

COUNTY				ID#					
Visit Type:	O In	itial	OF	Revis	it		Pilo	t:O	

Reason for Visit: O Neighborhood Canvass O Tenant Complaint O Referral	l (from)
Initial Visit First Attempt:	Revisit First Attempt:
Date / / / / / / / / / / / / / / / / / / /	Date / / / / / / / / / / / / / / / / / / /
O Initiated O Refused O No one home O Vacant	O Initiated O Refused O No one home O Moved O Vacant
Initial Visit Second Attempt:	Revisit Second Attempt:
Date / / / /	Date / / /
O Initiated O Refused O No one home O Vacant	O Initiated O Refused O No one home O Moved O Vacant
Initial Visit Third Attempt:	Revisit Third Attempt:
Date / / /	Date / / /
O Initiated O Refused O No one home O Vacant	O Initiated O Refused O No one home O Moved O Vacant
Surveyor: First name	Lastname
Number of asthma assessment forms included 0 0 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8	O 9 O 10
Housing information (Initial Visit Only):	
O Rent, private O Rent, public O Own O Unknown	
If rental, renter receives: O Rental Assistance O Section 8	O Unknown
Building is owner occupied? O Yes O No O Unknown	
Units in building O 1 O 2 O 3 O 4 O 5 O > 5	
Age of Building O Post-1978 O 1950-1978 O Pre-1950	O Unknown
Household Information	
Race of respondent? (choose all that apply) O White O Black or African American O American Indian	or Native American
O Asian O Other	O Unknown
Is the respondent Spanish/Hispanic/Latino? O Yes O No	O Unknown
Does respondent have high school diploma or GED? O Yes	O No O Unknown
Does anyone in the household receive food stamps or public a	ssistance? O Yes O No O Unknown



New York State Department of Health Healthy Neighborhoods Program Home Intervention Form

COUNTY				ID#					
COUNTY									

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^{*} Use your own judgment to continue with the asthma questions and intervention. Use the asthma screening questions on the Asthma Information Sheet as a guide to identify residents with asthma or asthma symptoms.



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Visit Type:	:O Ir	nitial	ı Revisi	it			l

Tobacco Control	Υ	1	N	U
Does anyone smoke in the home or is there evidence of smoking (ashtrays, smell)? (If no, skip #2-4)		0	0	0
2) Is smoking allowed in the home?	0	0	0	0
Is smoking limited to certain rooms inside the home?	0	0	0	0
4) Has anyone taken the Smoke Free Home Pledge?	0	0	0	0

Tobacco Control	(check all that apply)								
Interventions	Ref Edu Bro Prod Other Evidence								
1) Fax-to-Quit	000000								
2) Smokers' Quitline	000000								
Smoking cessation kit	000000								
4) Smoke Free Home Pledge	000000								
5) Other cessation programs	000000								

Fire Safety	Υ	I	N	U
Does residence have functional smoke detector(s) on every floor with living space?	0	0	0	0
Is a smoke detector audible from each sleeping space?	0	0	0	0
3) Is there a functional smoke detector in the common areas of multi-dwelling buildings?	0	0	0	0
4) Is there a functional fire extinguisher?	0	0	0	0
5) Do exits function properly?	0	0	0	0
6) Are there any electrical hazards?	0	0	0	0
7) Are there improperly stored flammables?	0	Ō	Ō	Ō
8) Are EDITH practiced?	0	0	0	0

Fire Safety Interventions	(check all that apply) Ref Edu Bro Prod Other Evidence
Battery for smoke detector	000000
2) Electrical cover plate	000000
Electrical fuse	000000
4) Fire Extinguisher	000000
5) Multi-outlet strip with circuit breaker	000000
6) Smoke Detector	000000
7) EDITH	000000

Lead (Pre-1978 dwellings only)	Υ	Т	N	U
1) Did tenant receive Protect Your Family From Lead in Your Home?	0	0	0	0
2) Were any renovations done recently?	0	0	0	0
Is there chipping, peeling, deteriorated, chalking paint indoors?	0	0	0	0
Is there chipping, peeling, deteriorated, chalking paint outdoors?	0	0	0	0
5) Has an elevated blood lead level been investigated by DOH at this address?	0	0	0	0

Lead	(check all that apply)								
Interventions	Ref	Edu	Bro	Prod	Other	Evidence			
1) Lead-safe cleaning	0	0	0	0	0	0			
2) Lead-safe work practices	0	0	0	0	0	0			
3) Lead-safe work training course	0	0	0	0	0	0			

