STATE OF HAWAII
HEALTH AND FUNCTIONAL ASSESSMENT INSTRUCTIONS
CHILD AND ADULT

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GENERAL INSTRUCTIONS

All sections for the appropriate age and program type must be answered.

When conducting the HFA for LTSS members, it is required to obtain and record current vital signs.

Service Coordinators are expected to prepare for all visits using additional available resources (e.g. claims data, medication history, utilization history, etc.) and telephonic responses to expedite the assessment process and make the most of the member's time.

Completion of the assessment is required to include a face to face interview with the member.

When conducting re-assessments, if there are no changes from the most previous assessment, check "No Change From Previous Assessment".

In accordance with the Home and Community Based final rule issued in January 2014, the following must be included in the planning process:

1. **Provide necessary information and support in order to enable the member to make informed choices, including providing choices regarding services and supports and who provides those services.**
2. **Ensure that the member directs the planning process to the maximum extent possible.**
3. **Ensure that the planning process reflects cultural considerations of the member.**
4. **Ensure that the planning process is conducted in plain language and in a manner that is accessible to members with disabilities and interpreted into the member's primary language for those with limited English proficiency.**
5. **Ensure that the member understands how to request updates to the plan as needed.**

SECTION A. ADMINISTRATIVE INFORMATION	
A1. Member	
a. Member Name	*a. Goal: To document personal information necessary to identify the member.* a. Instruction: Enter member's legal name (Last, First, Middle Initial). If member has no middle initial, leave blank.
b. Date of Birth	*b. Goal: To document personal information necessary to identify the member.* b. Instruction: Enter date of birth (MM/DD/YYYY). Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year.
c. Medicaid ID #	*c. Goal: To document personal information necessary to identify the member.* c. Instruction: Enter Medicaid Identification (ID) number assigned by the Department of Human Services (DHS). Enter 10 digits for Medicaid ID number.
A2. Assessment	
a. Reason for Assessment 1. Initial 2. Reassessment 3. Annual 4. Change of Condition/Status	*a. Goal: To document the reason for conducting an assessment.* a. Instruction: Check appropriate box to indicate reason for assessment.

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	a. Definitions: 1. **Initial**- An assessment that is conducted for the first time. 2. **Reassessment-** An assessment that is conducted every three (3) months for LTSS and six (6) months for SHCN. 3. **Annual-** An assessment that is conducted every 12 months. 4. **Change in Condition/Status -** A reassessment that is conducted within ten (10) days when significant events occur in the life of a member, including but not limited to, the death of a caregiver, significant change in health status, change in living arrangement, institutionalization and change in provider(s) (if the provider(s) change affects the service plan) follow up reassessment, etc.
b. Assessment Reference Information 1. Date 2. Time 3. Assessment Location 4. Member's Resident Address 5. Identify any safety issues that a SC may encounter during the assessment.	*b. Goal: Ensure that the assessment is timely and occurs at times and locations of convenience to the member. Document the assessment reference information which is the date, time, and location in which the assessment was conducted. Also document any safety issues that a SC may encounter during the assessment.* b. Instruction: Enter the assessment reference information. 1. Enter date. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. 2. Enter time. Enter 2 digits for hour and minutes. Use zero (0) as a filler digit. Check "AM" or "PM." 3. Enter assessment location e.g., member's home, nursing facility, etc. 4. Enter member's resident address. 5. Safety issues include environmental hazards, dogs, etc.
c. Assessor(Primary) 1. Assessor Name 2. Title	*c. Goal: To document identifiers necessary to identify the primary assessor.* c. Instruction: Document Primary assessor(s) information. The assessor is the person(s) that conducted the health and functional assessment. 1. Enter Primary assessor's legal name 2. Enter Primary assessor's title e.g., RN, SW, LSW etc.
d. Assessor (Consult) 1. Assessor Name 2. Title	*d. Goal: To document identifiers necessary to identify the consult assessor.* d. Instruction: Document Consult assessor(s) information. The assessor is the person(s) that conducted the health and functional assessment. 1. Enter Consult assessor's legal name 2. Enter Consult assessor's title e.g., RN, SW, LSW etc.
e. Additional Health Plan Insurance 1. Health Plan Name 2. Subscriber Name 3. Subscriber Number 4. Are you a veteran 5. Are you receiving any veteran benefits	*e. Goal: To document any additional health plan insurance, if applicable. Review available supporting documentation. SC and provider(s) must be able to identify additional insurance to coordinate appropriate services without duplication.* e. Instruction: Identify any additional health plan insurance. 1. Enter health plan name. 2. Enter subscriber name, the person responsible for plan.

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	3. Enter subscriber number; most subscriber numbers can be located on the insurance card. 4. Check "Yes" or "No" to indicate whether member is a veteran. 5. Check "Yes" or "No" to indicate whether member is receiving any veteran benefits. Identify the benefits.
f. Medicare 1. Medicare ID# 2. Medicare Advantage Plan Name ID#	*f. Goal: To document Medicare coverage, if applicable. SC and provider(s) must be able to identify Medicare information to coordinate appropriate services.* f. Instructions: Identify Medicare coverage. 1. Check "Yes" or "No" to indicate whether the member has Medicare coverage. Enter the ID number. 2. If yes, check "Yes" or "No" to indicate whether the member has Medicare Advantage. Enter the Plan Name and ID number.
g. Other Individual(s) Participating in the Assessment 1. Is there a legal guardian or representative assisting in the assessment? ☐ Yes ☐ No 2. Other individuals present? ☐ Yes ☐ No 3. Name of Participants Name / Relationship / Purpose	*g. Goal: To document other individual(s) that assisted during the assessment. SC and provider(s) must be able to identify the individual(s) that assisted during the assessment to assist with development and implementation of SP.* g. Instruction: Identify all other individual(s) that assisted during the assessment i.e., parent, legal guardian, spouse, sibling, aunt/uncle, interpreter, agency worker, etc. 1. Check "Yes" or "No" to indicate whether the member has a legal guardian or representative assisting in the assessment. 2. Check "Yes" or "No" to indicate if there were any other individuals present. 3. List the name of participants, relationship, and purpose.
h. Comments	h. Enter additional comments as needed. Indicate if member is aware that they can choose individuals invited. Including, if no one present was chosen by the member, indicate why no one of the member's choice were present.
A3. Legal Information ☐ No Change from Previous Assessment	
a. Legal Responsibility (ies) 1. Self 2. Legal Guardian, Name 3. Authorized Representative, Name 4. Healthcare Power of Attorney, Name 5. Family Educational Rights and Privacy Act (FERPA) 6. Other, Name 7. Identify parents or adults who are NOT allowed information on the member, only if identified on a legal document. Name:	For re-assessments: If no changes, indicate at top of section. *a. Goal: To document the individual(s) that have legal responsibility (ies) in regard to member. Review available supporting documentation. SC and provider(s) must be able to identify these individuals to coordinate services.* a. Instruction: Check all appropriate boxes that identify individuals that have legal responsibilities in regards to the member. For each box checked, identify whether a copy of the document was obtained for the record. 1. Member 2. Enter legal guardian's legal name. 3. Enter authorized representative's legal name.

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	4. Enter healthcare power of attorney's legal name. 5. Check "Yes" or "No" to indicate whether a Department of Education consent form was obtained. 6. Enter legal responsibility and other's legal name. 7. Enter any individuals not allowed information on the member as identified in a legal document.
b. Advance Directives 1. Do you have an Advance Directive? 2. If yes, do you have a copy of the Advance Directive? 3. If no, would you like more information on Advance Directives? 4. Health Plan obtained copy for records 5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST) 6. Location of POLST	*b. Goal: To document advance directives, if applicable. Review available supporting documentation. SC and provider(s) must be able to identify the member's needs as stated in the advance directives to coordinate services.* b. Instruction: 1. Check "Yes" or "No" to indicate whether the member has an Advance Directive. Skip to number 3 if checked "No." 2. Check "Yes" or "No" to indicate whether the member has a copy of the Advance Directive. 3. Check "Yes" or "No" to indicate whether the member would like more information on Advance Directive. 4. Check "Yes" or "No" to indicate whether the health plan has obtained a copy of the Advance Directive. 5. Check "Yes" or "No" to indicate whether the member has a Physician Orders for Life-Sustaining Treatment (POLST) 6. Document location of POLST.
c. Emergency Contact(s) 1. Name – Primary/Secondary 2. Relationship to member 3. Address 4. Phone Number 5. Email Address	*c. Goal: To document the emergency contacts. SC must be able to identify emergency contacts to participate in the development and implementation of emergency planning.* c. Instructions: Obtain information regarding emergency contacts. 1. Obtain the name of the primary and secondary contact person. 2. State the relationship to the member 3. Obtain the Address 4. Obtain the telephone number 5. Obtain the Email address
d. Emergency Plan (Complete this question for HCBS Community 1. Is your Individualized Emergency Back-up Plan Form completed? ☐ Yes ☐ No 2. If yes, where is it located? 3. If no, **complete ATTACHMENTS for QI Individualized Back-up document and provide a copy to member.**	*d. Goal: To document the emergency plan. SC must be able to assist in the development and implementation of the emergency planning.* d. Instructions: Assist member in emergency planning. Ensure that member and other individuals understand the emergency plans in place. 1. Check "Yes" or "No" if the Emergency Back-up plan Form is completed. 2. If "Yes", where is it located 3. "If "No", **complete ATTACHMENTS for QI Individualized Back-up document and provide a copy to member.**
e. Comments – Identify any risk factors	e. Enter additional comments as needed and identify any risk factors.
SECTION B. DEMOGRAPHIC INFORMATION	

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B1. Demographics ☐ No Change from Previous Assessment	
a. Gender 1. Male 2. Female 3. Preferred Gender Identity	*a. Goal: To document personal information necessary to identify the member.* a. Instruction: Document gender. Check "Male" or "Female" to indicate gender. If member is transgender, document preferred identified gender.
b. Relationship Status 1. Single 2. Married 3. Divorced 4. Separated 5. Widowed 6. Other	*b. Goal: To document current relationship status.* b. Instruction: Identify the current relationship status of the member. Check appropriate box to indicate relationship status. If "Other," enter relationship status.
c. Ethnicity 1. African American 2. American Indian or Alaska Native 3. Asian i. Cambodian ii. Chinese iii. Filipino iv. Indian v. Japanese vi. Korean vii. Laotian viii. Vietnamese ix. Other 4. Caucasian 5. Hispanic or Latino 6. Native Hawaiian or other Pacific Islander i. Federated States of Micronesia ii. Native Hawaiian iii. Palauan iv. Marshallese v. Samoan vi. Tongan vii. Other 7. Other	*c. Goal: To document and understand member's ethnic background. Health plan staff and provider(s) must be culturally sensitive.* c. Instructions: Identify ethnicity. Check all appropriate boxes to indicate which best describe ethnicity. If "Other," enter ethnicity. Note: Federated States of Micronesia includes Yap, Chuuk, Pohnpei, and Kosrae.
B2. Communication ☐ No Change from Previous Assessment	
a. Primary Means of Communication 1. Verbal 2. Non Verbal 3. Written 4. American Sign Language 5. Other	*a. Goal: To document the member's primary means of communication. Health plan staff and provider(s) must be able to communicate with the member.* a. Instruction: Check appropriate box to indicate primary means of communication. a. Definitions: 1. **Verbal-** Member is able to communicate verbally.

