OUTCOMES FOR CHILDREN WITH HEARING LOSS LONGITUDINAL STUDY

~ SERVICES & PROVIDER SURVEY (SPS) ~
Birth to 3 Years

SERVICES & PROVIDER SURVEY (SPS)

I choose to: ☐ complete the survey ☐ not complete the survey

Identifying Information

Enter the data entry code: ______________________________ Today's Date: ______________________

First name of professional completing form: ____

Last name of professional completing form: ____

Professional's phone number: ____

Professional's email address: ____

Agency name: ____

Agency address: ____

____

This program is: ☐ Public ☐ Private ☐ Other ☐ Prefer not to answer

1. Is the child currently enrolled in early intervention services?

☐ Yes
☐ No
☐ Unknown
☐ Prefer not to answer

If no...

2. What was the approximate date of the child's or family's last early intervention service? ____________________

3. What was the main reason for leaving early intervention? (check all that apply)

☐ Family moved away. Please indicate any available new location information for the family below.
☐ Family discontinued service (e.g. no longer interested). Please give reason below.
☐ Child changed household or custody (e.g. changed foster family). Please give new address below if you have it.
☐ Family had transportation barriers
☐ Repeated attempts to contact family were unsuccessful
☐ Child was no longer eligible for service
☐ Child is deceased
☐ Don't know
☐ Prefer not to answer
☐ Other (please specify below)

____

____

____

4. If you selected that the child is no longer eligible for service, please indicate why:

   ☐ Based on assessment results
   ☐ Based on attainment of goals
   ☐ Due to both assessment results and attainment of goals
   ☐ Prefer not to answer

5. About how long did it take after hearing loss was suspected or diagnosed for early intervention services to begin?

   ________ months

6. How would you best describe this child's environment, Monday through Friday? (please choose all that apply)

	Full Time	**Part Time**	**Prefer not to answer**
At home with parent	☐	☐	☐
In the home of a family member (other than the parent)	☐	☐	☐
Public/Regular (school district) preschool setting	☐	☐	☐
Private preschool setting	☐	☐	☐
Center-based preschool for deaf or hard of hearing children	☐	☐	☐
Center-based preschool program (multi-categorical/special education)	☐	☐	☐
Daycare	☐	☐	☐
Another setting (please specify) _______________________	☐	☐	☐

Services Provided

7. You have been identified as the professional who sees this child most frequently in relation to their hearing loss and the IFSP. From the following list, in the first column please select the profession that best describes yours. In the second column please identify other professionals who provide services to this child/family.

Check appropriate boxes to indicate which providers are serving the child and indicate if they serve in a primary role or a support role.	**Your Profession (check only one)**	**Other Professionals (check all that apply)**	**Prefer not to answer**
Early intervention specialist	☐	☐	☐
Early childhood special education teacher	☐	☐	☐
Speech language pathologist	☐	☐	☐
Teacher of the deaf and hard of hearing	☐	☐	☐
Certified auditory-verbal therapist	☐	☐	☐
Audiologist	☐	☐	☐
Family counselor	☐	☐	☐
Genetic counselor	☐	☐	☐
Occupational therapist	☐	☐	☐
Ophthalmologist	☐	☐	☐
ENT physician	☐	☐	☐
Physical Therapist	☐	☐	☐
Service Coordinator	☐	☐	☐
Social Worker	☐	☐	☐
Other (please specify)______________________________	☐	☐	☐

8. Please identify the location(s) where this child received early intervention services. Check the location where services were received most frequently and second most frequently. (check no more than two)

	Most frequent location	**Second most frequent location**	**Prefer not to answer**
In the home	☐	☐	☐
Home of a care provider (what was relationship, if any, to child)	☐	☐	☐
Regular daycare environment	☐	☐	☐
Private preschool setting	☐	☐	☐
Specialized center-based early intervention program (multi-categorical)	☐	☐	☐
Clinic or office (therapist's office)	☐	☐	☐
Specialized center-based preschool for the deaf or hard-of-hearing children	☐	☐	☐
Another setting (e.g. extended family or neighbor's home) (please specify) ________________________________	☐	☐	☐

9. In your opinion, was the location in which services were most frequently provided conducive for implementing intervention goals?