Indoor Air Quality	Υ	ı	N	U
 Is there a working carbon monoxide detector? 	0	0	0	0
2) Carbon monoxide reading ppm				
Are there any malfunctioning appliances that could result in an indoor air hazard?	0	0	0	0
 Is the furnace/heat source filter dirty or missing? 	0	0	0	0
5) Is a humidifier or vaporizer used?	0	0	0	0
6) Temperature (indoor reading) °F				
7) Relative humidity (indoor reading) %				
Does every room have ventilation (windows open/bathroom ventilated)?	0	0	0	0
9) Is there a chemical smell indoors?	0	0	0	0
10) Is there an odor from scented home products?	0	0	0	0
11) Has the building been tested for radon?	0	0	0	0

Indoor Air Quality Interventions	(check all that apply) Ref Edu Bro Prod Other Evidence								
1) CO detector	000000								
2) Battery for CO detector	000000								
3) Furnace filter	000000								
4) Radon kit placed	000000								
5) Thermometer	000000								

Comments			







New York State Department of Health Healthy Neighborhoods Program Home Intervention Form

General Conditions	Υ	ı	N	U
Is there significant dust accumulation?	0	0	0	0
Is there significant clutter in the dwelling?	0	0	0	0
Is there evidence of effective housecleaning?	0	0	0	0
Is there improperly stored garbage or rubbish in the dwelling?	0	0	0	0
5) Is there improperly stored garbage or rubbish in or near the building?	0	0	0	0
6) Are there rats? (evidence or reported)	0	0	0	0
7) Are there mice? (evidence or reported)	0	0	0	0
Are there cockroaches? (evidence or reported)	0	0	0	0
Is there food/harborage for cockroaches in the dwelling?	0	0	0	0
Is there wall-to-wall carpeting or are there large rugs?	0	0	0	0
11) Are walls, ceilings, doors, floors, and stairs in good repair?	0	0	0	0
12) Are there any roofing or structural leaks?	0	0	0	0
13) Are there any plumbing leaks?	0	0	0	0
14) Is there evidence of mold/mildew? (observed or musty smell)	0	0	0	0

(observed of filasty sificil)		
Agencies/Services/Other contacts		
Environmental/residential	Refer	Evi
1) Code Enforcement	00	0
2) Cooperative Extension	0	Ŏ
3) County Lead Prevention Program (CLPP)	0	0
4) Fire department	Ŏ	000
5) Gas or utility company	Ŏ	0
6) Home Energy Assistance Program	Ŏ	0
7) Housing & Urban Development (HUD)	Ō	0
8) Landlord	Ŏ	0
9) Weatherization	0	0
Health		
Alcohol or substance abuse treatment	0	00
2) American Cancer Society	0	0
3) American Lung Association	0	0
4) Blood lead testing	0	0
5) Child Health Plus	00000	0000
6) Community health workers	0	
7) Environmental health program	000	0000
8) Family Health Plus	0	0
9) Medicaid	0	0
10) Office of the Aging	Ŏ	
11) Office of Temporary Disability Assistance	0	0
12) Primary care provider (doctor or clinic)	0	0
Food/nutrition		
1) Food pantry	000	0
2) Food Stamp Program	0	Ō
3) Voucher for meals	0	0
4) Women, Infants & Children (WIC)	0	0
Social services		
1) Adult Protective Services	Ŏ	0
2) Child Protective Services	Ŏ	0
3) Continuing education or GED	0	0
4) Domestic violence program	0	0
5) Legal Aid Society	Ŏ	Ŏ
6) Senior citizen program	0	0
Other	0	0

COUNTY				ID#						
Visit Type: Initial O Revisit										

General Conditions	(check all that apply) Ref Edu Bro Prod Other Evidence								
Interventions	nei	<u> Luu</u>	ыо	F100	Other	Evidence			
1) Cleaning/housekeeping	0	0	O	_O	O				
2) Clutter/clear exitways	0	0	0	0	0	0			
3) Garbage control (interior/exterior)	0	0	0	0	0	0			
4) Rats	0	0	0	0	0	0			
5) Mice	0	0	0	0	0	0			
6) Cockroaches	0	0	0	0	0	0			
7) Integrated Pest Management	0	0	0	0	0	0			
8) Maintenance	0	0	0	0	0	0			
9) Other pests	0	0	0	0	0	0			
10) Moisture problems	0	0	0	0	0	0			
11) Mold problems	0	0	0	0	0	0			
12) Other	0	0	0	0	0	0			