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	2. **Non Verbal-** Member is unable to communicate verbally but is able to communicate by using hand gestures, facial expressions, eye contact, body language, etc. 3. **Written-** Member is unable to communicate verbally but prefers to and able to communicate in writing. 4. **American Sign Language –** Member is able to communicate through Sign Language primarily used in the United States. 5. **Other-** If "Other," enter type of communication e.g., speech communicating device, etc.
b. Primary Spoken Language 1. English 2. Chinese (Cantonese) 3. Chinese (Mandarin) 4. Chuukese 5. French 6. German 7. Hawaiian 8. Ilocano 9. Japanese 10. Korean 11. Laotian 12. Marshallese 13. Palauan 14. Samoan 15. Spanish 16. Tagalog 17. Tongan 18. Vietnamese 19. Visayan 20. Other	*b. Goal: To document the member's primary spoken language. Health plan staff and provider(s) must be able to communicate with the member in a language other than English, if preferred.* b. Instructions: Check appropriate box to indicate preferred language for a day to day communication. If "Other," enter preferred language for a day to day communication.
c. Interpretation 1. Do you need an interpreter?	*c. Goal: To document interpretation services. Health plan staff and provider(s) must be able to communicate with the member and offer interpretation services, as needed.* c. Instructions: Check "Yes" or "No" to indicate whether the member needs interpreter services.
d. Primary Written Language 1. English 2. Braille 3. Chinese (Cantonese) 4. Chinese (Mandarin) 5. Chuukese 6. French 7. German 8. Hawaiian 9. Ilocano 10. Japanese 11. Korean	*d. Goal: To document the member's primary written language. Health plan staff and provider(s) must be able to communicate with the member in a written language other than English, if preferred.* d. Instructions: Check appropriate box to indicate preferred language for written materials. If "Other," enter preferred language for written materials.

12. Laotian 13. Large format 14. Marshallese 15. Palauan 16. Samoan 17. Spanish 18. Tagalog 19. Tongan 20. Vietnamese 21. Visayan 22. Other	
e. Translation 1. Do you need a translation?	*e. Goal: To document translation services. Health plan staff and provider(s) must be able to communicate with the member and offer translation services, as needed.* e. Instructions: Check "Yes" or "No" to indicate whether the member needs translation services.
f. Other Assistive Communication Device(s) 1. Other Assistive Communication Device(s)	*f. Goal: To document use of any other assistive communication device(s).* f. Instructions: List all other assistive communication device(s) e.g., TTY, TTD, etc. Check box if none.
g. Comments	g. Enter additional comments as needed.
B3. Residence and Living Arrangements ☐ No Change from Previous Assessment	
a. Residence 1. Own Private house/apartment 2. Rent Private house/apartment/room 3. Houseless (with or without shelter) 4. Assisted Living Facility (ALF) 5. Adult Residential Care Home (ARCH) 6. Expanded Adult Residential Care Home (E-ARCH) 7. Foster Home (Children) 8. DD Adult Foster Home 9. Community Care Foster Family Home (CCFFH) 10. Nursing Facility (NF) 11. Rehabilitation hospital/unit 12. Psychiatric hospital/unit 13. Acute care hospital 14. Other	*a. Goal: To document where the member is currently residing. SC and provider(s) must be able to identify and verify current residence to coordinate services.* a. Instruction: Check appropriate box to indicate where the member is currently residing. a. Definitions: **1. Own Private house/apartment-** Any house, apartment, or condominium owned by the member. **2. Rent Private house/apartment/room-** Any house, apartment, condominium, or room rented by the member. **3. Houseless (with or without shelter) -** Member has no permanent residence (a house, apartment, condominium, room, or a place to stay on a regular basis). Member may reside on the streets, in car, in open areas, or at a homeless shelter, e.g., Institute for Human Services (IHS), etc. **4. Assisted Living Facility (ALF) -** A licensed facility that consists of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

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	5. **Adult Residential Care Home (ARCH)-** A licensed facility that provides twenty-four (24) hour living accommodations, for a fee, for five unrelated people who require minimal assistance in the activities of daily living and do not need assistance from skilled, professional personnel on a regular long-term basis. 6. **Expanded Adult Residential Care Home (E-ARCH) -** A licensed facility that provides twenty-four (24) hour living accommodations, for a fee, for five unrelated people who require at least minimal assistance in the activities of daily living and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of E-ARCHs: *Type I* – allowing five (5) or fewer residents and up to six (6) residents may be allowed at the discretion of the department with no more than (3) nursing facility level residents; and *Type II* – allowing six (6) or more residents with no more than twenty (20%) nursing facility level residents of the home's licensed capacity. 7. **Foster Home (Children) -** a home that a minor has been placed into as a ward of the State. 8. **DD Adult Foster Home** – a home that a DD member has been placed into. 9. **Community Care Foster Family Home (CCFFH) -** A certified home that provides twenty-four (24) hour living accommodations, including personal care and homemaker services. 10. **Nursing Facility (NF) -** A licensed facility that provides appropriate care to persons referred by a physician. Such persons are those who: Need twenty-four (24) hour a day assistance with the normal activities of daily living; Need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis; and may have a primary need for twenty-four (24) hours of skilled nursing care on an extended basis and regular rehabilitation services. 11. **Rehabilitation hospital/unit-** Any licensed acute care facility, e.g., Rehabilitation Hospital of the Pacific, etc. in the service area to which a member is admitted to rehabilitation services pursuant to arrangements made by a physician. 12. **Psychiatric hospital/unit-** Any licensed acute care facility, e.g., Kahi Mohala Behavioral Health, Kekela Queens Medical Center, etc. in the service area to which a member is admitted to receive psychiatric services pursuant to arrangements made by a physician. 13. **Hospital-** Any licensed acute care facility in the service area to which a member is admitted to receive inpatient services pursuant to arrangements made by a physician. 14. **Other-** If "Other," enter current residence, e.g., DD Domiciliary Homes, DD Foster Homes, ICF-ID, etc.

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b. Living Arrangement 1. Alone 2. With spouse/partner only 3. With spouse/partner and other(s) 4. With child (not spouse/partner) 5. With parent(s)/guardian(s) 6. With sibling(s) 7. With other relative(s) 8. With non-relative(s) 9. Other	*b. Goal: To document current living arrangements. SC and provider(s) must be able to identify and verify current living arrangements to coordinate services.* b. Instructions: Check appropriate box to indicate the current living arrangement. If "Other," enter current living arrangements. b. Definitions: **1. Alone-** Lives by self. **2. With spouse/partner only-** Lives with spouse or partner, boyfriend or girlfriend. **3. With spouse/partner and other(s) -** Lives with spouse or partner and other individual(s), whether family or unrelated. **4. With child (not spouse/partner) -** Lives with child(ren) only, or child(ren) and other individual(s) but not spouse or partner. **5. With parent(s)/guardian(s) -** Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individual(s) but not spouse or partner or child(ren). **6. With sibling(s) -** Lives with sibling(s) only, or sibling(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s) or child(ren). **7. With other relative(s) -** Lives with relative(s) (i.e., aunt or uncle) only, or relative(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s), sibling(s) or child(ren). **8. With non-relative(s) -** Lives in a group setting (e.g., NF, CCFFH, etc.). **9. Other**, if "Other", enter living arrangements.
c. Type of Subsidized Housing i. Hawaiian Homestead ii. Section 8 iii. Public Housing iv. Other	c. *Goal*: *To document the type of subsidized housing.* c. Instructions: Check the appropriate box.
d. Comments	d. Enter additional comments as needed.
SECTION C. MEDICAL INFORMATION	
C1. Disease Diagnosis(es) ☐ No Change from Previous Assessment	
a. Disease Diagnosis(es) 1. List Disease Diagnosis(es) 2. ICD-10 Code 3. Date of Onset	*a. Goal: To document current disease diagnosis(es) or medical conditions related to the member's need for long term care services. SC and provider(s) must be able to understand disease process and identify needs based on member's current condition. Do not include conditions that have been resolved or no longer affect the member's ability to perform functional activities.* a. Instructions: Identify and list significant past and current disease diagnosis(es) or medical conditions related to the member's need for long term care. Enter significant disease diagnosis, medical condition, or surgical procedure. **May attach a list of diagnoses from an electronic medical record system as long as it contains the 3 elements**

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	of disease diagnosis name, ICD-10 code, and date of onset for each diagnosis. 1. Enter 3-5 digits for ICD 10 code. Use zero (0) as a filler digit. 2. Enter date of onset. This will assist in developing appropriate interventions and goals on the SP. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown.
b. Comments – Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
C2. Transplant ☐ No Change from Previous Assessment	
a. Transplant 1. Have you had a transplant? 2. What type of transplant? 3. Is member compliant with transplant related medication and provider follow-up? 4. If not, document the action plan	*a. Goal: To document whether member had a transplant.* a. Instructions: Identify if member had a transplant. 1. Check "Yes" or "No" to indicate whether the member had a transplant. 2. Indicate the type of transplant. 3. Check "Yes" or "No" to indicate whether the member is compliant with transplant related medication and provider follow-up. 4. If not, document the action plan.
b. Comments – Identify any risk factors.	b. Enter additional comments as needed and identify any risk factors.
C3. Medications (Prescribed and OTC) ☐ No Change from Previous Assessment	
1. Are you taking any medications, including vitamins, supplements, herbal or OTC medications? 2. If **Yes, attach a current Medication list and/or complete the Medication Attachment Form. Attach to assessment and service plan.** 3. Allergies. Specify.	*a. Goal: To document member's current medications. SC and provider(s) must be able to identify medications and indications.* a. Instructions: List all current medications. 1. Check "Yes" or "No" if member is taking any medications, i.e., prescribed medications, vitamins, supplements, herbal or OTC medications. **2.** If **Yes, attach a current Medication list and/or complete the Medication Attachment Form. Attach the list(s) to assessment and service plan.** 3. If No, skip to #3 Allergies. Specify. 4. If ATTACHMENT for Medications is used, list all current medications. i. Document Brand or Generic name ii. Document the purpose of the medication. iii. Document the recommended dose. Include measure, e.g., ml, mg, mcg, etc. iv. Document the route to administer medication, e.g., by mouth, IM, G Tube, etc. v. Document frequency medication is it given, e.g., BID, TID, Daily, PRN, etc. vi. Document prescribing physician/provider. If there is no ordering physician, for example taking Calcium as a supplement. Leave blank. vii. Check "Yes" or "No" if member is compliant taking medications. Enter additional comments or special instructions as needed.

