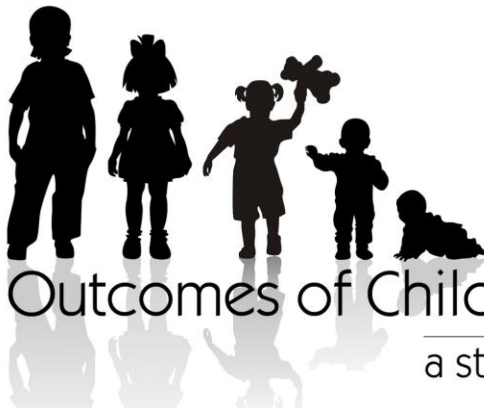

Outcomes of Children with Hearing Loss

a study of children ages birth to six

Annual Family Interview

Birth-to-Three Version

Name: ________________________ **ID:** __________________________

Male **Female** **D.O.B:** ______________________

Today's Date: _________________ **C.A:** _________________________

Current Grade: ________________ **Parent Name:**_________________

Phone Number: ____

Email Address: ____

Survey Participant: ____

A. INTRODUCTION

Hello, my name is Barb Peterson. I am trying to reach [NAME] about [CHILD]'s participation in the study *Outcomes of Children with Hearing Loss*. Is this the correct number for [NAME]?

May I speak with NAME?

I'm calling as part of the research study, *Outcomes of Children with Hearing L*oss, that your family is enrolled in. Our records indicate your last research visit was [DATE] and you are listed as someone who can answer questions about [CHILD], your family and [CHILD]'s provider services. Is that correct?

When you consented to be in the study, you were told that we would do a telephone interview once a year. Recently, a letter was mailed reminding you of the interview and letting you know that I would be calling. My questions will take about [NUMBER] minutes. Everything you say will be kept completely confidential and you may refuse to answer any question I ask you. Nothing you say will ever be reported individually about you, [CHILD] or your family. And no information you give will be shared with [CHILD]'s service providers.

Is this is a good time to talk? Can we start the interview now?

> If yes, proceed.
> If hesitates due to time, tell [NAME] you can start and call back if you need to stop before you finish.
> If no, schedule a time to call back for the interview.

We've tried to prevent this from happening, but I may ask you things that you've told others before. Please bear with me!

A.1.

1. To start, what is your relation to [CHILD]? If response is "mother" or "father", probe to be more specific.

Biological Mother	
Adoptive Mother	
Stepmother	
Foster Mother	
Sister	
Aunt	
Grandmother	
Biological Father	
Adoptive Father	
Stepfather	
Foster Father	
Brother	
Uncle	
Grandfather	
Legal Guardian	
Other (specify)________________________	
Refused	

2. Has [CHILD]'s living arrangement changed since we last talked?

Yes	
No	
Refused	

3. If yes, where does he/she live currently?

With other parent	
With another relative (specify)____________________________	
Other (specify)____	
Refused	

A.2. <u>HOUSEHOLD CHARACTERISTICS</u>
The next questions are about your household.

1. How many persons (adults and children) live in your household? ____________
   (Definition of household is persons who live in the same housing unit at least five nights a week most weeks.)

2. Have there been any changes in the people living in your household since the last time we talked? Has anyone moved away, or moved in?
   Yes No

If yes, let's talk about adults (18 years or older) first:

Name	Age	Relationship to Child	Education	Moved in- Moved away?	Hearing Loss
					Y N
					Y N

Key for adult relationships:

Biological Mother
Biological Father
Adoptive Mother
Adoptive Father
Stepmother
Stepfather
Foster Mother
Foster Father
Legal Guardian
Grandmother
Grandfather
Other Adult Relative: specify
Unrelated Adult: specify

Key to adult levels of education:

a	Completed elementary school
b	Completed junior high
c	Received General Education Diploma (high school equivalence)
d	Completed high school
e	Completed 1 or more years of technical/vocational school
f	Completed technical/vocational school
g	Completed 1 or more years of university/college
h	Bachelor's degree
i	Completed 1 or more years of graduate school
j	Master's degree
k	Course work completed for PhD, but no dissertation; Law degree without bar; Medical degree without internship completed
l	Ph.D.; Law degree with bar; Medical degree with internship completed

How about any changes involving children in the home? Please list each child (younger than age 18) in the home, his/her relationship to [CHILD], age, & grade. Have any new siblings arrived?

Name	Relationship to Child	Age	Grade	Hearing Loss
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

Key for child relationships:

Full biological brother	Step sister
Full biological sister	Foster brother
Half brother	Foster sister
Half sister	Cousin (female)
Adopted brother	Cousin (male)
Adopted sister	Other related child: specify
Step brother	Other unrelated child: specify

3. Does the mother live in the home with [CHILD]?
    ____ Yes **[SKIP TO #6]**
    ____ No
    ____ Refused

4. If mother does not live in the home with [CHILD], how much contact does he/she have with mother?

No contact	
Occasional contact (three times a month or less)	
Frequent contact(four times a month or more)	
Refused	

5. About how many days has [CHILD] spent with his/her mother in the last month? ____________
    (range 0-31)

6. Does the father live in the home with [CHILD]?
    ____ Yes **[SKIP to SECTION B]**
    ____ No
    ____ Refused

7. If father does not live in the home with [CHILD], how much contact does he/she have with father?

No contact	
Occasional contact (three times a month or less)	
Frequent contact (four times a month or more)	
Refused	

8. About how many days has [CHILD] spent with his/her father in the last month? ____________
    (range 0-31)

A.3. CHILD UPDATES

Next I would like to update some of the information we have. If anything is incorrect or has changed, please let me know.

