Chapter 5: Initial Assessment (IA)

Introduction

Through the Initial Assessment, the Healthy Start worker determines the services needed, based upon professional judgment, family priorities, safety concerns, immediate needs, risk factors, assets, and the family's ability to access services. When determining which participants need further intervention through the Healthy Start Program, the role of the Healthy Start worker is to recognize and facilitate the family as the authority on their own concerns, priorities, strengths, and resources.

Definition of Services

The Initial Assessment is a face-to-face in-depth evaluation of the participant's risks factors, corresponding needs, resources, and potential for change.

Provider Qualifications

Healthy Start workers are health care providers, health-related professionals, or qualified paraprofessionals working under the supervision of a professional, who function in partnership with the participant or family in providing linkage to programs and resources to address risk factors identified on the risk screen or referral.

At a minimum, the Healthy Start worker must meet the qualifications and demonstrate the competencies outlined in Chapter 6, The Healthy Start Program.

Healthy Start services must be provided in accordance with the constraints of the professional's practice act, established protocols and the individual's education, training, and experience. **Paraprofessionals must provide services under the supervision of a professional supervisor.** If a referral is made for additional services such as substance abuse treatment, mental health counseling, or clinical medical services, the Healthy Start worker must ensure the participant is being referred to entities or individuals with the appropriate credentials or licensing to provide the service.

Standards and Criteria

Standard 5.1 All prenatal women, families with children under the age of three, women who have experienced a recent loss (miscarriage, stillbirth, infant death) and women who have recently had an infant placed out of the home (adoption or removal by DCF) who are referred to the Healthy Start Program by CI&R will receive an Initial Assessment.

Criteria:

5.1.a The referred person/family will receive an Initial Assessment or attempt at Initial

Assessment within five business days of the completion of the Initial Intake. If the initial attempt to contact is not successful, an additional attempt to contact will be made within ten business days of the first attempt. The third attempt to contact will be made within ten business days of the second attempt.

5.1.b At a minimum, the Initial Assessment includes all Initial Assessment service delivery activities specified in this chapter.

5.1.c Contact attempts will be varied as to time of day.

5.1.d Written notification of the status of the Initial Assessment and plan for further services or closure are provided to the prenatal care provider or child's primary care provider within 30 calendar days of the first attempt to contact. If the child's primary care provider is not known, document in the case file why written notification is not possible.

5.1.e If a referral has been made to Healthy Start due to risk of child maltreatment, written notification of the status of the Initial Assessment and plan for further services or closure are provided to the referral source within 30 calendar days of the first attempt to contact.

5.1.f Healthy Start services are provided in a manner that adheres to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care https://www.thinkculturalhealth.hhs.gov/clas.

Standard 5.2 All Healthy Start participants who will participate in the Healthy Start Program will have an Individualized Plan of Care.

Criteria:

5.2.a The Individualized Plan of Care (IPC) is a written plan of identified needs, goals, interventions, and progress towards meeting the goal(s) based on the Healthy Start worker's evaluation of the participant's risks and needs.

5.2.b The IPC is initiated at the Initial Assessment, and is re-evaluated at each subsequent encounter.

Standard 5.3 All Healthy Start participants who will receive the Healthy Start Program will have a Family Support Plan.

Criterion:

The family support plan is required for all Healthy Start Program participants and is initiated at the Initial Assessment face-to-face with the participant.

Standard 5.4 In conjunction with the participant, the Healthy Start worker will facilitate the participant's access to adequate health care, other health care funding options and resources through provision of appropriate referrals.

Criteria:

5.4.a At a minimum, Healthy Start workers will evaluate the participant's ability to access and, if necessary, facilitate access to:

1. Medicaid and Title XXI eligibility determination
2. Prenatal and postpartum care
3. Child primary health care
4. Immunization services
5. Family planning services
6. Adult primary care services including mental health and drug treatment
7. WIC
8. Housing
9. Transportation
10. Food
11. Child care
12. Managed Care Organization

5.4.b Each pregnant or interconception woman or infant/child who has been assessed to be in need of community services is referred to a qualified provider within five working days.

Standard 5.5 Healthy Start workers will participate in the development of collaborative networks of care within the community and will refer and/or transition care to specialized community providers with whom they have interagency agreements.