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C4. Treatment(s) and Therapy(ies) ☐ No Change from Previous Assessment	
a. List Treatment(s) and Therapy(ies) 1. Treatment/Therapy 2. Prescribing Provider 3. Provider/Agency 4. Frequency 5. Comments/Needs	*a. Goal: To document treatment(s) and therapy(ies) and assure necessary services are provided.* a. Instructions: Identify and list all treatment(s) and therapy(ies). 1. Document treatment/therapy name. Refer to Appendix A. Enter 2 digits for treatment/therapy. If "Other" enter 99 and document treatment/therapy. 2. Document ordering provider. If there is no ordering provider, for example treatment discontinued but member would like to continue treatments as needed, leave blank. 3. Document provider or agency delivering treatment/therapy, e.g. treatment is wound care and wound RN is from a home health agency. 4. Document frequency treatment/therapy is given, e.g., wound care BID, weekly, PRN, etc. 5. Enter additional comments or needs. **Note: Complete Skilled Nursing Tool for any additional treatment or therapy. Refer to Appendix A for treatment and therapies that require assessment with Skilled Nursing Tool (identified with an asterisk).**
C5. Medical Equipment and Supplies ☐ No Change from Previous Assessment	
a. List Medical Equipment and Supplies 1. Medical Equipment and Supplies 2. Type/Description/Amount 3. Prescribing Provider 4. Indicate Rent or Own 5. Vendor and Phone Number 6. Comments/Needs	*a. Goal: To document medical equipment and supplies.* a. Instructions: Identify and list medical equipment and supplies. 1. Document medical equipment/supply. Refer to Appendix B. Enter 2 digits for medical equipment/supply. If "Other" enter 99 and document medical equipment/supply. 2. Brief description of medical equipment or supply and the amount used , e.g., 4 X 4 split gauze, Devilbiss suction canister, Diapers – 150/month, etc. 3. Document prescribing provider. If there is no prescribing provider, state in comments/needs. 4. Check whether rent or own. 5. Document vendor or supplier and contact number. 6. Enter additional comments or needs, e.g., supplies are delivered as needed or every 15th of the month, rental expires end of month. **Note: Complete Skilled Nursing Tool for any additional treatment or therapy. Refer to Appendix B for medical equipment and supplies that require assessment with Skilled Nursing Tool (identified with an asterisk).**
C6. Physician(s) and Provider(s) ☐ No Change from Previous Assessment	
a. Physician(s) and Provider(s) 1. List Physician(s)/Provider(s) Name 2. Specialty 3. Address 4. Phone Number 5. Fax Number	*a. Goal: To document current physician(s) and provider(s). SC must be able to identify current physician(s) and provider(s) to effectively communicate, collaborate, and coordinate services. The physician(s) and provider(s) will participate in the development and implementation of the SP.*

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	a. Instructions: Identify and list current physician(s) and provider(s). 1. Enter the name of the physician or provider(s) name. List the primary physician/provider(s) first. 2. Enter physician/provider(s) specialty. 3. Enter physician/provider(s) address. 4. Enter physician/provider(s) phone number. 5. Enter physician/provider(s) fax number.
C7. Utilization of Hospital, Emergency Room, and Physician Services ☐ No Change from Previous Assessment	
1. How many times did you go to the hospital within the past twelve months 2. How many times did you go to the emergency room within the past six months	*a. Goal: To document date of last hospitalization. This information will assess the stability of the member's condition(s).* a. Instructions: Document last acute hospitalization. 1. Check the box which indicates the number of times the member has been hospitalized in the past twelve months 2. Check the box which indicates the number of times the member has accessed an emergency room in the past six months.
a. LAST Primary Care Provider Visit 1. Date of LAST Primary Care Provider visit 2. Reason	*a. Goal: To document date of last Primary Care Provider visit. This information will assess the stability of the member's condition(s).* a. Instructions: Document last Primary Care Provider visit. 1. Enter date of visit. Enter 2 digits for month and day. Use zero(0) as a filler digit. Enter 4 digits for year. Check box if unknown. 2. Document response for Reason for visit.
b. NEXT scheduled Primary Care Provider visit	*b. Goal: to document date of next scheduled Primary Care Provider visit.* b. Instructions: Document date of next scheduled Primary Care Provider visit. 1. Enter date of visit. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown 2. Document response for Reason for visit
c. Other Provider visit Type: NEXT scheduled visit Other Provider visit Type: NEXT scheduled visit Other Provider visit Type: NEXT scheduled visit	*c. Goal: To document date of next Provider visit other than Primary Care (i.e. specialists, surgeons, etc.)* c. Instructions: Document date of next scheduled visit with Provider other than Primary Care Provider. 1. Document what type of provider 2. Enter date of visit. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown 3. Document response for Reason for visit
d. Comments – Identify any risk factors	d. Enter additional comments as needed and identify any risk factors.

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C8. Prevention & Immunizations ☐ No Change from Previous Assessment	
a. Screening(s) 1. Breast Cancer screening in the LAST YEAR 2. Cervical Cancer screening in the LAST YEAR 3. Colorectal screening in the LAST YEAR 4. Osteoporosis screening in the LAST 5. Prostate Cancer screening in the LAST 2 YEARS 6. Total Cholesterol measured in the LAST YEAR 7. Weight/Height measured in the LAST YEAR 8. Well member visit/EPSDT screening (0 to 20 years) in the LAST YEAR 9. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR 10. TB Results 11. Date of last TB Chest X-ray 12. LAST Well Child visit 13. Are your immunizations up to date 14. Date of Pneumococcal Vaccination 15. Date of LAST Influenza Vaccination 16. Other	*a. Goal: To document recommended child and adult preventive screenings. Refer to the CDC Recommended Preventive Screenings for Adults and QI Covered Preventive Services for Adults (RFP Appendix J). Health plan and provider(s) must be able to identify whether the member has met recommended screenings to coordinate health education, counseling, and/or preventive care.* a. Instructions: Identify preventive screening(s) that was completed. 1. For Screenings from #1-6, check "Yes" or "No" to indicate whether the preventive screening was completed. Check "N/A" if not applicable. Check box if unknown. 2. For #7 and #8, check "Yes" or "No" to indicate whether the preventative screening was completed. 3. If "Yes" for TB Skin test, indicate "Negative" or "Positive." 4. If "Positive" for TB results, indicate date of Chest X-ray. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown. 5. #12 applies to children (ages 0-21). Enter date of last Well Child visit. 6. For #13, check "Yes" or "No" if immunizations are up to date. Check next box if unknown. 7. Enter date of pneumococcal vaccination. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown. 8. Enter date of influenza vaccination. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown. 9. For #16, enter other vaccinations.
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
SECTION D. GENERAL HEALTH	
D1. Birth History (Complete for Children Only, through age 18 years) ☐ No Change from Previous Assessment	
a. Birth History 1. Did your mother have any problems while she was pregnant with you? 2. If yes, describe. 3. Did you have any problems when you were born? 4. If yes, describe. 5. Did you have to stay in the Neonatal Intensive Care Unit (NICU) after you were born? 6. If yes, describe.	a. *Goal: To document birth history which includes any problems during mother's pregnancy or immediately after birth.* a. Instructions: Identify any problems during mother's pregnancy or immediately after birth. 1. Check "Yes" or "No" to indicate whether member's mother had any problems while she was pregnant. 2. If, yes describe and document response. 3. Check "Yes" or "No" to indicate whether member had problems when s/he was born. 4. If, yes describe and document response. 5. Check "Yes" or "No" to indicate whether member was in the ICU after s/he was born. 6. If, yes describe and document response.

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b. Comments – Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
D2. Developmental Milestones (Complete for Children only, through age 18 years) ☐ No Change from Previous Assessment	
a. Developmental Milestones 1. Infancy (Birth-12 months) i. Recognizes familiar people. ii. Follows objects with eyes both in same direction. iii. Pull to a standing position. iv. Know approx. five or six words. 2. Toddler (1-3 years) i. Developing autonomy by becoming more independent and involved in self-care. ii. Spontaneously shows affection for familiar playmates, family and other familiar people. iii. Using or formulating sentence structure in their speech. iv. Able to walk up stairs and/or open a door. 3. Preschool (3-6 years) i. Developing mastery over movement and play. ii. Fantasizes and developing fears. iii. Developing ability to make choices. 4. School (6-12 years) i. Follows rules and likes to do things the "right way." ii. Enjoys school and peers. iii. Have supportive adults in their lives 5. Adolescence (12-18 years) i. Able to think abstractly/logical thought and deductive reasoning. ii. Concerns about looking and being different from others. iii. Ability to make choices and have control.	*a. Goal: To assess any delays in developmental health. SC must be able to identify developmental changes to make a referral to PCP for further evaluation.* a. Instructions: Identify any delays in developmental health. Check "Yes" or "No" to indicate whether member meets the developmental milestone. **Note: For members that do not meet the developmental milestones in the age group identified, SC will need to ask the questions that are relevant to member at the time of the assessment.**
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
D3. Cognition ☐ No Change from Previous Assessment	
a. Cognition 1. Is member Comatose? "Yes" or "No" **If yes, Go to Section D6** 2. Mental Status. Choose One (1) i. Oriented: Mentally alert and aware of surroundings?	*a. Goal: To assess member's alertness and ability to respond to general health assessment questions and cognition assessment.* Instructions: Check all that apply. 1. Check "Yes" or "No" if member is comatose. If yes, do not assess for Cognition. **Go to Section D6.** 2. Mental Status

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ii. Disoriented: Partially or intermittently, requires supervision. If yes, describe. iii. Disoriented and/or disruptive? If yes, describe. **If disoriented or 65 years of age or older, complete the Mini-Cog Attachment.**	i. Check "Yes" or "No" if member is oriented and mentally alert and aware of surroundings ii. Check "Yes" or "No" if member is disoriented or intermittently, requires supervision. iii. Check "Yes" or "No" if member is disoriented and/or disruptive **If disoriented or 65 years or older, complete the Mini-Cog Attachment.** For more information on the Mini-Cog Administration and Scoring, see YouTube video at: https.//www.youtube.com/watch?v=De7al.
b. Comments – Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
D4. Vision/Hearing/Speech & Communication ☐ No Change from Previous Assessment	
a. Vision Check ALL that apply 1. Visual impairment. Describe 2. Uses corrective lenses. i. Glasses ii. Contacts 3. Able to see with the corrective lenses? 4. Date of LAST Eye Exam	*a. Goal: To assess the member's ability to see objects in adequate light (with corrective lenses). SC and provider(s) must be able to identify visual impairments that may affect functional activities.* a. Instructions: Check ALL that apply to identify any visual impairments and assess the member's ability to see objects in adequate light (with or without corrective lenses). 1. Indicate whether the member has a visual impairment. Describe impairment e.g., near or far sightedness, legally blind, detached retina, color blind etc. 2. Indicate whether the member use corrective lenses. Check Glasses or Contacts. 3. Indicate whether member is able to see with the corrective lenses. 4. Enter date of last eye exam. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown. a. Test: With corrective lenses or appliances have member look at newspaper/book then have member read aloud the largest font to the smallest font. Observe eye movement and visual acuity.
b. Hearing Check ALL that apply 1. Hearing impairment, Describe 2. Uses a hearing aid? 3. Able to hear with the hearing aid? 4. Date of LAST hearing exam	*b. Goal. To assess the member's ability to hear (with hearing aids or appliances). SC and provider(s) must be able to identify hearing impairments that may affect functional activities or ability to communicate.* b. Instructions: Check ALL that apply to identify any hearing impairments and assess the member's ability to hear (with hearing aid or appliances). 1. Indicate whether the member has a hearing impairment. Describe impairment e.g., hearing loss caused by genetics, environment, etc.

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	2. Indicate whether the member uses a hearing aid. 3. Indicate whether the member is able to hear with the hearing aid. 4. Enter date of last hearing exam. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown. b. Test: With hearing aids or appliance continue with interview then ask about hearing function. Observe the member's verbal responses and social interactions.
c. Speech 1. Speech pattern i. Coherent ii. Incoherent iii. No speech 2. Date of LAST Speech Evaluation	*c. Goal: To assess the member's speech clarity. SC and provider(s) must be able to identify speech impairments that may affect ability to communicate.* c. Instruction: Identify member's speech capability. 1. Check appropriate box to indicate the member's speech capability. c. Test: Interact with member, observe and listen for clarity in member's verbal responses. c. Definitions i. **Coherent-** Clear, comprehensible words ii. **Incoherent-** Unclear, slurred, mumbled iii. **No speech-** No spoken words Enter date of last speech evaluation, if applicable. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown.
d. Communication 1. Ability to verbally express ideas i. Adequately communicates needs/wants ii. Has difficulty communicating needs/wants iii. Unable to communicate needs/wants	*d. Goal: To assess the member's ability to express or communicate needs, requests, and engage in social conversation (i.e., in form of verbal, written, sign language or other communication device). SC and provider(s) must be able to identify any expression difficulty that may affect ability to communicate.* d. Instruction: Identify the member's ability to express ideas and ability to understand others. 1. Check appropriate box to indicate the member's ability express or communicate needs, requests, and engage in social conversation (i.e., in form of verbal, written, sign language or other communication device). d. Test: Interact with member, observe and listen to the member's efforts to communicate with the assessor. d. Definitions- i. **Adequately communicates needs/wants-** Able to express thoughts and ideas clearly without difficulty.