1. Has [CHILD]'S amplification (hearing aids or FM) changed in any way since the last time you were contacted?

	Yes	No
Hearing Aid(s)		
FM System		

If yes, please describe:

2. Has [CHILD] had any major health problems, injuries, head injuries, hospitalizations or other diagnoses since the child's last appointment with us?
Yes No

If yes, please describe in detail:

3 Do you have any other concerns regarding [CHILD]'S health at this time?
Yes No

If yes, please describe in detail:

4. Since we last saw you, how has [CHILD]'s overall health been?

Excellent	
Very Good	
Good	
Fair	
Poor	

5. How long has it been since [CHILD] was last seen for a regular check-up?

_______has never been seen by a physician

_______ age at time of appointment (in months)

6. Has [CHILD] needed special medical equipment since you were last contacted?
Yes No

If yes, please describe in detail:

7. Has [CHILD] had any surgeries in the past year (including tubes)?

Surgery Type	**Reason (if appropriate)**

8. Has there been a change in [CHILD]'s health insurance?
Yes No

If yes, please describe in detail:

9. Since we last contacted you, have you or a close family member had any concerns for [CHILD]'s development in the following areas?

Domain	Y/N	What is the concern?
Motor skills/coordination		
Balance		
Play/pretending		
Activity level		
Social skills		
Sleep habits		
Ability to calm self		
Interactions with other children		
Behavior		

10. Has [CHILD] made gains or progress this year your family is especially excited about?

11. When was your child's IFSP written? ________________________ ____ Don't know
____ Child has no IFSP

12. Could you tell me why [CHILD] has no IFSP?
____ Did not qualify
____ Parent's choice to not pursue services

B. SERVICES FOR CHILDREN BIRTH-TO-THREE YEARS OLD

I'd like to talk with you about any changes that have occurred regarding the professionals who provide services to your child. For this section, we are primarily interested in the professionals who provide hearing, communication, and/or educational support services. We will ask about other professionals and therapies (such as Physical Therapy, Occupational Therapy, etc.) a little bit later.

Who are the current professionals providing services to your child? Please provide the name, profession/role, address, phone number and email address of the hearing aid specialist, audiologist, early interventionist, teacher, speech pathologist, or any other therapist focusing on hearing, communication, and/or education.

Name	Profession/Role	Address	Phone	Email

____ Child receives no services

B.1. AUDIOLOGY SERVICES

Next, I'd like to talk with you about the services your child receives. First, I'd like to learn about your child's audiology services.

1. Does [CHILD] see a professional for hearing tests?
   ____ Yes
   ____ No **[SKIP to #5]**
2. Where does [CHILD] go for hearing tests and/or hearing aid services?
   Check any that apply.

Private practice audiologist	
Speech and Hearing Center	
Hospital or Clinic	
School	
Hearing aid dealer	
Other (describe)	

3. How often does [CHILD] see the hearing professional? (Approximate # of times per year)

Once a year	
Twice a year	
Three times a year	
Every three months	
Other (specify)	
Don't know	
Refused	

4. When [CHILD] needs to see the hearing professional, how long do you usually need to wait for an appointment?

About two weeks	
Two to four weeks	
One to two months	
Appointment made in advance	
Other (specify)	

5. Does [CHILD] currently wear hearing aids?
   ____ Yes
   ____ No **[SKIP to #12]**

6. If [CHILD]'s earmolds need to be replaced, how long does the process typically take?

About two weeks	
Two to four weeks	
One to two months	
Other (specify)	

7. When [CHILD'S] hearing aids need to be repaired, how long does the process typically take?

About two weeks	
Two to four weeks	
One to two months	
No repair needed	
Other (specify)	

8. Is [CHILD] given loaner hearing aids during the repair period?
   ____ Yes
   ____ No
   ____ Loaner not needed
   ____ We have a back-up pair

9. Do you think hearing aids help [CHILD] hear better?
   ____ Yes
   ____ No
   ____ Don't know
   ____ Doesn't wear hearing aids

Please explain ____

10. What is your level of confidence in this professional's ability to effectively work with your child?

	Select One
Very Confident	
Confident	
Neutral	
Not Confident	
Very Unconfident	

11. Please rate your experiences with this professional (remind them that all information is confidential). On a scale of 1-5: 1 = I strongly disagree, 2 = I disagree, 3 = Neutral, 4= I Agree, and 5 = I strongly agree.

They have helped me:	**Rating 1-5**	**Comments:**
By being supportive when I have questions and concerns about my child's hearing loss		
Understand the audiogram		
Manage and care for the hearing aids &/or FM		
Insert earmolds properly		
Know what to expect from hearing aids &/or FM		
Anticipate how my child would respond to the hearing aids		
Know how to troubleshoot hearing aids		
Know how to encourage my child's use of hearing aids		
Strategies for hearing aid use outside of the home		

12. Does [CHILD] use a personal FM system in any of the following places?

Location	Yes	No
During therapy		
At home		
At child-care		
Preschool		
Does not have FM		
Don't know		
Refused		

B.2. COMMUNICATION

1. Our goal is for our child to learn to:
   _____ Use Spoken Language
   _____ Use Spoken Language but know some signs
   _____ Use Sign
   _____ Other (specify) ______________________________

