</tr>
<tr>
<td>Mala?</td>
<td>5</td>
</tr>
</tbody>
</table>
A7. (HAND R CARD #34) Por favor digame 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 SABE</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 últicamente</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
### Appendix B10: Project Milagro Evaluation – Coping Survey

**Coping** (English)

**Client ID:** _______ _______  
**Group:** ☐ HA ☐ SA ☐ HS  
**Today's Date:** _______ _______  
**Identified Event:** __________________________

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

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes, Once or Twice</th>
<th>Yes, sometimes</th>
<th>Yes, fairly often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
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<td>2.</td>
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<tr>
<td>3.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
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<td></td>
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<tr>
<td>8.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>10.</td>
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<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>No</td>
<td>Yes,</td>
<td>Yes,</td>
<td>Yes,</td>
</tr>
</tbody>
</table>

37
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Took things a day at a time one step at a time</td>
<td></td>
</tr>
<tr>
<td>16. Tried to step back from the situation and be more objective</td>
<td></td>
</tr>
<tr>
<td>17. Went over the situation in my mind to try to understand it</td>
<td></td>
</tr>
<tr>
<td>18. Tried not to act too hastily or follow my first hunch</td>
<td></td>
</tr>
<tr>
<td>19. Told myself things that helped me feel better</td>
<td></td>
</tr>
<tr>
<td>20. Got away from things for a while</td>
<td></td>
</tr>
<tr>
<td>21. I know what had to be done and tried harder to make things work</td>
<td></td>
</tr>
<tr>
<td>22. Avoided being with people in general</td>
<td></td>
</tr>
<tr>
<td>23. Made a promise to myself that things would be different next time</td>
<td></td>
</tr>
<tr>
<td>24. Refused to believe that it happened</td>
<td></td>
</tr>
<tr>
<td>25. Accepted it; nothing could be done</td>
<td></td>
</tr>
<tr>
<td>26. Let my feelings out somehow</td>
<td></td>
</tr>
<tr>
<td>27. Sought help from persons or groups with similar experiences</td>
<td></td>
</tr>
<tr>
<td>28. Bargained or compromised to get something positive from the situation</td>
<td></td>
</tr>
<tr>
<td>29. Tried to reduce tension by:</td>
<td></td>
</tr>
<tr>
<td>a. drinking (alcohol) more</td>
<td></td>
</tr>
<tr>
<td>b. eating more</td>
<td></td>
</tr>
<tr>
<td>c. smoking more</td>
<td></td>
</tr>
<tr>
<td>d. exercising more</td>
<td></td>
</tr>
<tr>
<td>e. taking more tranquilizers</td>
<td></td>
</tr>
</tbody>
</table>
Por favor indique a continuación cómo reaccionó usted con respecto a este evento:

Escriba el nombre de este evento/situación ____________________________________________

Por favor escoja el problema más importante que le haya afectado.

1. Traté de informarme más al respecto de el problema
2. Hablé con mi esposo u 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 preparé para lo peor
7. No me preocupé; pense que todo saldría bien
8. Me desquité con otras personas cuando me sentí enojada o deprimida
9. Traté de ver el lado positivo de la situación
10. Me ocupé en otras cosas para evitar pensar en el problema

No  Si, Una o Dos veces  Si, algunas veces  Si, frecuentemente

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

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. Traté 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

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
   Stage I = 100-80 Stage II = 70-60 Stage III = 50-40 Stage IV = 30-20
9. Kamofsky Scale assessment:
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 ☐ wasting syndrome ☐ meningitis
☐ gynecological problems (abnormal PAP, yeast infections) ☐ dementia (memory impairment)
☐ cervical cancer ☐ mood disorders (anxiety disorders)
☐ Kaposi's Sarcoma (lesions in the skin or internal organs) ☐ TB
☐ thrush (fungal infection) ☐ Hepatitis B
☐ toxoplasmosis (swelling, lesions in brain) ☐ Hepatitis C
☐ other, specify: __________________________________________

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

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

### Medication Side Effects

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

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

### Alternative Treatments

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

- [ ] herbal/homeopathy
- [ ] nutritional supplements
- [ ] acupuncture
- [ ] proper nutrition/diet
- [ ] healer/curandera
- [ ] 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

- ☐ 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>
</tr>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

- ☐ alcohol
- ☐ cocaine/crack
- ☐ marijuana
- ☐ heroin
- ☐ PCP
- ☐ amphetamines/speed