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	ii. **Has difficulty communicating needs/wants**- Able to express thoughts and ideas, may be delayed responses, has difficulty finding the right words, no prompting needed. iii. **Unable to communicate needs/wants-** Able to express basic needs (i.e., eat, drink, sleep, toilet, etc.), difficulty finding words or finishing thoughts, prompting needed.
e. Comprehension 1. Ability to understand others i. Understands ii. Usually understands iii. Sometimes understands iv. Rarely or never understands	*e. Goal: To assess the member's ability to express or communicate needs, requests, and engage in social conversation (i.e., in form of verbal, written, sign language or other communication device). SC and provider(s) must be able to identify any comprehension difficulty that may affect ability to communicate.* e. Instruction: Identify the member's ability to express ideas and ability to understand others. 1. Check appropriate box to indicate the member's ability to comprehend others (i.e., in form of verbal, written, sign language or other communication device). e. Test: Interact with member, observe and listen to the member's responses. e. Definitions- i. **Understands-** Able to comprehend without difficulty. ii. **Usually understands**- Able to comprehend with minimal to no prompting, may miss some parts of conversation. iii. **Sometimes understands-** Has some difficulty comprehending, responds only to simple and direct questions. May need to rephrase question or use gestures to enhance comprehension. **Rarely or never understands-** Limited or unable to comprehend based on verbal and non-verbal responses.
f. Comments – Identify any risk factors	f. Enter additional comments as needed and identify any risk factors.

D5. Mood, Behavior, and Psychological Well Being – PHQ9 for Adults / PSC 17 for Children	
Note: Disease management may be appropriate for member that has been previously diagnosed with a behavioral health diagnosis**. If concerns are identified through this assessment, and the member does not have a behavioral health diagnosis, SC should refer member to PCP for further evaluation**.	
a. Depression (PHQ-9 Foundation) **(FOR ADULTS)** Over the LAST 2 WEEKS , how often have you been bothered by any of the following problems: 1. Little interest or pleasure in doing things i. None ii. Several days iii. More than half the days iv. Nearly everyday 2. Feeling down, depressed, or hopeless i. None ii. Several days iii. More than half the days iv. Nearly everyday	*a. Goal: To assess the member's mood or risk for depression. SC and providers must be able to identify change in mood to make appropriate referrals for disease management and need for further evaluation.* *a.* Instructions: Assess mood and risk for depression. Ask member "Over the last two weeks, how often have you been bothered by any of the following problems." 1. Check the appropriate boxes questions 1-9 to indicate how often member has been bothered by the following problems. a. Definitions- i. **None**- No problems. ii. **Several days** – Has been bothered at least 1-6 days. iii. **More than half the days** – Has been bothered at least 7-11 days.

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3. Trouble falling or staying asleep, or sleeping too much i. None ii. Several days iii. More than half the days iv. Nearly everyday 4. Feeling tired or having little energy i. None ii. Several days iii. More than half the days iv. Nearly everyday 5. Poor appetite or overeating i. None ii. Several days iii. More than half the days iv. Nearly everyday 6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down i. None ii. Several days iii. More than half the days iv. Nearly everyday 7. Trouble concentrating on things, such as reading the newspaper or watching television i. None ii. Several days iii. More than half the days iv. Nearly everyday 8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual i. None ii. Several days iii. More than half the days iv. Nearly everyday 9. Thoughts that you would be better off dead, or of hurting yourself in some way i. None ii. Several days iii. More than half the days iv. Nearly everyday	iv. **Nearly every day** – Has been bothered at least 12-14 days.
Sub Score:	Add columns from None, Several days, More than half the days, Nearly everyday.

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b. Total Score	b. Instructions: Add score for questions 1-9. Enter 2 digits for total score. Score may be 00-27. Use zero (0) as a filler digit. If unable to complete and unable to evaluate enter 99. i. **None**- Zero (0) points ii. **Several days-** 1 point iii. **More than half the days-** 2 points iv. **Nearly every day-** 3 points b. Interpretation of Score: Any score greater than or equal to 5, refer member to PCP for further evaluation.
c. Depression (Pediatric Symptom Checklist **(FOR CHILDREN)** NOTE: If member scores 15 or higher on Pediatric Symptom Checklist or answers yes to questions b or c, SC should refer member to PCP or CAMHD for further evaluation. Who is answering these questions? Parent/Representative Child	
How often has your child been affected by any of the following problems: 1. Feels sad, unhappy i. Never ii. Sometimes iii. Often 2. Feels hopeless i. Never ii. Sometimes iii. Often 3. Dislikes themselves i. Never ii. Sometimes iii. Often 4. Worries a lot i. Never ii. Sometimes iii. Often 5. Seems to be having less fun i. Never ii. Sometimes iii. Often 6. Fidgety, unable to sit still i. Never ii. Sometimes iii. Often 7. Daydreams too much i. Never ii. Sometimes iii. Often 8. Distracted easily i. Never	*c. Goal: To assess the member's needs for emotional and behavioral problems and/or risk for delay in emotional and behavioral development.* *c.* Instructions: Assess for cognitive, emotional and behavioral problems, either self-reported or parent reported answers to questions 1-17. 1. Check the appropriate boxes questions 1-17 that are rated "Never", "Sometimes" or "Often". c. Definitions- i. **Never**- No problems. ii. **Sometimes**- 1 – 3 times a week. iii. **Often**- Occurring daily or more than 4 times a week.

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ii. Sometimes iii. Often 9. Has trouble concentrating i. Never ii. Sometimes iii. Often 10. Acts as if they have endless energy i. Never ii. Sometimes iii. Often 11. Fights with other children i. Never ii. Sometimes iii. Often 12. Does not listen to rules i. Never ii. Sometimes iii. Often 13. Does not care about others i. Never ii. Sometimes iii. Often 14. Teases others i. Never ii. Sometimes iii. Often 15. Blames others for his/her troubles i. Never ii. Sometimes iii. Often 16. Does not like to share i. Never ii. Sometimes iii. Often 17. Takes things that do not belong to him/her i. Never ii. Sometimes iii. Often	
Sub Score	Add columns from Never, Sometimes, Often
d. Total Score	d. Instructions: Add score for questions 1-17. Enter 2 digits for total score. Score may be 00-34. Use zero (0) as a filler digit. i. **Never**- Zero (0) points ii. **Sometimes**- 1 point iii. **Often**- 2 points d. Interpretation of Score: A total score of above 15 or higher suggests the presence of significant behavioral or emotional problems and the appropriate referrals should be made.

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e. Major Life Stressor(s) 1. Have you had any recent major life stressor(s) 2. If yes, explain.	*e. Goal: document and evaluate major life stressor(s). Affects member's mood and/or behavior.* e. Instructions: Identify major life events that affect mood and/or behavior. 1. Check "Yes" or "No" to indicate whether member reports current major life stressor(s), e.g., death of family member, separation or divorce, major illness, change in living arrangements, etc. 2. If yes, have member explain. Document response.
f. Coping Skills Check ALL that apply 1. Have difficulty at work 2. Have difficulty caring for things at home, 3. Have difficulty getting along with people?	*f. Goal: To assess coping skills.* f. Instructions: Check ALL that apply to indicate member coping skills. f. Definitions- 1. Indicate whether member has difficulty at work 2. Indicate whether member has difficulty caring for things at home 3. Indicate whether member has difficulty getting along with people.
g. Anger Check ALL that apply 1. Angers easily 2. Have felt persistent anger with self or others. Describe what happens when member gets angry.	*g. Goal: To assess anger tendencies. SC and providers must be able to identify anger tendencies to make appropriate referrals for disease management and need for further evaluation.* g. Instructions: Check ALL that apply to indicate anger tendency and need for referral. 1. Indicate whether member reports getting angry easily. 2. Indicate whether member reports feelings of persistent anger with self or others, e.g., easily annoyed, anger at care received. If yes, continue to question 3. Document response to what happens when angry.
h. Anxiety Check ALL that apply 1. Gets anxious easily or worries excessively 2. Suffers from panic attacks 3. Feels like something terrible is going to happen	*h. Goal: To assess anxiety. SC and providers must be able to identify anxiety to make appropriate referrals for disease management and need for further evaluation.* h. Instructions: Check ALL that apply to indicate anxiety. 1. Indicate whether member reports getting anxious easily or worry excessively. 2. Indicate whether member reports having panic attacks. 3. Indicate whether member reports feelings of something terrible is going to happen.
i. Behavior (Either Observed or Asked) Check ALL that apply 1. Wanders 2. Verbally abusive to self and/or others? 3. Physically abusive to self and/or others?	*i. Goal: To assess behaviors that may be harmful to self and/or others. Assessor may ask other individuals at the assessment to confirm behaviors. SC and providers must be able to identify harmful behaviors to make appropriate referrals for disease management and need for further evaluation.*

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4. Socially inappropriate or displayed disruptive behaviors? 5. Resisting caregiving? 6. Other emotional or behavioral problems. Describe	i. Instructions: Check ALL that apply to indicate behaviors. 1. Indicate whether member wanders, moving from one place to another without purpose. 2. Indicate whether member is verbally abusive to self and/or others. 3. Indicate whether member is physically abusive to self and/or others. 4. Indicate whether member is socially inappropriate or displayed disruptive behaviors. 5. Indicate whether member resists caregiving. 6. Indicate other emotional or behavioral problems. Describe.
j. Social Relationships Check ALL that apply 1. Had conflict or anger with family or friends. Explain. 2. Felt fearful of a family member or close acquaintance. Explain. 3. Felt neglected, abused, or mistreated. Explain.	*j. Goal: To document and evaluate interactions and involvement in social environment.* j. Instructions: Check ALL that apply to indicate social relationships. 1. Indicate whether member reports having conflict or anger with family or friends. Explain and document response. 2. Indicate whether member reports feeling fearful of a family member or close acquaintance. Explain and document response. 3. Indicate whether member reports feeling neglected, abused, or mistreated. Explain and document response.
k. Comments - Identify any risk factors	k. Enter additional comments as needed and identify any risk factors.
D6. Health Status ☐ No Change from Previous Assessment	
a. Vital Signs (Required for LTSS) 1. Temperature: ____ F i. Mode: 2. Pulse: ____ bpm i. Mode: 3. Respirations: ____ per min 4. Oxygen Saturation: ___% i. Mode: 5. Blood Pressure: ____/____ i. Location: ii. Position: iii. Usual blood pressure range: ____-____/____-____	*a. Goal: To document a baseline for vital signs. SC and provider(s) must be able to identify changes in vital signs to coordinate and provide appropriate services as needed. Any vital signs outside of normal limits, SC should make referral to PCP for further evaluation.* a. Instructions: Obtain vital signs. Vital signs required for LTSS members. 1. Obtain temperature using a thermometer. Document reading in Fahrenheit and document mode e.g., temporal, axillary, oral, etc. 2. Obtain pulse. Document number of beats per minute and document mode e.g., radial, pedal, via pulse oximetry attached to right big toe, etc. 3. Obtain respirations. Document number of respirations per minute. 4. Measure oxygen saturation, only for members that have respiratory problems, e.g., Shortness of Breath, Asthma, COPD, has/use oxygen or ventilator dependent. Document saturation in percent and document mode e.g., via pulse oximetry attached to right index finger, etc. 5. Obtain blood pressure. Document blood pressure reading, location (e.g., right arm, left arm), and position of member