2. What led you to choose this communication approach?

____

3. How do you typically communicate with [CHILD] at home?

COMMUNICATION TYPE	YES	NO
Spoken Language & Natural Gesture		
Spoken Language & A Few Signs		
Spoken Language & Sign Language		
10 – 50 signs		
51 – 100 signs		
More than 100 signs		
Other (specify______________________________)		

4. How do [CHILD]'s service providers/teachers communicate with her/him?

COMMUNICATION TYPE	YES	NO	Don't Know
Spoken Language & Natural Gestures			
Spoken Language & A Few Signs			
Spoken Language & Sign Language			
10 – 50 signs			
51 – 100 signs			
More than 100 signs			
Other (specify______________________________)			

5. In your opinion, are [CHILD]'s service providers/teachers skilled in the type of communication they use?
   Yes ____ No____ Don't Know____ No services ____

6. Compared to other children about the same age, how well does [CHILD] make [his/her] needs known to you? Would you say…

	Select One
doesn't communicate at all	
has a lot of trouble communicating	
has a little trouble communicating	
communicates just as well as other children	
don't know	
refused	

7. Do adults who don't know [CHILD] very well find [him/her] to be…

	Select One
very hard to understand	
somewhat hard to understand	
fairly easy to understand	
very easy to understand	
child doesn't communicate with people they don't know	
don't Know	
refused	

8. Do you have any current concerns for your [CHILD]'s communication? (describe)

B.3. HOME-BASED SERVICES

Now, let's talk about [CHILD]'s early intervention or therapy services. First we'll start with Home-Based Services.

1. Does anyone regularly come to your home to work with [CHILD] to provide early intervention or therapy services?
   ____ Yes
   ____ No **[SKIP TO SECTION B.4.]**
   ____ Don't know **[SKIP TO SECTION B.4.]**
   ____ Refused **[SKIP TO SECTION B.4.]**

2. How regularly are you, or another adult in the home able to participate in [CHILD]'s home-based sessions? This question is specifically about participation in therapy sessions (not conferences, parent meetings, etc.).
   - □ Always
   - □ Most of the time
   - □ About half the time
   - □ Some of the time
   - □ Not very often
   - □ Never

3. Do any other family members regularly participate in home-based sessions? This question is specifically about participation in therapy sessions (not conferences, parent meetings, etc.). Check all that apply:
   - □ Family members do not participate
   - □ Mother (stepmother)
   - □ Father (stepfather)
   - □ Siblings: how many are typically present? _________
   - □ Grandmother
   - □ Grandfather
   - □ Other: ____________________________________

4. After the home-based sessions, who carries out the activities planned with the professional(s) for [CHILD]?
   - □ Mother (Stepmother)
   - □ Father (Stepfather)
   - □ Mother and Father
   - □ Siblings: list number of sibs typically present ________
   - □ Grandmother
   - □ Grandfather
   - □ Family members did not receive any guidance about activities to carry out at home
   - □ Family members were not able to carry-out planned activities
   - □ Other: ___________________________________

5. When you first started Early Intervention services, what did you think the services would be like?

6. What is your impression of the purpose of these sessions **now**? NOTE: PARENT MAY SELECT MORE THAN ONE
   - □ provide the family with information regarding [CHILD's] hearing loss
   - □ provide support to your family
   - □ provide services to develop [CHILD's] communication
   - □ demonstrate activities that support [CHILD's] overall development

7. How many people regularly provide home-based therapy services? NOTE: THIS INCLUDES SERVICES THAT HAVE JUST STARTED IF THEY ARE PLANNED TO BE REGULAR.

   Number of Providers: ___ Don't know ___ Refused ___

8. How often do the providers come to the home to work with you and [CHILD]? If >1, say, “Let’s start with the one who comes most often.”

Provider 1 (Name):________________________________ Profession: (choose one) ____ Teacher of Deaf & Hard of Hearing ____ Speech-Language Pathologist ____ Early Childhood Educator (Early Interventionist) ____ Special Education Teacher ____ Physical Therapist ____ Occupational Therapist ____ Other: _____________________________________ ____ Don’t know	Total Minutes/Month (interviewer calculates based on responses to left)
Two times a week for: _____ min each session	
One time a week for: _____ min each session	
Three times a month for:____ min each session	
Two times a month for: ____ min each session	
One time a month for: _____ min each session	
Less than one time a month: (ask parent to describe)	
Consultation only: (ask parent to describe frequency)	
In an average month, how often were visits missed? Approximately _________ sessions per month (number)	
Other/Comments:	

<table>
<tr><td>Provider 2 (Name):________________________________

Profession: (choose one)
____ Teacher of Deaf & Hard of Hearing
____ Speech-Language Pathologist
____ Early Childhood Educator (Early Interventionist)
____ Special Education Teacher
____ Physical Therapist
____ Occupational Therapist
____ Other: ______________________________________
____ Don't know</td><td>Total Minutes/Month (interviewer calculates based on responses to left)</td></tr>
<tr><td>Two times a week for: ______ min each session</td><td></td></tr>
<tr><td>One time a week for: ______ min each session</td><td></td></tr>
<tr><td>Three times a month for:_____ min each session</td><td></td></tr>
<tr><td>Two times a month for: _____ min each session</td><td></td></tr>
<tr><td>One time a month for: ______ min each session</td><td></td></tr>
<tr><td>Less than one time a month: (ask parent to describe):</td><td></td></tr>
<tr><td>Consultation only: (ask parent to describe frequency):</td><td></td></tr>
<tr><td colspan="2">In an average month, how often were visits missed?
Approximately _________ sessions per month
(number)</td></tr>
<tr><td colspan="2">Other/Comments:</td></tr>
</table>