- ☐ methamphetamines
- ☐ hallucinogens (LSD, mushrooms)
- ☐ club drugs (roffies, ecstasy, Special K, GHB)
- ☐ inhalants (whippets, poppers, etc.)
- ☐ prescription meds (Vicodin, Valium, etc.)
- ☐ other, specify: ________________

2. How long did the client use drugs?

- ☐ less than 1 year
- ☐ 1-5 years
- ☐ over 5 years

3. How long has the client been drug-free?

- ☐ less than 1 month
- ☐ 1-6 months
- ☐ over 6 months

4. At what age did client first started drinking alcohol or using drugs? _______ years
### All Changes in Home Environment and/or Family Composition

<table>
<thead>
<tr>
<th>Client BFS ID #</th>
<th>Group (circle one): SA HA HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Information</td>
<td>Name</td>
</tr>
<tr>
<td>Index Child</td>
<td></td>
</tr>
<tr>
<td>Biological Mother</td>
<td></td>
</tr>
<tr>
<td>Biological Father</td>
<td></td>
</tr>
<tr>
<td>Primary Caregiver Relationship to Index Child</td>
<td></td>
</tr>
</tbody>
</table>

#### 1st Change in Home Environment/Family Composition

- **Change(s) that Occurred Affecting Index child and/or primary caretaker?**
- **Type or Reason for change**
- **Siblings Involved?**
- **Date of Change**

#### 2nd Change in Home Environment/Family Composition

- **Change(s) that Occurred Affecting Index child and/or primary caretaker?**
- **Type or Reason for change**
- **Siblings Involved?**
- **Date of Change**

#### 3rd Change in Home Environment/Family Composition

- **Change(s) that Occurred Affecting Index child and/or primary caretaker?**
- **Type or Reason for change**
- **Siblings Involved?**
- **Date of Change**
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
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>Signature of the Participant</td>
<td>Date</td>
<td>Staff’s Signature</td>
<td>Date</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
Appendix C 1  In-home Visit Progress Report

AIA - Project Milagro

In-Home Visit Progress Report

<table>
<thead>
<tr>
<th>Case Name:</th>
<th>Date of Visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Number:</td>
<td>Session # for Month:</td>
</tr>
<tr>
<td>Client available:</td>
<td></td>
</tr>
<tr>
<td>Family (counseling)</td>
<td>□ yes</td>
</tr>
<tr>
<td>Client (counseling)</td>
<td>□ yes</td>
</tr>
<tr>
<td>Group (counseling)</td>
<td>□ yes</td>
</tr>
</tbody>
</table>

<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>

Primary Topics Discussed On Face-To Face Visit (As Applicable)

- [ ] Child's Functioning/ Development
- [ ] Parental Functioning / Parent Education
- [ ] Case Management/ Advocacy
- [ ] Family Dynamics & Communication
- [ ] Substance Abuse
- [ ] Health/ Medical/Dental issues
- [ ] Safety Factors (environmental)
- [ ] Stress Management (Problem solving)
- [ ] Physical / Sexual/Verbal abuse
- [ ] Immediate Basic Needs
- [ ] Mental Health issues
- [ ] Personal goals:
- [ ] Anger Management/ Conflict resolution
- [ ] Domestic Violence/ Self-Esteem / Empowerment
- [ ] Other:

☐ 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*
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: 

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Project Milagro

Buenos Aires Family Services

5233 East Beverly Blvd.
East Los Angeles, CA 90022

323.728.9577 • 323.728.3483
fs@bienvenidos.org
www.bienvenidos.org

Free and confidential services
Servicios son gratuitos y confidenciales

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.
**OUR MISSION:**<br>Increase the permanence, safety, and well-being of HIV and/or drug affected children.

**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 en equipo ofrecen servicios en el hogar que incluyen asesoría, 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 el 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 Tiempo de Hijos
- Desarrollo Infantil

**Project Milagro** offers hope and a better quality of life for Latina women and their families affected by HIV/AIDS or substance abuse. Compassionate, culturally sensitive staff offer in-home counseling, education, and advocacy with the goal of creating a safe environment for children. Team-based services help fragile families create a plan to ensure their children remain within their home environment. Referrals to a wide network of social, medical, and community resources decrease parental stress, depression, and isolation – for more stable and healthy families.