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	(e.g., sitting, laying, standing). Ask member for usual blood pressure reading. Check box if unknown.
b. Fall History Check ALL that apply 1. Member having problems with balance 2. Fall(s) within the last 30 DAYS: 3. Fall(s) within the past 31-90 DAYS: 4. Date of Last Fall: Outcome	*b. Goal: To document history of falls. SC and provider(s) must be able to identify history of falls to further assess risk for future falls.* b. Instructions: Check ALL that apply to indicate the fall history in the last 90 days. 1. Indicate whether member is having problems with balance. 2. Indicate whether member has had 1 or more falls within the last 30 days. 3. Indicate whether member has had 1 or more falls within the past 31 to 90 days. 4. Enter date of last fall and the outcome.
c. Pain 1. Communication of Pain: i. Member is verbal and able to answer ii. Member is non-verbal and unable to answer iii. Member is non-verbal but able to answer. Describe. iv. Caregiver/Authorized Representative is answering based on observation 2. Current pain: 3. Location: 4. Type: 5. Frequency : 6. Intensity: i. Numeric Rating Scale, OR ii. FACES Pain Rating Scale 7. Breakthrough pain: 8. Pain management:	*c. Goal: To evaluate current pain and pain management. SC and provider(s) must be able to identify effective and ineffective pain management to coordinate and provide appropriate services as needed.* c. Instructions: Evaluate current pain and pain management. 1. Check appropriate box to indicate individual reporting pain. If member is non-verbal but able to answer, describe how member is communicating, e.g. facial expressions or body language such as pointing, grimacing, etc. 2. Check “Yes” or “No” to indicate whether member is currently experiencing pain. 3. Document location of pain. 4. Describe type of pain e.g., aching, stabbing, pressure, etc. Document response. 5. Describe frequency of pain e.g., constant, intermittent, etc. Document response. 6. Document intensity of pain. Assessor may use the FACES Pain Rating Scale or Numeric Rating Scale (0-10). 7. Check “Yes” or “No” to indicate whether member has experienced breakthrough pain. 8. Describe all methods of pain management e.g., change position, pain medication, relaxation, etc
d. Substance/Drug Use 1. Smoking Use – Do you use tobacco, smokeless tobacco, or E-cigarettes 2. Alcohol Use – Do you drink any alcohol products 3. Other Substance/Drug Use – Do you use any other substance(s). **If the answer is “Yes” to questions 1-4, COMPLETE THE ATTACHMENT for Substance Use and attach to assessment.**	*d. Goal: To evaluate substance use and willingness to change. SC and provider(s) must be able to identify substance use to coordinate and provide appropriate services as needed.* d. Instructions: Evaluate tobacco, alcohol, and other substance use. 1. Smoking Use - Check “Yes” or “No” if member uses tobacco, smokeless tobacco, or E-cigarettes. 2. Alcohol Use - Check “Yes” or “No” to indicate whether member uses any alcohol products 3. Other Substance/Drug Use – Check “Yes” or “No” to indicate whether member uses any other substance(s)

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	If the answer is "Yes" to questions 1-4, COMPLETE THE ATTACHMENT for Substance Use and attach to assessment.
e. Cardiac/Respiratory Check **ALL** that apply: Have you experienced any of the following: 1. Palpitations (feels like butterflies, pounding, skipping a beat, racing) 2. Faster than normal heart rate (tachycardia) 3. Slower than normal heart rate (bradycardia) 4. Missing or skipping a heartbeat (irregular heart rhythm 5. Swelling below the knee or feet 6. Dizziness or feel like passing out (syncope) 7. Chest pain 8. Lack of color or discoloration of hands, feet or lips 9. Excessive tiredness, decreased energy 10. Shortness of breath or difficulty breathing a) If yes, how would you describe your shortness of breath Mild Moderate Severe b) When do you experience shortness of breath c) What relieves your shortness of breath If any of the boxes above from 1-9 are checked, COMPLETE THE ATTACHMENT for Heart Disease and attach to this assessment. If box 10 is checked in addition to any of the boxes 1 to 9 or if box 10 is the only box checked, COMPLETE THE ATTACHMENT for Respiratory/Tracheostomy/Ventilator AND THE ATTACHMENT for Heart Disease and attach both to this assessment.	*e. Goal: To document member's cardiac and/or respiratory condition and recommend appropriate referral as needed.* e. Instructions: Check ALL that apply. Have you experienced any of the following: 1. Palpitations (feels like butterflies, pounding, skipping a beat, racing) 2. Faster than normal heart rate (tachycardia) 3. Slower than normal heart rate (bradycardia) 4. Missing or skipping a heartbeat (irregular heart rhythm 5. Swelling below the knee or feet 6. Dizziness or feel like passing out (syncope) 7. Chest pain 8. Lack of color or discoloration of hands, feet or lips 9. Excessive tiredness, decreased energy 10. Shortness of breath or difficulty breathing a) If yes, how would you describe your shortness of breath Mild Moderate Severe b) When do you experience shortness of breath – Indicate specific times of day and/or specific situations which brings on shortness of breath. c) What relieves your shortness of breath – Specify interventions that relieve shortness of breath. If any of the boxes above from 1-9 are checked, COMPLETE THE ATTACHMENT for Heart Disease and attach to this assessment. If box 10 is checked in addition to any of the boxes 1 to 9 or if only box 10 is checked, COMPLETE THE ATTACHMENT for Respiratory/Tracheostomy/Ventilator AND THE ATTACHMENT for Heart Disease and attach both to this assessment.
f. Comments - Identify any risk factors	f. Enter additional comments as needed and identify any risk factors.
D7. Nutrition ☐ No Change from Previous Assessment	
a. Height, Weight, and Body Mass Index (BMI) 1. Height ____ feet ____ inches i. Date of height measurement: 2. Weight ____lbs. i. Date of weight measurement:	*a. Goal: To document the member's current height, weight, and Body Mass Index (BMI) to monitor nutrition and stability. SC and provider(s) must be able to identify changes in weight or nutrition to coordinate health education, counseling, and/or disease management.*

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3. BMI i. Date BMI calculated:	a. Instructions: Record most recent height, weight, and BMI calculation. SC may obtain information from the most recent provider visit. 1. Enter 1-2 digits for feet and 1-2 digits for inches. Use zero (0) as a filler digit. Check box if unknown. i. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown. 2. Enter 1-3 digits for pounds. Use zero (0) as a filler digit. Check box if unknown. i. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown. 3. Enter 3 digits for BMI Calculation. Check box if unknown. Refer to the National Institutes of Health (NIH) Body Mass Index Table 1 at *www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm* Enter 3 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown.
b. Dental 1. Do you have any broken, fragmented, loose, or non-intact natural teeth? 2. Do you have dentures? 3. Do you use your dentures? Explain 4. Are you currently experiencing any toothaches or pain? 5. Date of LAST Dental Exam:	*b. Goal: To document any current dental problems or concerns. SC and provider(s) must be able to identify dental barriers to oral intake.* b. Instructions: Identify any dental problems or concerns. 1. Check "Yes" or "No" to indicate whether member has any broken, fragmented, loose, or non-intact natural teeth. 2. Check "Yes" or "No" to indicate whether member has dentures. 3. Check "Yes" or "No" to indicate whether member uses dentures. If no, explain. 4. Check "Yes" or "No" to indicate whether member is currently experiencing any toothaches or pain. 5. Provide date of LAST dental exam. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. Check box if unknown.
c. Weight Loss or Gain 1. Describe the foods or meals that you normally eat. 2. Has a physician or provider recommended a special diet for you? 3. If yes, explain. 4. Has a physician or provider counseled you for your weight loss or weight gain? 5. Is there a plan for managing your weight? 6. If yes, describe plan.	*c. Goal: To document weight loss or weight gain. SC and provider(s) must be able to identify changes in nutrition to coordinate health education, counseling, and/or disease management.* c. Instructions: Identify weight loss or weight gain. 1. Document response. 2. Check "Yes" or "No" to indicate whether a physician or provider recommended a special diet. 3. If yes, Explain 4. Check "Yes" or "No" to indicate whether a physician or provider counseled member for weight loss or weight gain. 5. Check "yes" or "no" to indicate whether there is a plan for managing member's weight.

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	6. If yes, document response.
d. Nutritional Intake 1. Are you able to eat by mouth? 2. Are you able to feed yourself independently? 3. If no, explain. 4. Do you have difficulty chewing and/or swallowing? 5. Do you cough or choke during meals or when swallowing medications? 6. Do you hold food in your mouth/cheek instead of swallowing? 7. Date of swallow evaluation, if applicable 8. Dietary Modifications i. Regular ii. Chopped iii. Minced iv. Pureed v. Thickened liquids 9. Do you require enteral feedings? i. Nasogastric (NG) Tube ii. Gastrostomy Tube (GT) iii. Gastrojejunostomy (G/J) Tube 10. Do you require parenteral feedings? i. Total Parenteral Nutrition (TPN) ii. Other, parenteral feeding:	*d. Goal: To evaluate mode of nutritional intake. SC and provider(s) must be able to identify dietary modifications if applicable to coordinate and provide appropriate services as needed.* *d.* Instructions: Identify mode of nutritional intake and dietary modifications. If member requires tube or parenteral feedings, refer to Skilled Nursing Tool to determine allotted hours. 1. Check "Yes" or "No" to indicate whether member is able to eat by mouth. 2. Check "Yes" or "No to indicate whether member is able to feed self independently. 3. If no, explain and document response. 4. Check "Yes" or "No" to indicate whether member have difficulty chewing and/or swallowing. 5. Check "Yes" or "No" to indicate whether member cough or choke during meals or when swallowing medications. 6. Check "Yes" or "No" to indicate whether member hold food in mouth/cheek instead of swallowing. 7. If applicable, indicate date of swallow evaluation. 8. Check appropriate dietary modification, if applicable. 9. Check "Yes" or "No" to indicate whether member has enteral feedings. If yes, check appropriate mode. i. Nasogastric (NG) Tube ii. Gastrostomy Tube (GT) iii. Gastrojejunostomy (G/J) Tube 10. Check "Yes" or "No" to indicate whether member has parenteral feeding. If yes, check appropriate mode. i. Total Parenteral Nutrition (TPN) ii. If "Other" enter type of parenteral feeding.
e. Comments - Identify any risk factors	e. Enter additional comments as needed and identify any risk factors.
D8. Continence ☐ No Change from Previous Assessment	
a. Continence 1. Bladder Continence i. Continent ii. Control with catheter or ostomy iii. Incontinent 2. Bowel Continence i. Continent ii. Control with ostomy iii. Incontinent	*a. Goal: To document any bladder and/or bowel continence. SC and provider(s) must identify bladder and/or bowel continence needs to coordinate and provide appropriate services as needed.* a. Instructions: Identify bladder and/or bowel continence. 1. Check appropriate box to indicate bladder continence. 2. Check appropriate box to indicate bowel continence.
b. Do you use incontinence products?	*b. Goal: To document need for incontinence supplies.* b. Instructions: Identify use of any incontinence products/ 1. Check "Yes" or "No" if member is incontinent and/or uses incontinence products.
c. Comment - Identify any risk factors	c. Enter additional comments as needed and identify any risk factors.
D9. Skin ☐ No Change from Previous Assessment	