9. I want to ask about why services were missed. I will read a list of possible reasons and ask you to indicate the two main reasons. Which of the following caused [CHILD] to miss services? (INTERVIEWER: PROBE FOR 1ST AND 2ND MOST COMMON REASON)

____ No services were missed
____ Don't know

Reason	**Most Common**	**2nd Most Common**
Reasons related to the child (e.g., child was sick)		
Reasons related to the family (e.g., transportation, parent forgot about appointment)		
Reasons related to the professional (e.g., provider illness, staff not available)		

10. In your own words, describe what typically happens on a home visit. How do you and the provider work together? NOTE: IF PARENT IS DESCRIBING ACTIVITIES OF MORE THAN ONE PROVIDER, PLEASE BE SURE TO SPECIFY WHICH ACTIVITIES ARE RELATED TO EACH SPECIFIC SERVICE PROVIDER.

11. Does the time the professional comes work well for your family's schedule?
    ____ Yes
    ____ No
    Comments: ____

12. Did the home-based services [CHILD] received meet your expectations? (In other words, did the child make the progress expected?)

	Select One
Did not meet my expectations	
Did in some ways, but not others	
Neutral	
Met my expectations	
Exceeded my expectations	
Don't know	
Refused	

Comments: ____

13. How much effect have home-based services had on [CHILD]'s development? Would you say that home-based services have had...

	Select One
A very negative effect	
Some negative effect	
No effect	
Some positive effect	
A very positive effect	
Too soon to tell	
Don't know	
Refused	

Comments: ____

14. What do you value most about the Home-based Services?

____

15. Is there anything you want to change about Home-based Services?

____

B.4. COMMUNICATION/THERAPY SERVICES OUTSIDE THE HOME

1. Does [CHILD] receive communication/therapy services outside of the home?
   No ___ **[PLEASE HAVE PARENT EXPLAIN WHY NOT AND SKIP to SECTION C.1.]**

   ____

   ____ Yes
   ____ Don't know **[SKIP to SECTION C.1.]**
   ____ Refused **[SKIP to SECTION C.1.]**

2. If any services are provided outside the home, are they provided in:

SETTING	Yes	If Yes, go to section:	No	Check the **ONE** setting where your child receives most of his/her services
Specialized center-based services for children with hearing loss	□	**B.5.**	□	□
Center for children with exceptional needs	□	**B.5.**	□	□
Typical preschool setting	□	**B.6.**	□	□
Nursery school or daycare center	□	**B.6.**	□	□
Daycare in someone else's home	□	**B.6.**	□	□
Therapist's clinic or office	□	**B.6.**	□	□
Hospital clinic	□	**B.6.**	□	□
After-school program	□	**B.6.**	□	□
Other (specify)______________________	□	**B.6.**	□	□

B.5. CENTER-BASED SERVICES FOR CHILDREN WITH HEARING LOSS OR SPECIAL NEEDS

Now I want to ask you about special programs [CHILD] attends that are primarily for children with hearing loss or other special needs.

NOTE: IF RESPONDENT SAYS THE CHILD RECEIVES SERVICES IN A CHILDCARE (I.E. DAY CARE, CHURCH, PRESCHOOL, ETC, SAY, "We have questions about that later."

1. How often do the providers work with [CHILD]? If >1, say, "Let's start with the one who sees [CHILD] most often."

Provider 1 (Name):____________________________ Profession: (choose one) ____ Teacher of Deaf & Hard of Hearing ____ Speech-Language Pathologist ____ Early Childhood Educator (Early Interventionist) ____ Special Education Teacher ____ Physical Therapist ____ Occupational Therapist ____ Other: ______________________ ____ Don't know	Total Minutes/Month (interviewer calculates based on responses to left)
Two times a week for: ______ min each session	
One time a week for: ______ min each session	
Three times a month for:_____ min each session	
Two times a month for: _____ min each session	
One time a month for: ______ min each session	
Less than one time a month: (ask parent to describe)	
Consultation only: (ask parent to describe frequency)	
In an average month, how often were visits missed? Approximately _________ sessions per month (number)	
Other/Comments:	

Provider 2 (Name):____________________________ Profession: (choose one) ____ Teacher of Deaf & Hard of Hearing ____ Speech-Language Pathologist ____ Early Childhood Educator (Early Interventionist) ____ Special Education Teacher ____ Physical Therapist ____ Occupational Therapist ____ Other: ______________________ ____ Don't know	Total Minutes/Month (interviewer calculates based on responses to left)
Two times a week for: _____ min each session	
One time a week for: _____ min each session	
Three times a month for:____ min each session	
Two times a month for: ____ min each session	
One time a month for: _____ min each session	
Less than one time a month: (ask parent to describe):	
Consultation only: (ask parent to describe frequency):	
In an average month, how often were visits missed? Approximately _________ sessions per month (number)	
Other/Comments:	

2. I want to ask about why services were missed. I will read a list of possible reasons and ask you to indicate the two main reasons. Which of the following caused [CHILD] to miss services? (INTERVIEWER: PROBE FOR 1ST AND 2ND MOST COMMON REASON)