**SERVICES**
- 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

**MUY TRAGAMISION:** Asegura la permanencia, seguridad y bienestar de niños afectados por el VIH/SIDA y/o drogas.

El programa está disponible a familias con niños menores de seis años que viven en el área del Este, Sureste de Los Angeles 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

Written by
Lourdes Carranza
December 2008
BIENVENIDOS
Los Angeles, California
213 785 5906
www.bienvenidos.org

This workbook is dedicated to all the courageous and caring parents living with a terminal illness and their cherished children.

Funding for this workbook was provided by the Abandoned Infants Assistance grant award (2004-2008), Children's Bureau Administration for Children and Families-Department of Human Health Services.

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.

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.

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:

- 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 counsel or 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.
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 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.
> Is it important for you to plan for the future care of your children?
  Yes No

> Have you considered talking to someone about this?
  Yes No
  If yes, who?

> Is there someone who would care for your children in the event that you couldn't?
  Yes No
  If yes, who?

> Has anyone cared for your children in the past?
  Yes No
  If yes, who?

> Do you want to express your wishes and ensure that your children do not end up with a particular person?
  Yes No

> Do you need information on who to contact for emotional support and/or legal counsel?
  Yes No

> Do you need information on benefits and services for you and your surviving children?
  Yes No

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
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.

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.

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.
SECTION 6
Additional Information and Resources

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.

Section 8 provides low income housing through rent subsidies.

HOPWA Section 8 provides housing assistance to people living with HIV/AIDS.

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

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

Los fondos para la creación de este folleto fueron provistos por la Concesión de Subsidios para la Asistencia a los Niños Abandonados (2004-2008) y la Oficina de la Agencia Infantil para Niños y Familias-Departamento de Servicios Humanos de Salud.

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

Contenido

Introducción

Propósito de este folleto

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Sección 5 Asegure su Plan

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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 ayudarlo 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 animarlo a continuar, nos gustaría compartir lo 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 entraran 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.
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.

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 limitado, 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 aun guardián 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 sólo 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 importantísimo en el proceso de su planificación.

Para ayudarle en el proceso de selección de un guardián 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?

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 quienes están 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 estén 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? Si no, ¿cómo cree usted que él/ella responderá 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 su cuidado a sus hijos?
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. 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 decirles 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.

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.

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.

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:

> 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 5

Asegure su Plan

La garantía de sus deseos y la determinación de su plan es uno de los pasos más importantes en la definición del futuro de sus hijos. En el caso de que la necesidad se presente, el plan se pondrá en acción y se tomarán las decisiones más complicadas. Para apoyarle con esto, le recomendamos los siguientes pasos que le ayudarán a poner sus ideas en acción. Si todavía no tiene una persona capacitada que le pueda ayudar a ligarse con los recursos que estarán 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.
> Concierte 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 guardián(tutor) y a personas de confianza.

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 previsto discutir cuestiones sobre la vida y la muerte a sus seres queridos. Siempre y cuando sea apropiado, le recomendamos que eche mano de apoyo y dirección espiritual así como de prácticas tradicionales pasadas que hayan sido eficaces al enfrentar acontecimientos importantes en sus vidas.
SECCIÓN 6
Información Complementaria y Recursos Adicionales

AYUDA FINANCIERA

CalWORKs GCaLWORKs: 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 en 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.

Incapacitación del Seguro Social (SSDI siglas en inglés) paga mensualmente a los beneficiarios menores de 65 años y a quienes dependan de ellos.

Ingresos Subsidiarios del Seguro (SSI siglas en inglés) les paga beneficios mensuales a personas con bajos ingresos 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”.

Cupones de alimentos Beneficios mensuales para personas con bajos ingresos para comprar alimentos con una tarjeta electrónica que transfiere beneficios (EBT siglas en inglés). Solicítesela personalmente en el Departamento local de Servicios Sociales Públicos (DPSS) o llame al (866) 613-3777. También puede comunicarse vía Internet en www.ladpss.org.


Vivienda Llame al Instituto de la Vivienda del Condado de LA al teléfono (800) 731-4663 o comuníquese vía Internet en www.laccd.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 y niños bajo cuidado adoptivo). Llame al (800) 430-4264 o comuníquese vía Internet a www.lacd.org.

Familias Saludables Programa de aseguración 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 apoyo legal gratuito y servicios para 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 en www.lafla.org.

Condiciones Especiales de Inmigrante Juvenil 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