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a. Skin Check ALL that apply 1. History of skin breakdown or pressure sores. 2. Have any skin break down, tears, or open sores. 3. Have any blood, drainage, or odor from a wound. Describe the wound(s) and location(s).	*a. Goal: To document current skin condition. SC and provider(s) must be able to identify any skin problems to coordinate and provide appropriate services as needed.* a. Instructions: Check ALL that apply to identify any skin problems. Complete question 3, if questions 1 and 2 are checked or member uses incontinence products. If a supplement such as the Braden Scale is used, please attach a copy to this assessment. 1. Indicate if member has any history of skin breakdown or pressure sores. 2. Indicate if member has any current skin break down, tears, or open sores. 3. Indicate if member has any blood, drainage, or odor from a wound. 4. Have member describe the wound(s) and location(s). SC must physically check wound and document findings. (e.g., type of wound, location, measurement, description of wound bed, surrounding tissue, drainage, and odor).
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
D10. Musculoskeletal ☐ No Change from Previous Assessment	
a. Bones, Muscles, or Joints Check ALL that Apply 1. Have any history of bone, muscle, or joint abnormalities or complications. 2. Have any current bone, muscle, or joint abnormalities or complications. Describe your bone, muscle, or joint abnormalities or complications. 3. Had a bone, muscle, or joint surgery or procedure. Date of Surgery/Procedure and Type	*a. Goal: To document current musculoskeletal condition. SC and provider(s) must be able to identify any bone, muscle, or joint problems that affect functional activities to coordinate and provide appropriate services as needed.* a. Instructions: Check ALL that apply to identify any musculoskeletal problems. 1. Indicate any history of bone, muscle, or joint abnormalities or complications. 2. Indicate any current bone, muscle, or joint abnormalities or complications. Describe current bone, muscle, or joint abnormalities or complications. Document response. 3. Indicate any surgical procedures performed for bone, muscle, or joint. 4. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. Enter type of surgical procedure performed.
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
D11. Family Planning ☐ No Change from Previous Assessment	
a. Reproductive Health 1. Prescreening for children: Are you sexually active? 2. Are you Pregnant? 3. If yes, complete ATTACHMENT for Pregnant Female 4. (For Females) Would you like to become pregnant in the next year? 5. (For Males) Would you like your partner to become pregnant in the next year?	*Goal: To document reproductive health.* a. Instructions: Identify family planning status. 1. **This question requires subjective assessment on the part of the interviewer. It may not be appropriate to ask a child unless sexual activity is suspected**. If this question is asked of a child, check "Yes" or "No" to indicate if member is sexually active? (for minors only if appropriate). If the answer is "No" or it is suspected the child is not sexually active, do not complete this section and continue to the next section (D12).

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6. Are you currently using birth control? 7. If yes, are you satisfied with your method of birth control? 8. If no, find out why, and provide basic information on contraceptive options available. 9. Are you comfortable discussing your reproductive health with your PCP or family planning provider? 10. Do you need help finding a family planning provider to help with your reproductive health?	2. Check "Yes" or "No" to indicate whether the member is pregnant. 3. If yes, complete the attachment for pregnant female. 4. (For Females) Check "Yes", "I'm okay either way", "I don't know", or "No" to indicate whether you would like to become pregnant in the next year. 5. (For Males) Check "Yes", "I'm okay either way", "I don't know", or "No" to indicate whether you would like your partner to become pregnant in the next year. 6. Check "Yes" or "No" to indicate whether the member is currently using birth control and specify type. 7. If Yes, Check "Yes" or "No" to indicate whether you are satisfied with your method of birth control. 8. If No, find out why, and provide basic information on contraceptive options available. Refer to PCP or family planning provider. 9. Check "Yes" or "No to indicate whether the member is comfortable discussing his/her reproductive health with the PCP or family planning provider. If no, assist member in finding a new family planning provider. 10. Check "Yes" or "No" to indicate whether the member needs help finding a family planning provider to help with reproductive health and provide assistance in finding a family planning provider.
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
D12. Functional Status ☐ No Change from Previous Assessment	
a. Long Term Services and Support (LTSS) 1. Do you have concerns about taking care of yourself? Describe 2. Do you currently have a caregiver who assist with these activities? 3. Is there assistance and/or services that you need to remain in your home? 4. Complete Functional Assessment below.	*a. Goal: To assess function and need for assistance with IADLs and ADLs* *a. Instructions. Document member's current concerns/needs for assistance and how these are being addressed.* 1. Check "Yes" or "No" to indicate if member has concerns about taking care of themselves. Describe. 2. Do you currently have a caregiver who assist with these activities? 3. Is there assistance and/or services that you need to remain in your home? 4. Complete Functional Assessment below for each member.
b. Instrumental Activities of Daily Living (IADLs) (COMPLETE IADLs FOR ADULTS ONLY) 1. Routine house cleaning i. Independent ii. Minimal iii. Moderate iv. Total 2. Laundry (washing, drying, ironing, mending)	*b. Goal: To assess function and document the degree of assistance needed to complete Instrumental Activities of Daily Living (IADLs). SC must be able to assess need to coordinate services.* b. Instructions: Identify the degree of assistance needed to complete IADLs. If minimal, moderate, or total is checked and the assessor has determined that the member meets the requirements for services, complete Personal Assistance Tool to determine allotted hours.

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i. Independent ii. Minimal iii. Moderate iv. Total 3. Shopping/Errands i. Independent ii. Minimal iii. Moderate iv. Total 4. Transportation/Escort 5. Meal Preparation i. Independent ii. Minimal iii. Moderate iv. Total 6. Other	1. Routine House Cleaning- How routine house cleaning is performed. Check appropriate box to indicate degree of assistance needed. 2. Laundry- How laundry (washing, drying, ironing, mending) is performed. Check appropriate box to indicate degree of assistance needed. 3. Shopping and Errands- How shopping and errands are performed (exclude transportation). Check appropriate box to indicate degree of assistance needed. 4. Transportation/Escort – How transportation with escort is performed. Check appropriate box to indicate degree of assistance needed. 5. Meal Preparation- How meals are prepared. Check appropriate box to indicate degree of assistance needed. 6. Document other functions not described above; e.g. light yard work, simple home repairs. If not applicable, check "NA". b. Definitions- i. **Independent**- No assistance, set up, or supervision ii. **Minimal-** Able to complete some tasks with assistance, includes oversight, encouragement or cueing, or supervision iii. **Moderate**- Able to complete some of task but needs assistance with most of task to complete the task iv. **Total** – Unable to complete tasks on own or needs assistance to complete the task
c. Activities of Daily Living (ADLs) 1. Eating/Feeding i. Independent ii. Minimal iii. Moderate iv. Total 2. Bathing i. Independent ii. Minimal iii. Moderate iv. Total 3. Dressing upper body i. Independent ii. Minimal iii. Moderate iv. Total 4. Dressing lower body i. Independent ii. Minimal iii. Moderate iv. Total 5. Grooming/Personal hygiene i. Independent ii. Minimal	*c. Goal: To assess function and document the degree of assistance needed to complete Activities of Daily Living (ADLs). SC must be able to assess need to coordinate services.* c. Instructions: Identify the degree of assistance needed to complete ADLS. If minimal, moderate, or total is checked and the assessor has determined that the member meets the requirements for services, complete Personal Assistance Tool to determine allotted hours. 1. Eating/Feeding- How eating/feeding and drinking are performed (regardless of skills). Check appropriate box to indicate degree of assistance needed. 2. Bathing- How bathing is performed (exclude washing back and hair). Check appropriate box to indicate degree of assistance needed. 3. Dressing upper body- How dressing and undressing upper body is performed. Check appropriate box to indicate degree of assistance needed. 4. Dressing lower body- How dressing and undressing lower body is performed. Check appropriate box to indicate degree of assistance needed. 5. Grooming/personal hygiene- How grooming and personal hygiene is performed (exclude bath and shower). Check appropriate box to indicate degree of assistance needed.

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iii. Moderate iv. Total 6. Toileting i. Independent ii. Minimal iii. Moderate iv. Total 7. Walks with or without assistive device i. Independent ii. Minimal iii. Moderate iv. Total v. Identify assistive device(s) 8. Do you have difficulty accessing areas of your house? If yes, explain. 9. Bed Mobility/Transfers i. Independent ii. Minimal iii. Moderate iv. Total 10. Manual wheelchair mobility v. Independent vi. Minimal vii. Moderate viii. Total 11. Medication assistance i. Independent ii. Minimal iii. Moderate iv. Total 12. Other	6. Toileting- How toilet is used (excludes toilet transfer). Check appropriate box to indicate degree of assistance needed. 7. Walks with or without assistive device- How member walks with or without assistive device inside and outside of home. Check appropriate box to indicate degree of assistance needed. If member walks using assistive device(s), document assistive device. Refer to Appendix B. Enter 2 digits for assistive device. If "Other" enter 99 and document assistive device. 8. Check "Yes" or "No" to indicate whether member has difficulty accessing areas of house. If yes, document response. 9. Bed Mobility/Transfers- How member moves between surfaces including to/from bed, chair, wheelchair, standing position. Check appropriate box to indicate degree of assistance needed. 10. Manual wheelchair mobility – how member moves while in the wheelchair. Check appropriate box to indicate degree of assistance needed. If not using wheelchair, check "NA" 11. Medication Assistance- How medications are managed. Check appropriate box to indicate degree of assistance needed. If not taking any medications, check "NA" 12. Document other functions not described above; i.e., checking and reporting any equipment or supplies that need to be repaired or replenished, taking and recording vital signs including blood pressure. If not applicable, check "NA" c. Definitions- i. **Independent-** No assistance, set up, or supervision ii. **Minimal-** Able to complete some tasks with assistance, includes oversight, encouragement or cueing, or supervision iii. **Moderate-** Able to complete some of task but needs assistance with most of task to complete. iv. **Total –** Unable to complete tasks on own or needs assistance to complete the task
d. Activity/Mobility/Exercise	*d. Goal: To assess and document physical activity. SC and provider(s) must be able to identify progress or decline of physical activity/exercise.* d. Instructions: Document your observations of member, e.g., able to walk, uses assistive device, etc.
e. Comments - Identify any risk factors	e. Enter additional comments as needed and identify any risk factors.
SECTION E. PSYCHOSOCIAL HISTORY	
E1. Member's Perspective	
a. Personal History/Lifestyle/Goals 1. Family Life i. Where did you grow up? ii. Describe family. 2. Education/Work/Occupation	*a. Goal: To assess member's perspective on what is happening in his/her life now and what member would like to happen in the future.* a. Instructions: Assess member's perspective on life. This should be done by "talking story" with the member. Note: SC should find out as much as they can about their member so they can understand and

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i. What was the highest level of education you completed? ii. What kind of work do you do, or did you do, or want to do? iii. Do you want to volunteer/work now? iv. What kind of work/volunteer did you do or do you want to do? 3. Recreation/Fun/Relaxation i. What are some things you enjoy doing? ii. Identify some people you enjoy spending time with and list their relationship. 4. Strengths/Accomplishments i. What are some of the things you feel you are good at doing? ii. What are some things you have done that you feel proud of? 5. Traditions/Rituals i. Do you have any cultural, personal, or religious beliefs? ii. Do these beliefs impact service expectations and delivery? iii. If yes, describe. iv. Are you able to attend religious services or engage in spiritual practices as often as you like? v. If no, explain 6. Home i. Did you choose the place where you live ii. Do you like where you live now? iii. If no, explain iv. Would you prefer to live somewhere else? v. If yes, explain vi. List alternative HCBS settings which member has considered 7. Routines i. What is a typical day like for you - - what is your daily routine from the time you get up until you go to bed? ii. What are the things you like about your routine? iii. What are the things you don't like about your routine? 8. Care Needs i. What are your thoughts/feelings about your disability/illness? ii. What are your current concerns/needs and how are you handling them? iii. Are you able to direct your care?	anticipate their needs better. If member shows no interest in interview questions, skip this section and document in comments section. If unable to obtain information from member, then obtain from parents, others, etc. 1. Family Life i. Document description of where member grew up. ii. Document description of family. 2. Education/Work/Occupation i. Document the highest level of education completed by member. ii. Document the work member engaged in. iii. Document if member expresses desire to volunteer and/or work now. iv. If "Yes", document the type of volunteer and/or work member wants to do. 3. Recreation/Fun/Relaxation i. Document the activities the member enjoys doing. ii. Identify some people that member enjoys spending time with and list their relationship. 4. Strengths/Accomplishments i. Document areas of strength. ii. Document accomplishments that member is proud of. 5. Traditions/Rituals i. If "Yes", document the member's response to any cultural, personal, or religious beliefs. ii. If "Yes", document the member's response which impact service expectations and delivery. iii. If yes, describe iv. Indicate whether member is able to attend religious services or engage in spiritual practices as often as he/she likes. v. If no, explain. 6. Home i. Check "Yes" or "No" to indicate whether member chose the place where he/she resides. ii. Check "Yes" or "No" to indicate if member likes where he/she lives now. iii. If "No", document response. iv. Check "Yes" or "No" to indicate if member prefers to live somewhere else. v. If "Yes", document response. vi. List alternative HCBS settings which member has considered. 7. Routines i. Describe member's daily routine. ii. Document what member likes about the routine. iii. Document what member does not like about the routine.