    ____ No services were missed
    ____ Don't know

Reason	**Most Common**	**2nd Most Common**
Reasons related to the child (e.g., child was sick)		
Reasons related to the family (e.g., transportation, parent forgot about appointment)		
Reasons related to the professional (e.g., provider illness, staff not available)		

3. How regularly are you able to participate in [CHILD]'s center-based therapy sessions? INTERVIEWER: This question is specifically about participation in therapy sessions (not conferences, parent meetings, etc.)
   - □ Always
   - □ Most of the time
   - □ About half the time
   - □ Some of the time
   - □ Not very often
   - □ Never

4. Do any other family members regularly participate in center-based therapy sessions? INTERVIEWER: This question is specifically about participation in therapy sessions (not conferences, parent meetings, etc.) Check all that apply:
   - □ Family members do not participate
   - □ Mother (Stepmother)
   - □ Father (Stepfather)
   - □ Siblings: how many are typically present? ________
   - □ Grandmother
   - □ Grandfather
   - □ Other: ___________________________________

5. After the center-based session, who carries out the activities planned with the professional(s) for [CHILD] at home?
   - □ Mother (Stepmother)
   - □ Father (Stepfather)
   - □ Mother and Father
   - □ Siblings: list number of sibs typically present ________
   - □ Grandmother
   - □ Grandfather
   - □ Family members did not receive any guidance regarding activities to carry-out at home
   - □ Family members were not able to carry-out planned activities
   - □ Other: ___________________________________

6. Does [CHILD] receive services individually or in a group setting?
   - □ Individual
   - □ Group
   - □ Individual and Group

7. How many of the children [CHILD] plays with or receives services with at the program(s) or center(s), have a **hearing loss**? Is it...

	Select One
none of them	
some of them (half or fewer)	
most of them (more than half)	
all of them	
not with other children	
don't know	
refused	

8. Do any of the children [CHILD] plays with or receives services with at the program(s) or center(s), have special needs **other than** hearing loss? Is it...

	Select One
none of them	
some of them (half or more)	
most of them (more than half)	
all of them	
not with other children	
don't know	
refused	

9. How many of the children are **typically developing** children with no hearing loss?

	Select One
None of them	
Some of them (half or more)	
Most of them (more than half)	
All of them	
Not with Other Children	
Don't Know	
Refused	

10. Did the center-based services you received for [CHILD] meet your expectations? (In other words, did the child make the progress you expected?)

	Select One
Did not meet my expectations	
Did in some ways, but not others	
Neutral	
Met my expectations	
Exceeded my expectations	
Don't know	
Refused	

Comments: ____

11. How much effect has center-based services had on [CHILD's] development? Would you say that center-based services have had...

	Select One
a very negative effect	
some negative effect	
no effect	
some positive effect	
a very positive effect	
too soon to tell	
don't know	
refused	

Comments: ____

12. What is your impression of the purpose of these sessions? NOTE: PARENT MAY SELECT MORE THAN ONE
    - □ Provide the family with information regarding [CHILD's] hearing loss
    - □ Provide support to your family
    - □ Provide services to develop [CHILD's] communication
    - □ Demonstrate activities that support [CHILD's] overall development

13. What do you value most about Center-based services?

    ____

14. Is there anything you want to change about Center-based services?

    ____

B.6. COMMUNICATION/THERAPY SERVICES AT OTHER SITES

1. Please describe the setting where services are provided: ______________________________

2. How often do the providers work with [CHILD]? If more than 1 say, "Let's start with the one who sees [CHILD] most often."

Provider 1 (Name):_________________________ Profession: (choose one) ____ Teacher of Deaf & Hard of Hearing ____ Speech-Language Pathologist ____ Early Childhood Educator (Early Interventionist) ____ Special Education Teacher ____ Other: ______________________ ____ Don't know	Total Minutes/Month (interviewer calculates based on responses to left)
Two times a week for: _____ min each session	
One time a week for: _____ min each session	
Three times a month for:____ min each session	
Two times a month for: ____ min each session	
One time a month for: _____ min each session	
Less than one time a month: (ask parent to describe)	
Consultation only: (ask parent to describe frequency)	
In an average month, how often were visits missed? Approximately _________ sessions per month (number)	
Other/Comments:	

Provider 2 (Name):___________________________ Profession: (choose one) ____ Teacher of Deaf & Hard of Hearing ____ Speech-Language Pathologist ____ Early Childhood Educator (Early Interventionist) ____ Special Education Teacher ____ Other: ______________________ ____ Don't know	Total Minutes/Month (interviewer calculates based on responses to left)
Two times a week for: _____ min each session	
One time a week for: _____ min each session	
Three times a month for:____ min each session	
Two times a month for: ____ min each session	
One time a month for: _____ min each session	
Less than one time a month: (ask parent to describe):	
Consultation only: (ask parent to describe frequency):	
In an average month, how often were visits missed? Approximately _________ sessions per month (number)	
Other/Comments:	

3. I want to ask about why services were missed. I will read a list of possible reasons and ask you to indicate the two main reasons. Which of the following caused [CHILD] to miss services? (INTERVIEWER: PROBE FOR 1ST AND 2ND MOST COMMON REASON)
   ____ No services were missed
   ____ Don't know

Reason	**Most Common**	**2nd Most Common**
Reasons related to the child (e.g., child was sick)		
Reasons related to the family (e.g., transportation, parent forgot about appointment)		
Reasons related to the professional (e.g., provider illness, staff not available)		