Criterion:

At a minimum, Healthy Start workers comply with the following interagency agreements:

1. Early Steps, Children's Medical Services
2. Regional Perinatal Intensive Care Centers (RPICC) and other Level III Centers
3. Department of Children and Families for pregnant, substance abusing women and substance exposed children
4. County health departments in the event the county health department is not the sole provider of care coordination

Standard 5.6 Healthy Start Initial Assessment services will be provided by qualified and trained providers who meet education, training, and competency standards for their position.

Criteria:

5.6.a Qualifications and competencies are met as specified in this chapter.

5.6.b Paraprofessionals work under the direct supervision of a qualified professional supervisor and adhere to the additional requirements as specified in the provider qualifications section of this chapter.

5.6.c All Healthy Start workers receive pre-service training on the Initial Assessment, Healthy Start process, Healthy Start Program services, area resources, and demonstrate competencies as specified in this chapter.

5.6.d Each agency providing Healthy Start will have a written orientation plan with checklist sign off for their personnel file.

5.6.e All providers will be knowledgeable of Department of Health (DOH) Information Security Privacy Policies including confidentiality, managing the security and confidentiality of data, and other security requirements.

5.6.f All Healthy Start staff will receive ongoing training.

5.6.g The Healthy Start worker is knowledgeable about eligibility requirements and fees for other services.

5.6.h The Healthy Start worker is knowledgeable about other funding sources, such as county service dollars, local agency services or funding, grant sources, private funds, and insurance services, such as Medicaid services.

5.6.i The Healthy Start worker is knowledgeable about Florida's Family Health Line, a statewide toll-free number (1-800-451-2229) for basic information and referrals for prenatal, infant and family health.

Standard 5.7 Participants may be closed at the Initial Assessment when it is determined further services are not needed, are not desired or the participant is receiving services from another home visiting program.

Criteria:

5.7.a At a minimum, three attempts to contact are made before closing as "Unable to Locate" any participant. In addition, prior to closure as "Unable to Locate", the Healthy Start worker should check resources for updated information regarding phone number and address or follow-through with care. Suggestions of resources include:

- Participant's health care provider
- WIC staff and WIC Information Project (WIP) System
- Immunizations staff and Florida SHOTS database
- FLORIDA Medicaid database (FMMIS)

5.7.b Initial Assessment closure activities include:

1. Assessment of the need for referrals to community services, primary care, family planning, interconception counseling, and assisting in accessing these services;
2. Notification of the prenatal or primary care provider of closure and collaboration in the event the provider recommends additional services;
3. Notification of referral source and/or Department of Children and Families when referral reason was risk of child maltreatment;
4. When appropriate, refer back to CI&R in order to transition to a more appropriate maternal-child home visiting program with release of information and record transfer; and
5. Providing the participant with information regarding the ability to return to Healthy Start if needed.

5.7.c Participants may be reopened and receive Healthy Start Program services if their needs change.

5.7.d Healthy Start is a voluntary program and the participant may choose to end services at any time.

Standard 5.8 Providers of Healthy Start services will document services in the approved data management system in a format determined by the local coalition and service provider within three business days of service completion.

Criteria:

5.8.a Services and attempts to provide services are documented in the approved data management system in the electronic record of the individual receiving the services.

5.8.b Content of services are documented in the participant's electronic record. Services that are provided to another person, on behalf of a Healthy Start Program participant (such as a mother of a Healthy Start infant participant), are documented in the child participant's record. In the event that a request in signed to release a Healthy Start child's records, all information that does not pertain to the child's medical condition must be redacted prior to release of record.

5.8.c The following services and activities, when provided, are documented in the participant's electronic record:

1. The participant's risk screening form, or documentation of risks, if referred by a community provider or self-referred.
2. Authorization for release of information, signed by the participant, or on behalf of the participant, for any information that is to be shared among payers, providers, or others.
3. All attempts, successful and unsuccessful, to contact the potential program participant.
4. All interactions with the program participant, the family, or with others impacting their receipt of services.
5. Identified risks and needs and how these are addressed or rationale for not addressing the risks and needs.

6. All closure activities.
7. Follow-up with the participant's prenatal or primary health care provider.

Standard 5.9 Providers of Healthy Start services will accurately code service information in the approved data management system within three business days of service completion.