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iv. If no, explain v. Do you have any specific end of life wishes or arrangements? vi. If yes, describe:	8. Care Needs i. Document member's thoughts/feelings about disability/illness. ii. Document member's current concerns/needs and how these are being addressed. iii. Indicate if member is able to direct care. iv. If "no", document response. v. Indicate whether member has any specific end of life wishes or arrangements. vi. If "yes", document response.
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
E2. Finances ☐ No Change from Previous Assessment	
a. Finances 1. Do you have concerns about your financial situation i. Housing/Rent ii. Monthly Expenses due to iii. Dependents iv. Other 2. What income sources do you have i. SSI ii. SSDI iii. DHS Financial Assistance iv. SNAP (food stamps) v. Employment vi. Other 3. Employment Income i. Full-time work ii. Part-time or temporary work iii. Unemployed 1) Seeking work 2) Not seeking work 4. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply. i. Food ii. Clothing iii. Utilities iv. Child Care v. Phone vi. Medicine or any Health Care (Medical, Dental, Mental Health, Vision vii. Other 5. Are you worried about losing your housing 6. Would it be helpful to review your monthly expense? **If yes, complete ATTACHMENT for**	*a. Goal: To assess member's need for financial assistance.* a. Instructions: Assess for financial assistance. 1. Check "Yes" or "No" to indicate whether the member have concerns about financial assistance. Check the boxes that apply. 2. Check the boxes that apply for income sources. 3. Check the boxes to identify employment income. 4. Check the boxes that apply. 5. Check "Yes" or "No" to indicate whether the member is worried about losing housing. 6. Check "Yes" or "No" to indicate whether the member would like to review monthly expenses. **If yes, complete ATTACHMENT for Financial Worksheet and/or make appropriate referral.** 7. Check "Yes" or "No" to indicate whether the member has previously applied for additional services 8. Check "Yes" or "No" to indicate that member is in the process of applying for additional assistance. 9. Check all that apply for Referrals

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Financial Worksheet and/or make appropriate referral. 7. Have you previously applied for additional services 8. Are you in the process of applying for additional assistance 9. Referrals i. Housing Assistance ii. Food Stamps iii. Social Security/SSI iv. Financial Management Assistance (e.g., Budget Assistance, Rep Payee) v. Other	
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
E3. Social Supports ☐ No Change from Previous Assessment	
a. Social Supports 1. Family and/or friends living in the SAME residence i. Name (First, Last) ii. Age iii. Relationship iv. Contact Number v. Type of support 2. Family and/or friends NOT living in the same residence and providing support to member i. Name (First, Last) ii. Age iii. Relationship iv. Contact Number v. Type of support 3. Strong and supportive relationship with family	*a. Goal: To assess the member's social support system. SC and providers must be able to identify whether the current social supports provided are sufficient to maintain the member in the community.* a. Instructions: Identify current social supports. 1. Identify family and/or friends living in the same residence and providing supports to individual. Check "Yes" or "No" if there are no family and/or friends. Place an asterisk (*) to identify the Primary Caregiver. i. Enter name of family or friend that lives in the same residence. ii. Enter 2 digits for age. Use zero (0) as a filler digit. State in comments if unknown. iii. Enter relationship to member e.g., spouse, sibling, aunt/uncle, friend, etc. iv. Enter cell phone number. Indicate "C" for Cell, "H" for Home, "W" for Work v. Enter type of help provided e.g., chore, bathing, meal preparation, shopping, etc. 2. Identify family and/or friends NOT living in the same residence and providing supports to individual. Check "Yes" or "No" if there are no family and/or friends. i. Enter name of family or friend NOT living in the same residence and providing support. ii. Enter 2 digits for age. Use zero (0) as a filler digit. State in comments if unknown. iii. Enter relationship to member e.g., spouse, sibling, aunt/uncle, friend, etc. iv. Enter cell phone number. Indicate "C" for Cell, "H" for Home, and "W" for Work. v. Enter type of help provided e.g., chore, bathing, meal preparation, shopping, etc.

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	3. Check "Yes" or "No" to indicate whether the member has a strong and supportive relationship with family based on observations during the assessment.
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.
E4. Caregiver(s) ☐ No Change from Previous Assessment	
1. Name 2. Age 3. Relationship 4. Phone 5. Type of help 6. Outside Employment 7. Employer Name 8. Work hours/week a. Primary Caregiver Name 1. How do you feel about being a caregiver? 2. What do you do to care for yourself and your own needs? 3. Do you need help caring for member? 4. What are your plans if you are no longer able to care for member? 5. Have you discussed your plans with member? 6. If yes, how does member feel about your plans? 7. Do you have any other caregiving demands or responsibilities? 8. If yes, explain. 9. Do you have any concerns/needs?	*a. Goal: To assess the member's primary caregiver status for possible caregiver burn out. SC and providers must be able to identify whether the primary caregiver is experiencing caregiver burnout to coordinate caregiver supports e.g., respite care, education, and /or counseling etc.* a. Instruction: Assess the need for primary caregiver supports. 1. Document feelings on being a primary caregiver e.g., feeling stressed, doing ok, tired, overwhelmed, etc. 2. Document how caregiver takes care of self if feeling overwhelmed with caregiving e.g., take walks, go out, have another caregiver help, etc. 3. Check "Yes" or "No" to indicate if primary caregiver needs help providing care to member. 4. Document what will happen if s/he is unable to care for member e.g., another family member or friend will help or take over caregiving, member will go to a nursing facility or care home, etc. 5. Document if plans were discussed with member. 6. Document how member feels about the plans. 7. Check "Yes" or "No" to indicate if primary caregiver has any other caregiving demands or responsibilities, e.g., being a caregiver for another family member, having own family responsibilities, etc. 8. Explain if there are other caregiving demands or responsibilities. 9. Document any concerns/needs.
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.

THIS SECTION IS AN ATTACHMENT
A3.d QI Individualized Back Up Plan - - SEE ATTACHMENT
C3.2 Medications - - SEE ATTACHMENT
D3.a Cognition - - SEE ATTACHMENT
D6.d Substance Use - - SEE ATTACHMENT
D11.a Pregnant Female – SEE ATTACHMENT
E2.a Financial Worksheet - - SEE ATTACHMENT
One Page Description – MY PROFILE - - SEE ATTACHMENT

SECTION F. DISEASE SPECIFIC QUESTIONS
Goal: To identify status of current disease process. SC and provider(s) must be able to understand the disease to assist in developing appropriate interventions and goals on the SP. Instructions: Complete disease specific questions for those that have been identified in Section C1. Disease Diagnosis (es). SC will ask relevant questions appropriate to the member to gather information for SP. **Check ALL that apply and complete the attachment document questionnaire.**
F1. Asthma, Chronic Obstructive Pulmonary Disease (COPD), Respiratory/Tracheostomy/Ventilator - SEE ATTACHMENT

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F2. Cancer - SEE ATTACHMENT
F3. Diabetes - SEE ATTACHMENT
F4. End Stage Renal Disease (ESRD) - SEE ATTACHMENT
F5. Heart Disease - SEE ATTACHMENT
F6. Hepatitis B/C - SEE ATTACHMENT
F7. High Blood Pressure - SEE ATTACHMENT
F8. HIV/AIDS - SEE ATTACHMENT
F9. Seizures - SEE ATTACHMENT
SECTION G. CURRENT LTSS SERVICES AND SUPPORTS
****Complete Only for LTSS/At-Risk**

G1. Home and Community Based Services (HCBS) ☐ No Change from Previous Assessment	
a. List HCBS Services 1. HCBS Service 2. Provider/Agency 3. Frequency/Amount 4. Comments/Needs	*a. Goal: To document HCBS services.* a. Instructions: Identify current HCBS services. 1. Document HCBS services. Refer to Appendix C. Enter 2 digits for HCBS service. If "Other" enter 99 and document service. 2. Document provider/agency. 3. Document frequency/Amount of services provided per week, e.g., 10 hours per week. 4. Enter additional comments/needs as needed.
b. Comments	b. Enter additional comments as needed.

G2. Institutional Services ☐ No Change from Previous Assessment	
a. List Institutional Services 1. Institutional Service 2. Provider 3. Comments/Needs	*a. Goal: To document institutional services.* a. Instructions: Identify current institutional services. 1. Document institutional service. Refer to Appendix D. Enter 2 digits for institutional service. 2. Document name of institutional provider. 3. Enter additional comments/needs as needed.
b. Comments	b. Enter additional comments as needed.

G3. Programs ☐ No Change from Previous Assessment	
a. State Program(s) 1. Are you currently receiving services from any State Program(s)? 2. Name of School Attending 3. Identify State Program(s) i. DOE/Special Education ii. DOE/Physical, Occupational or Speech Therapy iii. DOE/Early Intervention iv. DOH/CAMHD v. DOH/AMHD vi. DOH/DDD vii. DHS/CCS viii. DHS/CWS	*a. Goal: To document other State program(s) that the member is currently receiving services, if applicable. SC must be able to identify State program(s) to effectively communicate, collaborate, and coordinate services without duplication.* a. Instructions: Identify State Program(s). 1. Check "Yes" or "No" to indicate if member is currently receiving services from any State Program(s) 2. Enter the name of the school the member is attending. 3. Check all appropriate boxes to indicate the State program(s). 4. Enter State program contact name and phone number. 5. Enter type of services/hours member is receiving. Check box if unknown.

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ix. DHS/APS x. Other	
b. Comments:	b. Enter additional comments as needed.
c. Non-State Program(s) 1. Identify Non-State Program(s)	*c. Goal: To document other Non-State program(s) that the member is currently receiving services, if applicable. SC must be able to identify Non-State program(s) to effectively communicate, collaborate, and coordinate services without duplication.* c. Instructions: Identify Non-State Program(s), i.e. Project Dana. 1. Enter Non-State program contact name and phone number. 2. Enter type of services/hours member is receiving. Check box if unknown.
d. Comments	d. Enter additional comments as needed.