Household/Injury Prevention Products	Given	Evidence
1) Bathtub strip	0	0
2) Bike helmet	0	0
3) Cabinet lock	0	0
4) Clothes	0	0
5) First aid kit	0	0
6) Flashlight	0	0
7) Night Light	0	0
8) Sash lock or window guard	0	0
9) Shock stop	0	0
10) Toothbrush	0	0
11) Water bottle	0	0
12) Other	0	0

Comments







COUNTY		ID#							
Visit Type Initial Revisit									
○ Adult ○	Child -	<u> </u>	3 ()4 (5 ⁻ 06	07 () 8 (9 (10		

Complete this form for each adult or child with asthma or asthma symptoms.* Asthma revisits should be made 3-6 months after the last asthma visit.

Potential asthma triggers			Stat	us	1	Asthma management			Sta	tus	
1) Does anyone smoke inside the home?		ΟY	ON			Has any other household member					
Is there evidence of significant dust accumulate	ation?		O N		-	ever been told that smoking in the home affects asthma?		0	YO	N C) U
3) Are there rats? (evidence or reported)		ΟY	ON	ΟU		2) Does s/he have a primary medical care		0	ΥO	N C) U
4) Are there mice? (evidence or reported)		ΟY	ON	ΟU		provider? 3) Does s/he have health insurance?			ΥO		
5) Are there cockroaches? (evidence or reported	re there cockroaches? (evidence or reported)		ON	ΟU		4) Does s/he have medicine prescribed by a			ΥO		
6) Is there evidence of mold or mildew?		ΟY	ON	ΟU		doctor for "quick relief"? * 4a) If yes, how many times in the past week					1
7) Are there any pets with fur or feathers?		ΟY	ON	ΟU	-	did s/he take his/her "quick relief" medicin	e?				
8) If yes to pets, does s/he sleep in the same room as the pet(s) with fur or feathers?		O Y	ON	ΟU		5) Does s/he have medicine prescribed by a doctor for controlling his/her asthma? *		0	ΥO	N C) U
Asthma diagnosis and symptoms		Stat	us			5a) If yes, did s/he take the "controller"		$\overline{}$	ΥO	N C	<u> </u>
1) Has s/he ever been told by a doctor or other health professional that s/he has asthma?		ΟY	ON	ΟU		medication every day in the past week? 6) Does s/he feel that their asthma is well					
2) Number of days that s/he had asthma	in pas	t \square			1	controlled?		0	ΥO	NC) U
attacks, episodes or worsening asthma symptoms:	3 month	ıs				7) Does s/he use a peak flow meter?		0	ΥO	N C) U
	in pas	t 🗀			1	8) Does s/he have a current written asthma		0	ΥO	N C) U
professional for worsening asthma or an asthma attack:	12 month					management (or action) plan?					
Number of overnight stays in the hospital because of asthma:	in pas	t 🗀				9) Does s/he (or parent of her/him) know the early warning signs of worsening asthma?		0	ΥO	N C) U
	month					10) Does s/he know what to do if his/her asthr	na	0	ΥO	N C) U
5) Number of visits to an ER or urgent care center because of asthma:	in pas	t 🗀				gets worse? 11) Does s/he know the triggers that make					
	month				1	his/her asthma worse?		O	ΥO	NC) U
6) Number of days of daycare, school, or work missed by this asthmatic because of his/her asthma:	in pas 3 month					12) Does s/he know what to do to get rid of or avoid asthma triggers?		0	YO	N C) U
7) Number of days of school or work missed	in pas				1	Asthma education, products, and					
by other family members because of this asthmatic's asthma:	3 month	ıs				referrals provided	Give	n	Evi	der	ıce
Comments:					1	1) Verbal and written information:				_	
					1	a) About asthma b) About asthma triggers	00			0	
						c) About astima triggers	0			0	
						Hypoallergenic pillow covers	0			0	
						3) Hypoallergenic mattress covers	0			Ö	
						Blank asthma management (or action) plan form	0			0	
						5) Referral for asthma services or	0			0	
						resources 6) Referral for primary care provider	0			0	
					1	7) Referral for health insurance coverage	Ö			Ö	
						8) Other (specify in Comments)	Ŏ			ŏ	
						* For help in explaining asthma attacks, quick medicines, or written asthma management pl Information Sheet.	relief ar an, refei	nd c	ontro the A	oller Asthn	na