Criterion:

Coding complies with the requirements of the Department of Health publication DHP 50-20 and as specified in Chapter 23, Healthy Start Coding, of these Healthy Start Standards and Guidelines.

Standard 5.10 Healthy Start service providers will develop and implement an internal continuous quality improvement (CQI) process.

Criterion:

The CQI process, developed in collaboration with the local Healthy Start coalition, includes an assessment of strengths, an assessment of areas needing improvement, and a plan for assuring maintenance of program quality and improvement.

Guidelines

Initial Assessment of service needs is a face-to-face evaluation done in collaboration with the participant and, as appropriate, the family. The Initial Assessment or an attempt at an Initial Assessment needs to be done within five business days after the Initial Intake has been completed to further identify and explore:

- Factors that may adversely affect the pregnancy, the mother's health status, or the child's health and/or developmental outcome
- Participant and family concerns, priorities, strengths, and resources
- Barriers to health care and other services
- Home environment

A. Service Delivery Activities of Initial Assessment:

Initial Assessment activities will be documented and an Individualized Plan of Care will be initiated. The service delivery activities of the Initial Assessment include the following:

1. A face-to-face interview with the participant or infant's/child's family with the participant present to assess interaction.

2. Completion of an authorization for release of medical information, as appropriate.

   The Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practice outlines the privacy practices of the county health department, informs clients how their information may be used and disclosed and what rights they have if their privacy is breached. Every participant must sign a form that authorizes disclosure of personal health information (PHI) for purposes of health operations, payment or treatment. This form may be the Department of Health's Initiation of Services form, DOH 3204 (11/08), the Prenatal Risk Screen, DH 3134 (4/08), or the Infant Risk Screen, 3135 (1/15). If a non-DOH form, authorizing disclosure of PHI is used, this form must permit disclosure or exchange of PHI between the treating physician, the Healthy Start coalition and the Florida Department of Health for purposes of healthcare operations, payment or treatment. The original of either or all of these forms must be maintained in the participant's file once executed. If a participant refuses to authorize disclosure, their PHI will not be disclosed and the refusal documented in the participant's file.

3. Joint determination of participant and family service needs in conjunction with the participant or family. Determination of service needs includes evaluation of:

   - All unresolved risk factors, corresponding need(s), and potential for change
   - Participant's and family's concerns, priorities, and resources
   - Child's or woman's physical and emotional well-being, safety, and general appearance
   - Ability to continue regular participation in ongoing health care, including past appointment regularity
   - Ability to comply with recommended treatments, such as obtain and take medications or stay on bed rest
   - Housing and household occupants
   - The home environment
   - Participant's and family's knowledge and attitudes about pregnancy, childbirth, parenting, and family life
   - Maternal and child interaction
   - Characteristics of the parent at risk for child maltreatment which include:
     - ✓ having a personal history of abuse, neglect, or violence
     - ✓ lack of knowledge of parenting skills
     - ✓ unrealistic expectations of the child
     - ✓ unmet emotional needs of the parent
     - ✓ substance abuse

- ✓ social isolation

- If unmarried, plans for establishing paternity, child support, and involvement of father in child's life
- Availability of a social support system
- Current situation with regard to:
  - ✓ Housing
  - ✓ Food, including current eligibility for WIC
  - ✓ Transportation
  - ✓ Family planning services
  - ✓ Health services
  - ✓ Eligibility and limits for Medicaid or other insurance and ability to access it
  - ✓ Knowledge of Medicaid services available, if applicable
  - ✓ School enrollment and participation
  - ✓ Family and self-sufficiency goals/economic stability
- Alcohol, tobacco, or other substance use

4. Risk factors in addition to those identified through the Initial Intake, access to care, and need for referrals. The Healthy Start worker should evaluate the participant's understanding of their risk factors and how to address them (refer to Risk Factor Matrices in Appendix D). Evaluation includes:
   - Ability to access needed services
   - Need for additional referrals
   - Need for additional information, encouragement, and monitoring.
5. Provide verbal or written follow-up to the prenatal care provider or child's primary care provider within 30 calendar days regarding assessment and progression of Healthy Start service delivery.