4. How regularly are you able to participate in [CHILD]'s therapy sessions? INTERVIEWER: This question is specifically about participation in therapy sessions (not conferences, parent meetings, etc.)
   - □ Always
   - □ Most of the time
   - □ About half the time
   - □ Some of the time
   - □ Not very often
   - □ Never

5. Do any other family members regularly participate in therapy sessions? INTERVIEWER: This question is specifically about participation in therapy sessions (not conferences, parent meetings, etc.) Check all that apply:
   - □ Family members do not participate
   - □ Mother (Stepmother)
   - □ Father (Stepfather)
   - □ Siblings: how many are typically present? _________
   - □ Grandmother
   - □ Grandfather
   - □ Other: ____________________________________

6. After the therapy session, who carries out the activities planned with the professional(s) for [CHILD] at home?
   - □ Mother (Stepmother)
   - □ Father (Stepfather)
   - □ Mother and Father
   - □ Siblings: list number of sibs typically present _________
   - □ Grandmother
   - □ Grandfather
   - □ Family members did not receive any guidance regarding activities to carry-out at home
   - □ Family members were not able to carry-out planned activities
   - □ Other: ____________________________________

7. Does [CHILD] receive services individually or in a group setting?
   - □ Individual
   - □ Group
   - □ Individual and Group

8. How many of the children [CHILD] plays with or receives services with at this setting have a **hearing loss**? Is it...

	Select One
none of them	
some of them (half or fewer than half)	
most of them (more than half)	
all of them	
not with other children	
don't know	
Refused	

9.. Do any of the children [CHILD] plays with or receives services with at this setting, have special needs **other than** hearing loss? Is it...

	Select One
none of them	
some of them (half or more than half)	
most of them (more than half)	
all of them	
not with other children	
don't know	
refused	

10. How many of the children [CHILD] plays with at the program are **typically developing** children with no hearing loss?

	Select One
None of them	
Some of them (half or fewer than half)	
Most of them (more than half)	
All of them	
Not with Other Children	
Don't Know	
Refused	

11. Did the services you received for [CHILD] at this setting meet your expectations? (In other words, did the child make the progress you expected?)

	Select One
Did not meet my expectations	
Did in some ways, but not others	
Neutral	
Met my expectations	
Exceeded my expectations	
Don't know	
Refused	

Comments: ____

12. How great an effect have services at this setting had on [CHILD's] development? Would you say that the services have had...

	Select One
a very negative effect	
some negative effect	
no effect	
some positive effect	
a very positive effect	
too soon to tell	
don't know	
refused	

Comments: ____

13. What is your impression of the purpose of these sessions? NOTE: PARENT MAY SELECT MORE THAN ONE
    - □ Provide the family with information regarding [CHILD's] hearing loss
    - □ Provide support to your family
    - □ Provide services to develop [CHILD's] communication
    - □ Demonstrate activities that support [CHILD's] overall development

14. What do you value most about the services at this setting?

    ____

15. Is there anything you want to change about services at this setting?

    ____

16. Would you say the amount of *summer* therapy services is...

	Select One
less than the amount he/she receives during the regular school year.	
the same amount that he/she receives during the regular school year.	
more than the amount he/she receives during the regular school year.	
no summer services	
don't know	
refused	

17. Who decided on the amount of summer therapy?

	Select One
service provider	
parents	
service provider and parents	
other (please specify) ____	
refused	

18. Would you say the *quality* of summer therapy services is...

	Select One
less than the services he/she receives during the regular school year.	
equal to the services he/she receives during the regular school year.	
better than the services he/she receives during the regular school year.	
don't know	
refused	

C.1. RATINGS ABOUT ALL THE SERVICES MY CHILD RECEIVES

I'd like to ask your family's experiences with service providers. As a reminder, everything you say will be kept completely confidential and you may refuse to answer any question I ask. No information you give will be shared with [CHILD]'s service providers now or in the future.

1. Please think about the person who works most often on communication development. What is this person's profession/role (example: a speech pathologist, teacher of the deaf, etc.)?

   Profession/role: ____

2. For each statement I read, please tell whether you strongly agree, agree, neutral, disagree, or strongly disagree. READ FIRST STATEMENT. Do you “1” strongly disagree, “2” disagree, “3” Neutral, “4” agree, or “5” strongly agree that this sounds like you? INTERVIEWER: DON’T disclose that there is a “don’t know” or “refused” option, but mark it accordingly if it is a response.

The professional...	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5	Don’t Know 6	Refused 7
respects the values and cultural background of my family.							
that provides services to my family values my opinions.							
helps me feel optimistic and hopeful about [CHILD]’S future.							

3. How have the services and information affected your family? Do you think your family is ... READ CATEGORIES. CODE ONE CATEGORY.

	Select One
worse off	
about the same	
somewhat better off	
much better off than you would have been without it	
too soon to tell	
don’t know	
refused	

4. If the professional has given you recommendations or advice about [CHILD] would you say you have used that advice ... READ CATEGORIES. CODE ONE CATEGORY.

	Select One
not applicable, has gotten no advice	**SKIP to # 6**
never	
hardly ever	
some of the time	
most of the time	
all of the time	**SKIP to # 6**
don’t know	**SKIP to # 6**
refused	**SKIP to # 6**

5. You commented that _____ of the time you follow the professional's advice. Can you comment on why you chose not to? **DO NOT** READ CATEGORIES. CODE ALL THAT APPLY.