SECTION H. TRANSPORTATION *****Do not complete for NF/CCFFH/E-ARCH*****	
a. Transportation 1. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply: a. Yes, it has kept me from medical appointments or from getting medications. b. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need. c. No **(Skip to Section I)** 2. Current Mode of Transportation (Select all that apply) i. Drives own vehicle ii. Family or friends **If member selects "Drives own Vehicle" or "Family or Friends" only, you may skip to Section I** iii. Public transportation a. Bus b. Handi-Van iv. Van a. Curb to curb b. Door to door c. Gurney v. Taxi vi. Air travel for specialist care vii. Other: 3. Are you able to use public transportation or can someone regularly transport you to obtain medical services? 4. If no, explain.	*a. Goal. To document current mode of transportation and to assess need for transportation services.* a. Instructions: Identify if transportation has impeded the member's ability to attend medical or non-medical appointments, or from getting things needed for daily living. For members who have answered yes to question 1, please identify current mode of transportation and transportation need. Once transportation and attendant needs are identified no additional questions need to be asked. **CCFFH and E-ARCH caregivers are responsible for transporting residents.** 1. Select all that apply for whether member has had lack of transportation. **If 'No' is selected, end this section and proceed to Section I** 2. Select all that apply for current mode of transportation. If "Other," enter mode of transportation**. If member selects i. drives own vehicle or ii. Family or friends, end this section.** 3. Check "Yes" or "No" if member is able to use public transportation or someone can regularly transport. 4. If no, explain and document response. 5. Check "Yes" or "No" if member is able to ambulate without assistance (with or without assistive device). 6. Check "Yes" or "No" if member able to ambulate to the local bus stop. Identify whether member can ambulate from house to the local bus stop, from the bus stop to medical appointment, and return home. 7. If no, explain and document response. If yes, SC should ask questions to assure that member is able to ambulate from their home to the local bus stop, bus stop to medical appointment, and return home. **Note: At this point, service coordinator should consider authorization of bus pass for transportation if member is able to safely use public transportation.** 8. Wheelchair bound only: Check "Yes" or "No" if member is able to self-propel to curbside for pick up.

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5. Are you able to ambulate without assistance (with or without device, to include wheelchair)? 6. Are you able to ambulate to the local bus stop (both house and medical appointments)? 7. Describe. 8. If wheelchair bound are you able to self-propel to curb side for pick up? 9. If wheelchair bound, are you able to transfer in and out of vehicle without assistance? 10. If the member needs assistance, do you have an attendant? 11. Does the member require any medical equipment when traveling? 12. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.) 13. Reason member is unable to get to curb side alone (Select all that apply) i. No attendant ii. Attendant is unable to help member to curb side iii. Member is bedbound iv. Member is non ambulatory v. Member is unable to transfer or receive assistance	9. Wheelchair bound only: Check "Yes" or "No" if member is able to transfer in and out of vehicle without assistance. 10. Check "Yes" or "No" if member needs an attendant during transportation. 11. Check "Yes" or "No" if member requires any medical equipment when traveling? Refer to Appendix B. 12. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.). Enter 2 digits for medical equipment. Refer to Appendix B. 13. Select all that apply for the reason member is unable to get to curb side. SC to consider authorization for Handi-Van, van, or taxi for medical appointment transportation. **Note: At this point, service coordinator should consider authorization of Handi-Van, Van, or Taxi for medical appointment transportation.**
b. Comments - Identify any risk factors	b. Enter additional comments as needed and identify any risk factors.

SECTION I. HCBS HOME ENVIRONMENT	
*****Complete only for HCBS and do not complete for NF/CCFFH/E-ARCH*****	
a. Current Home Check ALL that apply 1. Member feels safe in the home. 2. Member feels safe in the neighborhood. 3. Building has a secured lobby. Entry code and/or entry directions. 4. Elevator in the building. 5. Home accessible to wheelchairs or other assistive devices. 6. Identify the accessible Locations (Select all that apply) i. Doorways ii. Hallway iii. Bathroom iv. Exits	*a. Goal: To document any safety issues in the member's home environment.* a. Instructions: Check ALL that apply to identify any safety issues in the home environment. SC must be able to identify any needs for accessibility and/or adaptations to maintain safety in the home. 1. Indicate if member feels safe in the home 2. Indicate if member feels safe in the neighborhood. 3. Indicate if lobby is secured. Document entry instructions or security code. 4. Indicate if there is an elevator. 5. Indicate if home is accessible to wheelchairs or other assistive devices. 6. Identify accessible locations specifically for member, select all that apply. 7.
b. Exterior Assessment 1. Walkways free of clutter 2. Ramps/handrails i. Number of Exits ii. Accessible, Locations 3. Stairs	*b. Goal: To document any safety issues outside the home.* b. Instructions: Identify any safety issues outside of the home. Check "Adequate," "Inadequate," or "N/A." Enter applicable information in comments field and any additional safety issues or

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i. Number of steps to enter home ii. Locations 4. Water source i. Water catchment location 5. Other	concerns such as unpaved walkways. If "Other," enter environmental findings.
c. Interior Assessment 1. Clear pathway to exit/entry 2. Sturdy floors (other structural) 3. Handrails 4. Stairs i. Number of steps in home ii. Locations 5. Free of trash accumulation/trash disposal 6. Lighting 7. Tacked down rugs and carpets 8. Visible cords/electrical circuits 9. Telephone service and accessibility 10. Smoke/fire detector or fire extinguisher operational i. Locations 11. Grab bars/support structures i. Locations 12. Bathing/hand washing facilities i. Hot water ii. Running water 13. Food preparation areas clean 14. Kitchen appliances i. Stove ii. Refrigerator iii. Freezer iv. Microwave oven 15. Food storage 16. Pets in house (cats, dogs, etc.) secured 17. Laundry i. Washer ii. Dryer 18. Insects/other pests or rodents 19. Safe environment for oxygen use 20. Guns/weapons (locked/unlocked). If present, who is responsible 21. Sufficient space for equipment/supplies 22. Home ventilation i. Too hot ii. Too cold 23. Other	*c. Goal: To document any safety issues inside the home.* c. Instructions: Identify any safety issues inside the home. Check "Adequate," "Inadequate," or "N/A." Enter applicable information in comments field and any additional safety issues or concerns such as having pet locked up, are pets around home or outside when worker arrives, are the pets secured. If "Other," enter environmental findings.
d. Comments - Identify any risk factors	d. Enter additional comments as needed and identify any risk factors.

SECTION J. SUMMARY/NARRATIVE OF VISIT

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a. Provide a summary of visit Document, at a minimum the following: 1. For initial visit, provide a brief summary of each need identified in the service plan. Describe any assessed barriers which may prevent attainment of member's desired goals. 2. For subsequent visits, describe the changes identified in the HFA that resulted in a modification of the service plan and summarize any new need(s) added to the service plan. 3. Any issues/changes related to emergency planning.	*a. Goal: To document a summary of visit.* a. Instructions: Provide a summary of visit. Include additional information that affects the delivery of services i.e., any barriers and identify any needs that require follow up. Document, at a minimum the following: 1. For initial visit, provide a brief summary of each need identified in the service plan. Describe any assessed barriers which may prevent attainment of member's desired goals. 2. For subsequent visits, describe the changes identified in the HFA that resulted in a modification of the service plan and summarize any new need(s) added to the service plan. 3. Any issues/changes related to emergency planning.

APPENDICES

Appendix A. Treatments and Therapies

1. BiPAP/CPAP	13. Palliative care
2. Catheter care	14. Personal Emergency Response System (PERS)
3. Chemotherapy	15. Physical therapy
4. Chest physiotherapy	16. Psychological therapy
5. Cough Insufflator/Exsufflator*	17. Radiation
6. Dialysis	18. Respiratory therapy
7. Enteral Feeding*	19. Speech language therapy
8. Home Health	20. Suctioning*
9. Hospice care	21. Tracheostomy care*
10. IV therapy*	22. Transfusion
11. Occupational therapy	23. Ventilator care*
12. Oxygen therapy	24. Wound care*
	99. Other

Appendix B. Medical Equipment and Supplies

1. Bath chair/shower bench	16. Oxygen concentrator*
2. BiPAP/CPAP	17. Oxygen tank*
3. Cane	18. Patient lift
4. Catheter Supplies	19. Personal Emergency Response System (PERS)
5. Chest Vest	20. Pulse oximeter*
6. Commode	21. Scooter
7. Cough Insufflator/Exsufflator*	22. Specialty mattress
8. Enteral Feeding Supplies*	23. Stander
9. Feeding Pump*	24. Suction machine*
10. Grab bars	25. Toilet Chair
11. Hand held shower head	26. Tracheostomy Supplies*
12. Hospital Bed	27. Transfer board
13. Incontinence supplies	28. Walker
14. Nebulizer*	29. Wheelchair
15. Ostomy Supplies	99. Other

Appendix C. HCBS Services

1. Adult Day Care (ADC)	9. Home Maintenance
2. Adult Day Health (ADH)	10. Moving Assistance

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3. Assisted Living Facility (ALF) 4. Community Care Management Agency (CCMA) Services 5. Counseling and Training 6. Community Care Foster Family Home (CCFFH)/Expanded Adult Residential Care Home (E-ARCH) 7. Environmental Accessibility Adaptations (EAA) 8. Home Delivered Meals	11. Non-Medical Transportation 12. Personal Assistance Services – Level I (PA I) 13. Personal Assistance Services – Level II (PA II) 14. Personal Assistance- Level II (Delegated) (PA II- Delegated) 15. Personal Emergency Response Systems (PERS) 16. Respite Care 17. Skilled (or private duty) Nursing (SN) 18. Specialized Medical Equipment and Supplies 99. Other

Appendix D. Institutional Services

1. Acute Waitlisted ICF/SNF 2. Nursing Facility (NF), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF)	3. Sub-Acute Facility 4. Rehabilitation Center

Appendix E. Diseases

1. Asthma 2. Cancer 3. Chronic Obstructive Pulmonary Disorder (COPD) 4. Diabetes 5. End Stage Renal Disease (ESRD) 6. Heart Disease 7. Hepatitis B/C	8. High Blood Pressure 9. HIV/AIDS 10. Seizures 11. Shortness of Breath 12. Transplant 99. Other

Appendix F. Acronyms

1. **ADC** Adult Day Care 2. **ADH** Adult Day Health 3. **ADLs** Activities of Daily Living 4. **ALF** Assisted Living Facility 5. **AMHD** Adult Mental Health Division 6. **APS** Adult Protective Services 7. **ARCH** Adult Residential Care Home 8. **ASL** American Sign Language 9. **BMI** Body Mass Index 10. **CAMHD** Child and Adolescent Mental Health Division 11. **CCFFH** Community Care Foster Family Home 12. **CCMA** Community Care Management Agency 13. **CWS** Child Welfare Services 14. **DDD** Developmental Disabilities Division 15. **DHS** Department of Human Services 16. **DOE** Department of Education 17. **DOH** Department of Health	18. **EAA** Environmental Accessibility Adaptations 19. **E-ARCH** Expanded Adult Residential Care Home 20. **EPSDT** 21. **HCBS** Home and Community Based Services 22. **IADLs** Instrumental Activities of Daily Living 23. **ICF** Intermediate Care Facility 24. **LTSS** Long-Term Services and Supports 25. **MQD** Med-QUEST Division 26. **NF** Nursing Facility 27. **PA** Personal Assistance 28. **PERS** Personal Emergency Response Systems 29. **PCP** Primary Care Provider 30. **SC** Service Coordinator 31. **SHCN** Special Health Care Needs 32. **SN** Skilled Nursing (Private Duty) 33. **SNAP** Supplemental Nutrition Assistance Program 34. **SNF** Skilled Nursing Facility 35. **SP** Service Plan