B. **Plan of Action for Assuring Risk Appropriate Care:**

After the Initial Assessment, the Healthy Start worker will determine, based upon professional judgment, family priorities, safety concerns and immediate needs, what additional services are needed. Participants may:

- Receive the Healthy Start Program which includes ongoing face-to-face education, care coordination and a family support plan

- Be closed at the Initial Assessment with or without referral to other community-based services
- Be closed at the Initial Assessment and referred back to CI&R so the family can have access to a more appropriate home visiting provider

Determining Who Needs Healthy Start Program Services:

Healthy Start workers evaluate the risk status of participants and determine whether services are required to help reduce the risk. Although some risk factors identified on the Prenatal Risk Screen and Infant Risk Screen cannot be changed with interventions (e.g., age, race), these factors serve as markers for underlying situations that can be addressed. The Prenatal and Infant Risk Factor Matrix offers possible interventions for each risk factor – see Appendix E.

Because Healthy Start resources are limited, it is up to the Healthy Start provider to determine during the Initial Assessment the participants who are at a high need and would most benefit from the Healthy Start home visiting program. Consequently, when determining who will receive Healthy Start services, the Healthy Start worker must consider many different factors. One such factor is the participant's or family's safety concerns and immediate needs as listed in but not limited to knowledge or suspicion of current:

- Domestic violence
- Sexual abuse
- Child abuse or neglect
- Substance abuse
- Diagnosed mental illness (such as severe depression episodes, bipolar disorder, personality disorder, schizophrenia, etc.)
- HIV positive status
- Hepatitis B positive status
- Inadequate growth and development (e.g. small for gestational age)
- Safety concerns noted by the health care provider on the Prenatal Risk Screen or Infant Risk Screen form
- Language barriers
- Tobacco use
- Known history of abuse (i.e. child, domestic, sexual) and/or neglect in family/household
- Lack of basic needs such as housing and food
- Lack of health care including prenatal care

- If the participants answer yes to screening question for tobacco, drug/alcohol, depression and history of mental health counseling
- Other, using professional judgment

In addition to identifying participants with safety concerns or immediate needs, Healthy Start providers must also determine the participant's assets and whether their assets (e.g., strengths and resources) are adequate to offset their risk factors.

When the assets available to the family are adequate to offset the risk identified without Healthy Start intervention, Healthy Start Program services are not required.

Assets to Offset Needs Exceed Risk = **No Healthy Start Services Needed**

When the assets available to the individual or family do not offset those risks, Healthy Start Program services are required.

Risk Exceeds Assets = **Healthy Start Services Needed**

The figure below illustrates this risk appropriate concept. In this chart, only the population falling into the gray square—that is the population whose actual risk outweighs the availability of personal assets to counter the risk—would need to be targeted for Healthy Start services.

		Individual Has Risk	
		YES	NO
Individual Has Assets to Offset Risk	NO		
	YES		

Need for Healthy Start Services

No Need for Healthy Start Services

After taking into consideration safety concerns, immediate needs, and the strengths and assets participants bring to the relationship, decisions related to which services to provide are based on professional judgment, with consideration of the following:

- Participant's motivation to address the risk and/or need
- Severity of the risk and need

- Healthy Start provider's ability to provide services that link to the participant's risk and are likely to have a positive impact on outcomes, and
- Participant's ability to access other community resources available to offset the risk/need.

It is important to remember:

- The purpose of Healthy Start service-need evaluation, face-to-face assessment, and intervention is to appropriately address participants' identified risks in conjunction with the assets and strengths they bring with them.
- Healthy Start is but one provider available to provide care coordination, home visiting and other services.
- Many times, linking families with other community agencies is an adequate and appropriate intervention.
- Discussing risk status, providing information and referral on service options, and throwing out a lifeline in the form of how families can contact you may be adequate and appropriate Healthy Start service.
- If an explicit system of prioritizing is not in place, it may result in using a first-in/first-out system that does not allow targeting of services to those most in need of intervention. Implementing services without using risk appropriate care principles may result in the exhaustion of human and financial resources.
- Situations change, and reopening families to Healthy Start services at any time is expected and appropriate if the families' circumstances and service needs warrant that change.
- Research has demonstrated that increased intensity and duration of intervention is directly related to improved outcomes, especially for those families with the highest identified levels of risk and the least availability of strengths/assets to offset the risk.
- Families may live in ways in which the Healthy Start worker may not want to live or may not want them to live, but the job of the Healthy Start worker is to use his or her judgment to determine whether the situation poses a serious threat to the safety and well-being of the family or child.

