**Help Me Grow Readiness Assessment / Site Profile**

<table>
<thead>
<tr>
<th>Pediatric Site Name</th>
<th>Medical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site Address</th>
<th>Unit</th>
<th>City</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What is the population served:**

- __% American Indian/Alaskan Native__
- __% Hispanic/Latino__
- __% Asian__
- __% White/Caucasian__
- __% Black/African American__
- __% Other ____________________________

**Estimated % of families served who speak the following languages:**

- __% Arabic__
- __% Farsi__
- __% Tagalog__
- __% Cantonese__
- __% Mandarin__
- __% Vietnamese__
- __% English__
- __% Spanish__
- __% Other ____________________________

**Estimated total # of patients:**

- ___________

**Estimated percent by age served:**

- __% 0-5 years old__

**Estimated % of patients 0-5 years with Special Needs:**

- __%__

**Estimated % of patients 0-5 years with Medi-Cal:**

- __%__

1. **How do you screen children in your practice for emotional, cognitive, and developmental concerns?**
   - [ ] Surveillance/observation
   - [ ] Standardized tool, please name: ________________________________
   - [ ] Checklist
   - [ ] Other, please explain: __________________________________________

2. **What do you need to participate in the HMG program?**

3. **In addition to universal screening at 18 months, which of the following would you like to implement?**
   - [ ] 9 Month ASQ-3 Screener
   - [ ] 36 Month ASQ-3 Screener
   - [ ] M-CHAT (24 month: universal or targeted (circle one)
   - [ ] ASQ: Social Emotional: universal or targeted (circle one)
   - [ ] Other(Specify) __________________________________________
   - [ ] 48 Month ASQ-3 Screener (School Readiness)
   - [ ] Maternal Depression Screener
   - [ ] Maintenance of Certification (ABP)
4. Who in your office will participate in Help Me Grow in order to integrate developmental screening? (check all that apply)

- Physicians # ______
- Nurse Practitioners/Physician Assistants # ______
- Receptionists/Front Office Staff # ______
- Medical Assistants # ______
- Nurses # ______
- Other, please specify __________________________

5. What type of training and technical assistance would you and your staff require to conduct developmental screening? (check all that apply)

- Child development training
- Monthly phone check-ins
- Incentive supplies for families
- Monthly office visits/technical assistance
- Technical assistance to address office flow
- Technical assistance to address referrals
- Other, please explain __________________________

6. How do you address identified developmental concerns in your practice?

- We give information to the parent(s) and have them call referrals/resources
- We make the referral
- Other, please explain __________________________

7. What is most challenging about obtaining needed resources and referrals for your patients?

8. What assistance would help make these referrals easier?

9. Is the practice involved in other quality improvements efforts (i.e. Asthma, immunization registry)?

10. What Electronic Medical Record (EMR) are you using or intend to use?

Name of person completing the survey

Position at the pediatric site

Phone Number | Fax Number | Email