		Comments
Didn't understand what to do		
Too hard to do what he/she said		
Didn't agree with what he/she said		
Could not afford to do what he/she said		
Got conflicting advice from different people		
Other family member did not approve		
Did not fit in to family routines (I don't have enough time)		
Other (specify): ________________________		
Don't know		
REFUSED		
Already doing it		
Did not need it		
Advice was not appropriate		
Advice did not work		
Forgot advice		
Prefers own ideas		

6. Would you say that overall the professional, who works with you and [CHILD]… (On a scale of 1-5: 1 = I strongly disagree, 2 = I disagree, 3 = Neutral, 4= I Agree, and 5 = I strongly agree)

The Professional...	**Rating 1-5**	**Comments**
is knowledgeable and professional		
demonstrates good interpersonal skills with my family and child		
is available to talk with me on a regular basis		
is easy for me to talk to about my child and family		
is able to answer my questions about my child and his/her needs		
provides me with written information that is easy to understand		
keeps scheduled appointments		
provides a healthy, informative, and supportive parent guidance program		

7. Now think about all of the professionals that provided services in the last year. The following questions ask you to rate the helpfulness of specific aspects of [CHILD's] services. You may not have needed assistance in a number of these areas. Please let me know when this is the case. For the other items please rate the helpfulness on a scale of 1-5: 1 = never helpful, 2 = sometimes helpful, 3 = helpful half of the time, 4 = usually helpful, 5 = always helpful. (INTERVIEWER: NN = DID NOT NEED assistance in this area).

In the *Past Year* Professionals Have Helped Me...	**Helpfulness Rating (1–5)**	**NN**	**Comments**
by being supportive when I have questions and concerns about my child's hearing loss			
understand how hearing loss can affect my child's communication development			
understand how hearing loss can affect my child's academic development			
understand how hearing loss can affect my child's social development			
by providing unbiased information about the communication options for children with hearing loss			
understand the audiogram			
learn to manage my child's amplification			
learn to provide listening opportunities throughout the day for my child			
incorporate language learning activities into daily routines			
incorporate early literacy/reading skills at home)			
have realistic timelines for communication development			
manage my child's behavior			
meet other parents who have children with hearing loss			
learn to advocate for my child in meetings			
understand the roles and responsibilities of various agencies			
understand the IFSP process			
know about the legal rights of children with hearing loss like my child's			

8. Who decided on the **kinds** of services for your child? Was it...

mostly your family	
mostly the professionals	
you and the professionals together	
don't Know	
refused	

9. Who decided on the **amount** of services for [CHILD]? Was it...

mostly your family	
mostly the professionals	
you and the professionals together	
don't know	
refused	

10. How would you rate the amount of intervention services your child is getting? Would you say it is...

more than needed	
about the right amount	
less than needed	
enough of some, but not others (please comment below)	
don't know	
refused	

Comments: ____

11. How do you feel about the decisions that were made?

I felt very good about the decisions that were made	
I felt some of the decisions were good	
I 'm not sure	
I did not like the decisions that were made	
I was very unhappy about the decisions that were made	

12. How did you feel about your involvement in the decisions about your child's services? Do you feel you…

wanted to be more involved	
were involved about the right amount	
wanted to be less involved	
don't Know	
refused	

13. Are there services or therapies you think your child needs, but is not getting?
- ☐ Yes (please specify: ____)
- ☐ No
- ☐ Don't Know
- ☐ Refused

D.1. OTHER SERVICES

1. Does your child receive any additional services? (For example: Physical Tx, Occupational Tx, Sensory Integration Tx, etc.)
   - ____ Yes
   - ____ No **[SKIP TO SECTION E.1]**
   - ____ Don't know **[SKIP TO SECTION E.1]**
   - ____ Refused **[SKIP TO SECTION E.1]**

2. What additional services does [CHILD] currently receive and how often are sessions scheduled per month?

Therapy Type	**Frequency**	**How long is an average session (minutes)**	**Where**
	____ sessions per month *or* ◻ seen less than monthly		
	____ sessions per month *or* ◻ seen less than monthly		
	____ sessions per month *or* ◻ seen less than monthly		
	____ sessions per month *or* ◻ seen less than monthly		
	____ sessions per month *or* ◻ seen less than monthly		
	____ sessions per month *or* ◻ seen less than monthly		

E. CHILD-CARE, DAY-CARE, OTHER PROGRAMS

E.1. CHILD-CARE/DAY-CARE

1. At this time, is [CHILD] being regularly cared for by someone other than a parent or guardian? By regular, we mean for more than 10 hours a week. This includes child-care while a parent or guardian works or goes to school.
   ____ Yes
   ____ No **[SKIP TO SECTION E.2]**
   ____ Don't know **[SKIP TO SECTION E.2]**
   ____ Refused **[SKIP TO SECTION E.2]**

2. When [CHILD] is in child-care, where is that generally provided? NOTE: MORE THAN ONE MAY APPLY

[CHILD'S] home	
Someone else's home	
A child-care center	
Other, Specify	
Don't Know	
Refused	

3. How many different child-care arrangements has [he/she] been in this past year?

   Number ___________ (RANGE = 1-6)

4. How many total hours per week is [CHILD] in some type of child-care?

   Number of hours per week _______________ (Range 1 – 100)

5. Overall, how hard was it for you to find (an) appropriate child-care arrangement for [CHILD] given his/her hearing loss?

	Select One
Very difficult,	
Somewhat difficult	
Not at all difficult?	
Don't Know	
Refused	

If it was difficult, what were the challenges?