C. Family Support Planning:

During the Initial Assessment, family support planning should be initiated for all participants who will receive the Healthy Start Program (services beyond the Initial Assessment). If a participant refuses to sign a Family Support Plan (FSP), the Healthy Start worker will place the unsigned Family Support Plan in the chart and will document the refusal in addition to any other supporting information. Starting family support planning at the Initial Assessment allows the Healthy Start worker to help participants begin to set goals to reduce their identified risk factors or meet basic needs. The purpose of the Family Support Plan is to involve participants/families in activities that will reduce their identified risk factors and

therefore improve birth outcomes and their child's health. A Family Support Plan is not a plan of care. It is a participant-centered plan that helps participants and families create and live their own goals/dreams.

Note: If the participant/family will not receive the Healthy Start Program (services beyond the Initial Assessment), then a family support plan will not be initiated.

See Chapter 11, Healthy Start Care Coordination, for information on Family Support Planning and Chapter 23, Healthy Start Coding, for Family Support Plan coding guidelines.

D. Closure at the Initial Assessment:

Closure at the Initial Assessment occurs when services are declined, transitioned to another provider, no longer needed because risks are resolved, the participant is no longer eligible for services, or the participant is lost to contact.

Healthy Start services are discontinued when:

- The family and professional agree there is no need for further services
- The participant/family requests to discontinue participation
- The participant/family is receiving or going to receive services from another provider of care coordination such as Early Steps
- The participant cannot be located after three documented attempts have been made to locate

Service Delivery Activities of Initial Assessment Closure:

Initial Assessment closure activities will be documented and include the following:

- Assessment of the participant or family for unresolved need and assistance in locating a primary care provider for ongoing health care needs including family planning (e.g., up-to-date immunizations or Child Health Check Up visits)
- Completion of referrals to other service providers if continuing or additional services are needed and desired
- Notification of the participant's prenatal and/or primary service provider of the date and reason for closure
- Immediate written notification to referral source and/or Department of Children and Families if participant was referred due to substance abuse or child maltreatment concerns
- Transition to another care coordination provider with appropriate release of information and record transfer. (See Chapter 31, "Transition and Interagency Agreements.")

***Before declaring a participant lost to contact*,** at least three documented attempts to locate should be made.

Documentation

Healthy Start Initial Assessment services, or the provision of Healthy Start Initial Assessment services, must be documented in the participant's electronic record in the approved data management system within three business days of service. Healthy Start Initial Assessment documentation in the participant's electronic record must include:

- Prenatal Risk Screen, Infant Risk Screen or Referral
- Initial Assessment documentation
- Authorization for release of information, signed by the participant, or on behalf of the participant, for any information that is to be shared among payers, providers, or others
- Individualized Plan of Care
- Initiated Family Support Plan (if the participant will receive Healthy Start Program services beyond the Initial Assessment)

Coding

Services for the Healthy Start Initial Assessment should be coded in accordance with approved protocols and procedures for coding. Healthy Start Initial Assessment services require specific codes for service delivery. 3200-series and 3300-series codes should be entered into the approved data management system, by participant name, within three business days of service completion. The provider of the service should code one unit for every 15 minutes of services provided to the appropriate program component.

No group coding is allowed. This is necessary to provide for tracking, analysis, and program evaluation of client specific data.

Refer to Chapter 23, Healthy Start Coding, in the Healthy Start Standards and Guidelines for more specific information on coding, including coding for referrals and follow-ups.

Continuous Quality Improvement (CQI)

Every woman, infant, or child who is referred to Healthy Start through CI&R receives a timely Initial Assessment. The CQI process should be designed to measure and help improve the extent to which women and families receive the Healthy Start Initial Assessment, to eliminate barriers that prevent women from receiving services, and to reduce risk factors identified through the risk screen, referral, Initial Intake, and Initial Assessment.

The Healthy Start coalition should verify that the Healthy Start worker continues to meet provider qualifications and has continued their training in the home visiting programs and resources in the community.