- Good
- Fair
- Poor
- Prefer not to answer

10. If the setting was rated as poor or fair, what factors contributed to this rating?

- Noisy
- Visually distracting
- Frequent interruptions
- Other (please specify) ____
- Prefer not to answer

11. Please identify all of the services the child has received in the past 6 month time period as a part of his/her early intervention program. (check all that apply)

- None
- Amplification and/or Assistive devices
- FM
- Hearing Aids
  - binaural
  - monaural
  - bone conduction
- Loaner hearing aid(s)
  - binaural
  - monaural
- Consultation to daycare providers
- Family-to-family support/parent group
- Translation (interpreter services)
  - Sign Language
  - Foreign Language
- Sign language instruction
- Ancillary private therapies (i.e., AVT or speech therapy) ________ times/week
- Sensory integration therapy
- Transportation
- Other (please specify) ____
- Prefer not to answer

Service Frequency, Participation and Location

12. In an average month, how frequently and for what amount of time did you provide services for this child/family?
Example: Two times a month for 30 minutes per session.

___________ times per month for ___________ minutes per session

13. In an average month, how often were visits missed?

Approximately ___________ sessions per month
(number)

14. Which of the following caused this child to miss services? Please select the most common reason and the second most common reason.

Reason	Most Common	Second Most Common	Prefer not to answer
No services were missed	☐	☐	☐
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 service provider (e.g. provider illness, staff not available)	☐	☐	☐
Don't Know	☐	☐	☐

15. Which family members participate in at least one-half of the sessions?

	Yes	No	Prefer not to answer
Mother (stepmother)	☐	☐	☐
Father (stepfather)	☐	☐	☐
Siblings: list number of sibs typically present ________________	☐	☐	☐
Grandmother	☐	☐	☐
Grandfather	☐	☐	☐
Other relative	☐	☐	☐
Family members do not participate	☐	☐	☐
Other (please specify) _________________________	☐	☐	☐

16. If services were received in a center-based daycare setting, were the services provided to the child alone or to the child in a group?

☐ Child alone
☐ Child in a group (indicate number of children in the group ________)
☐ Both alone (______ percent) and in a group (______ percent)
☐ Not applicable
☐ Prefer not to answer

17 If services were provided in a center-based setting, how would you describe the other children in the group? (check all that apply)

☐ Children with hearing loss
☐ Children with normal hearing
☐ Children with other special needs
☐ Not applicable
☐ Prefer not to answer

18. If you could change two things about this child's services, what would they be? Please explain in the comment box below.

Current Caseload

19. About how many children/families do you serve? (e.g. your typical caseload, give your best estimate)

_______ Number of active children/families in your caseload

20. About how many of these cases are children with permanent hearing loss (of any degree)?

_______ (please give your best estimate)

21. About how many children with **mild to severe** permanent hearing loss do you currently serve? ________

22. About how many children with **profound** hearing loss do you currently serve? ________

23. Of the children with hearing loss on your caseload, ________ out of _________ have additional disabilities.

24. In addition to children with hearing loss, which of the following are included in the population of infants and toddlers currently served by your program?

	Yes	**No**	**Prefer not to answer**
Behavioral/emotional disorders, including autism	☐	☐	☐
Developmental delays	☐	☐	☐
Health Impairment/medically fragile	☐	☐	☐
Multiple impairments	☐	☐	☐
Orthopedic impairment	☐	☐	☐
Vision loss	☐	☐	☐
Motor impairments	☐	☐	☐
Other (please specify)____	☐	☐	☐

Personal Preparation

25. Please indicate the highest degree you have earned:

 Associate's degree
 Bachelor's degree
 Master's degree
 Doctoral degree
 Other (please specify) ____
 Prefer not to answer

26. Please indicate the area in which you earned your degree(s). (check all that apply)

 Education of the deaf and hard of hearing
 Early childhood education
 Special education
 Early childhood special education
 Speech-language pathology
 Audiology
     Masters
     Au.D.
 Other (please specify) ____
 No degree in this area
 Prefer not to answer

27. What certifications or licenses do you hold? (check all that apply)

 Teacher of the deaf and hard of hearing
 Early childhood education
 Special education teacher
 Early childhood special education
 Speech-language pathologist
 Audiology
 Other (please specify) ______________________________________
 Prefer not to answer

28. Do you have certification in the area in which you are currently employed?

 Yes
 No
 Prefer not to answer

29. What professional education have you had concerning children who are deaf or hard of hearing? (check all that apply)

 None
 Half-day in-service
 Day-long workshop or short course
 One – two weeks of specialized instruction
 Semester-long course
 Other (please specify) ____
 Prefer not to answer