____

6. How many adults are providing care for [CHILD] when [he/she] is in the primary child-care setting?
   Number of adults _______________ (Range 0 – 20)
   ____ Don't know
   ____ Refused

7. How many other children is [CHILD] usually with when [he/she] is in the primary child-care setting?
   Number of children _______________ (Range 0 – 80)
   ____ Don't know
   ____ Refused

8. Do any other children in the child-care setting have hearing loss?
   ____ Yes How Many? _______
   ____ No
   ____ Don't Know

9. Does [CHILD] wear hearing aids in the child-care setting? **[If NO, skip to #14]**
   ____ Yes
   ____ No
   ____ Don't know
   ____ Refused

10. Does [CHILD] use an FM system in the child-care setting?
   ____ Yes
   ____ No
   ____ Don't know
   ____ Refused

11. How comfortable are the child-care providers in caring for, checking & using [CHILD]'s amplification?

   Rate 1-5 with 1 low comfort; 5 very comfortable/experienced __________ (Hearing Aids)
   Rate 1-5 with 1 low comfort; 5 very comfortable/experienced __________ (FM system)

12. What happens if [CHILD]'s hearing aid(s) comes out at child-care? How do providers tend to respond?

	Select One
Replace the hearing aids	
Put them in a safe place	
I don't know	
Other (specify)	

13. How did your child-care providers learn hearing aid skills?

	Select One
Child-care providers do NOT have hearing aid skills	
From me (the parent)	
From [CHILD]'s audiologist	
From [CHILD]'s early interventionist	
Parent and service provider	
They knew before my child arrived	
I don't know	
Other (specify)	

14. Overall, how satisfied are you with the ability of [CHILD]'s child-care arrangements to meet [his/her] needs related to hearing loss? Would you say you are generally...

	Select One
very dissatisfied	
somewhat dissatisfied	
somewhat satisfied	
very satisfied	
mixed	
don't Know	
refused	

15. Thinking about [CHILD]'s early intervention goals, describe how goals are worked on at the child-care center?

	Select One
Goals are NOT worked on at the child-care center **(SKIP to E.2.)**	
Different people work with my child depending on who is available	
The same person always works with my child	
Not sure	
Refused **[SKIP to E.2.]**	

16. How would you describe the area in the child-care center where the staff works with [CHILD] on his/her goals?

	Select One
The location/room varies	
In a room with other children	
In a quiet room/setting	
Not sure	
Refused	

E.2. OTHER ACTIVITIES

1. Are there any other children's group activities that [CHILD] goes to at least once a month, such as story hours, play groups, gym programs, or other preschool programs?

PROGRAM	Check if Yes	How Often?	# of other children with hearing loss participating
Play Group			
"Mommy and Me"			
Park/Rec Play Time			
Story Hour (e.g. at Library)			
Sunday School/Church Child-care			
Lessons(e.g., Swimming, Gymboree, Art)			
Preschool			
Nursery School			
Other (specify______________________________)			
Don't Know			
Refused			

F.1. BEHAVIOR

Next I would like ask you some questions about your [CHILD]'s disposition.

1. Would you say that [CHILD]…

	Select One
has a lot of trouble playing with other children	
has a little trouble playing with other children	
has no trouble playing with other children	
is rarely around other children	
not age appropriate	
don't Know	
refused	

2. How easy is it for you to get a babysitter to take care of [CHILD]? Would you say it is… NOTE: IF RESPONDENT SAYS THEY DON'T USE /HAVEN'T YET USED A BABYSITTER SAY "If you suddenly needed one, how easy would it be to get one?"

	Select One
very hard	
somewhat hard	
fairly easy	
very easy	
don't Know	
refused	

3. Compared to other children [his/her] age, how easy is it to take [CHILD] with you when you go to the store or to an appointment. Would you say [he/she] is…

	Select One
much harder to take places	
a little harder to take places	
just as easy to take places	
easier to take than other children	
don't Know	
refused	

4. Would you say [CHILD]…

	Select One
often has temper tantrums	
sometimes has temper tantrums	
rarely has temper tantrums	
don't Know	
refused	

5. Does [CHILD]'s behavior affect progress in his/her therapies? Would you say [CHILD]'s behavior:..

	Select One
negatively affects progress in therapy	
does not affect progress in therapy	
positively affects progress in therapy	
don't Know	
refused	

6. If your family has a change in plans, how easy/difficult is that to explain to [CHILD]?

	Select One
Explaining a change is always really difficult	
Explaining a change is sometimes difficult	
Explaining a change is sometimes difficult & sometimes not	
Explaining a change is rarely difficult	
Explaining a change is never difficult	
Not age appropriate	
Don't Know	
Refused	

G.1. PARENT GROUPS

1. Do you and/or other family members attend any type of support group with other parents who have children with hearing loss?
   _____ Yes
   _____ No
   _____ Don't know**]**
   _____ Refused

2. If yes, how often?

Frequency	Select One
Twice a month	
Once a month	
Three-four times per year	
Other	
Refused	

3. Has being in the parent group been helpful to you or your family?

   Yes No

4. Would you share with me why it has/has not been helpful?

5. Do you use any sources of online support (list serves, Facebook, MySpace, etc)?

   Yes No

6. If so, can you tell me which online support sources you use?

   ____

   ____

7. How often do you read aloud to your child?

   _____ Seldom

   _____ Less than once a week

   _____ 1 – 2 times per week

   _____ 3 – 4 times per week

   _____ Every day

   _____ Several times per day