Examples of targeted outcomes to be measured through the CQI process include:

1. Percentage of:
    a. Women/families referred to Healthy Start who receive a completed Initial Assessment.
    b. Women/families who receive a completed Initial Assessment within 30 calendar days of the CI&R Initial Intake.
    c. Women/families who receive an Initial Assessment and go on to receive Healthy Start Program services.
    d. Women/families who receive Healthy Start Program services beyond the Initial Assessment and are still participating in the program 90-day post-enrollment.
2. Increase in correct coding of 3200-series codes and relevant 3300-series codes in the approved data management system to show Healthy Start Initial Assessment services were provided to participants by qualified Healthy Start workers.
3. Adequate training opportunities for Healthy Start workers in assessment and community resources.

Periodic participant satisfaction surveys can assist Healthy Start workers to identify areas in need of service expansion or improvement. Suggested questions to include on participant satisfaction surveys include:

- Was Healthy Start beneficial?
- Was staff courteous and helpful?
- Did the participant experience any barriers to services?
- Was the participant able to get the services to which they were referred?

Record reviews by Healthy Start supervisors are completed at least quarterly to determine the effectiveness of Healthy Start. A randomly selected sample of records from all Healthy Start participants, ranging from those who have been closed to Healthy Start at the Initial Assessment to those enrolled in the Healthy Start Program, will provide necessary information for determining the effectiveness of Healthy Start. Based on the information documented in the participant's record, including but not limited to the Initial Assessment notes, consider the following key questions when conducting a record review:

- What are the basic identified risk factors of the participant selected for record review, including information from the risk screen, the Initial Intake, and the Initial Assessment?
- What are the critical risk factors documented in the record?
- What are the protective factors of the participant/family?

- What are the action steps (interventions) to address the risk factors/concerns of the participant?
- Was the intervention appropriate for the risk factors and needs of the participant?
- When needed, did the participant follow through with participation in the Healthy Start Program?
- If the participant followed through with participation in the Healthy Start Program, what critical factors contributed to the success?
- If the participant did not follow through with participation in the Healthy Start Program, what critical factor(s) or barrier(s) contributed to the failure?
- If an Initial Assessment was not completed, were the number of attempts and type of attempts to contact adequate based on risk factors and safety concerns?

Answers to these questions should be documented thoroughly. As the record reviews are conducted over time, the answers will begin to indicate the effectiveness of the Healthy Start system as well as patterns of action and behavior that may provide a great deal of information about which components or critical factors of Healthy Start have the greatest impact on outcomes.

See Chapter 30, Continuous Quality Improvement, for additional information.

Resources and References

American Academy of Pediatrics	www.aap.org
American Congress of Obstetricians and Gynecologists	www.acog.org/
CDC	www.cdc.gov/pregnancy/
Department of Children and Families	www.myflfamilies.com/service-programs/abuse-hotline/howtoreport
Early Steps	www.floridahealth.gov/programs-and-services/childrens-health/early-steps/index.html
Florida WIC	http://www.floridahealth.gov/programs-and-services/wic/
Florida's Head Start State Collaboration Office	http://floridaheadstart.org/
Healthy People 2020	www.healthypeople.gov/
March of Dimes	www.marchofdimes.org
Office of Women's Health	www.womenshealth.gov/pregnancy
Safe Haven for Newborns	https://asafehavenfornewborns.com/

U.S. Department of Health & Human Services	https://homvee.acf.hhs.gov/Default.aspx
U.S. Preventative Services Task Force	www.uspreventiveservicestaskforce.org/
Zero to Three	https://www.zerotothree.org/resources/series/home-visiting-supporting-parents-and-child-development

Frequently Asked Questions

Q. The Initial Assessment is completed face-to-face with the participant. What if the baby (the participant) is in the NICU and it is not possible to complete the Initial Assessment in the NICU?

A. This is a unique situation. When possible, the Initial Assessment should be completed in the NICU with the parent/guardian present. When it is not possible for the Healthy Start worker to go into the NICU to complete the Initial Assessment, an exception will be allowed. We know the baby in the NICU is being provided medical care and is being monitored by medical professionals. Since the code 3101 “Needs Tracking Only” has been eliminated, in this case, the Initial Assessment can be completed without seeing the baby, but it must be documented why the baby was not present. Once the baby is released from the NICU, the Healthy Start worker should complete a face-to-face visit, with the parent and baby present, as soon as the parents will allow.

All Infant Initial Assessments must be completed with a parent/guardian and the baby present except in the case described above.

Notes