Professional Experience

30. How many years have you worked in early intervention? __________ years

31. Please indicate your level of comfort related to working with children with hearing loss in the list below.

AREA	COMFORT LEVEL					
	None	Very little	Moderate	Expert	Not Applicable	Prefer not to answer
Assessing speech development	☐	☐	☐	☐	☐	☐
Assessing language development	☐	☐	☐	☐	☐	☐
Assessing the appropriate communication approach for a child	☐	☐	☐	☐	☐	☐
Designing the appropriate intervention goals	☐	☐	☐	☐	☐	☐
Incorporating language development into daily activities such as dressing & meal time	☐	☐	☐	☐	☐	☐
Using toys and play to develop language	☐	☐	☐	☐	☐	☐
Expanding the child’s vocabulary repertoire	☐	☐	☐	☐	☐	☐
Developing a child’s oral skills	☐	☐	☐	☐	☐	☐
Developing a child’s sign language skills	☐	☐	☐	☐	☐	☐
Promoting early literacy for a child with hearing loss	☐	☐	☐	☐	☐	☐
Carryover of speech activities to the home	☐	☐	☐	☐	☐	☐
Carryover of language activities to the home	☐	☐	☐	☐	☐	☐
Inserting earmolds	☐	☐	☐	☐	☐	☐
Daily checks of the child’s hearing aid	☐	☐	☐	☐	☐	☐
Utilization of the Ling Six Sound test	☐	☐	☐	☐	☐	☐
Troubleshooting hearing devices	☐	☐	☐	☐	☐	☐
Using FM effectively	☐	☐	☐	☐	☐	☐
Developing a child’s ability to listen (auditory curricula)	☐	☐	☐	☐	☐	☐

32. How frequently do you communicate with the child’s audiologist?

- ☐ Never
- ☐ 1 – 2 times per year
- ☐ 3 – 4 times per year
- ☐ Frequently (please specify) ____
- ☐ Not applicable
- ☐ Prefer not to answer

33. How frequently do you communicate with the child's other service providers?

- ☐ Never
- ☐ 1 – 2 times per year
- ☐ 3 – 4 times per year
- ☐ Frequently (please specify) ____
- ☐ There are no other service providers
- ☐ Not applicable because ____
- ☐ Prefer not to answer

Family Centered Practices

The Individualized Family Service Plan

An Individualized Family Service Plan (IFSP) is a written plan that families and professionals develop together. The purpose of the IFSP is to identify services and people who can help families reach their goals.

34. Did the child have a multi-disciplinary evaluation?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

35. Did you develop an IFSP with the family?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

For the questions in this section, please think about the period of time when the IFSP was being developed.

36. When the IFSP was developed:

	Yes	Sometimes	No	Prefer not to answer	Comments
The family had time to get to know me before we began to write the IFSP	☐	☐	☐	☐	
The family decided who should participate on the IFSP team	☐	☐	☐	☐	
The family decided what would be written based on their priorities	☐	☐	☐	☐	

37. Whether an IFSP was developed or NOT,

	Yes	Sometimes	No	Prefer not to answer	Comments
The family was allowed to make decisions at their own pace	☐	☐	☐	☐	
The family was an equal partner in planning the goals and services	☐	☐	☐	☐	
The family had someone to help them coordinate the services they needed	☐	☐	☐	☐	
The family had a choice about how often their child & family received services	☐	☐	☐	☐	
The family had a choice about the location of the services (e.g. home vs. center)	☐	☐	☐	☐	
The family had a choice about how much they would participate in the services with their child	☐	☐	☐	☐	
Family routines were considered when services were scheduled	☐	☐	☐	☐	
When we disagreed about what was best for their child, the family's opinion was given more weight	☐	☐	☐	☐	

38. Which of the following statements best describes the progress this child has made in the past 6 months toward the outcomes specified in the IFSP? (check one)

The child has:

- ☐ Achieved more goals than expected in the IFSP
- ☐ Achieved about as many goals as expected in the IFSP
- ☐ Achieved fewer goals than expected in the IFSP
- ☐ Don't know
- ☐ Prefer not to answer

Comment: (please comment on observations you have made about factors influencing this child's progress)

Your Professional Role with this Child

39. Regarding the child's family, did you:

	Yes	Another Service Provider Assisted	No Assistance Provided	Uncertain	Prefer not to answer
Help with filling out forms, if assistance was needed?	☐	☐	☐	☐	☐
Help the parents contact parents of other children with hearing loss?	☐	☐	☐	☐	☐
Help the parents feel more confident in their ability to parent this child?	☐	☐	☐	☐	☐
Help the family find funding for services or equipment, if needed?	☐	☐	☐	☐	☐
Encourage the family to be the major-decision maker about their child?	☐	☐	☐	☐	☐
Help the family become knowledgeable about the hearing technology their child uses?	☐	☐	☐	☐	☐
Motivate the family to communicate with their child?	☐	☐	☐	☐	☐
Show the family how to incorporate language into their daily routines like dressing & bathing?	☐	☐	☐	☐	☐
Help the family prepare for the child's next therapeutic/educational setting?	☐	☐	☐	☐	☐

40. During sessions with the family, what is the approximate time that you spend on the following? (estimate the **number of minutes** in a one hour session)

________ Observing and guiding the caregivers as they interact with the child

________ Modeling strategies for the caregivers

________ Providing language and speech stimulation for the child

________ Educating family members

________ Working with siblings

________ Evaluating outcomes

________ Providing family support

________ Other (please specify) ____

Hearing Aid and FM Use

41. Does this child use hearing aids?

- ☐ Yes
- ☐ No (skip to #45)
- ☐ Don't know (skip to #45)
- ☐ Prefer not to answer (skip to #45)

42. Which statement best describes this child's **current use** of his/her hearing aid(s)?

	CHECK ONE
Easily accepts the hearing aid(s) and wears them on a full-time, daily basis	☐
Allows the hearing aid(s) to be placed in his/her ears but removes them periodically throughout the day	☐
Resists the hearing aid(s) being placed in his/her ears and it is a struggle to keep them in for any extended period of time	☐
Seldom uses the hearing aid(s)	☐
Probably never uses the hearing aid(s)	☐
Prefer not to answer	☐

Family's knowledge and confidence regarding hearing aids and FM

43. How would you describe the family's **level of knowledge** about managing their child's hearing aids? (conducting listening checks, trouble-shooting, changing batteries, etc)

	CHECK ONE
Doesn't know very much about how to manage the hearing aid(s)	☐
Has some knowledge but wants to learn more about managing the hearing aid(s)	☐
Has learned how to manage the hearing aid(s)	☐
Prefer not to answer	☐

44. Which of the following best describes the family's current **level of confidence** in managing their child's hearing aid(s)?

	CHECK ONE
Not yet confident managing the hearing aid(s)	☐
Beginning to be confident managing the hearing aid(s)	☐
Somewhat confident managing the hearing aid(s)	☐
Completely confident managing the hearing aid(s)	☐
Prefer not to answer	☐

45. Does this child use an FM system at home?

- ☐ Yes
- ☐ No (skip to #50)
- ☐ Don't know (skip to #50)
- ☐ Prefer not to answer (skip to #50)

46. Which best describes this child's current FM system use **at home?**

	CHECK ONE
Regularly uses the FM system in a variety of situations	☐
Occasionally uses the FM system	☐
Rarely uses the FM system	☐
Prefer not to answer	☐

47. How would you describe the family's **level of knowledge** about managing their child's FM system? (conducting listening checks, trouble-shooting, changing batteries, etc)

	CHECK ONE
Doesn't know much about how to manage the FM	☐
Has some knowledge but wants to learn more about managing the FM system	☐
Has learned how to manage the FM system	☐
Prefer not to answer	☐

48. Which of the following best describes the family's current **level of confidence** in managing their child's FM system?

	CHECK ONE
Not yet confident managing the FM	☐
Beginning to be confident managing the FM	☐
Relatively confident managing the FM	☐
Completely confident managing the FM	☐
Prefer not to answer	☐

50. Are there any issues surrounding service to infants/toddlers with hearing loss and their families that you find challenging? (please comment in the box below)

51. Are there any additional thoughts or concerns regarding provision of services to young children with mild to severe hearing loss that you would like to share with us? (please comment in the box below)

Thank you for completing our survey! Please select your gift card from the options below.

☐ $15 Starbucks Gift Card
☐ $15 Target Gift Card
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