STATE OF HAWAII
HEALTH AND FUNCTIONAL ASSESSMENT
CHILD AND ADULT

☐ Child ☐ Adult
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

Health Plan

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

a. Member Name — Last, First, MI
b. Date of Birth / /
c. Medicaid ID#

A2. Assessment

a. Reason for Assessment
- ☐ 1. Initial
- ☐ 2. Reassessment
- ☐ 3. Annual
- ☐ 4. Change of Condition/Status:

b. Assessment Reference Information
1. Date: / /
2. Time: __:__ ☐ AM ☐ PM
3. Assessment Location:
4. Member's Resident Address:
5. Identify any safety issues that a SC may encounter during the assessment.

c. Assessor (Primary)
1. Assessor Name:
2. Title:

d. Assessor (Consult)
1. Assessor Name:
2. Title:

e. Additional Health Plan Insurance
1. Health Plan Name:
2. Subscriber Name:
3. Subscriber Number:
4. Are you a veteran? ☐ Yes ☐ No
5. Are you receiving any veteran benefits? ☐ Yes ☐ No
   Identify:

f. Medicare
1. Medicare ☐ Yes ☐ No
   ID#
2. Medicare Advantage ☐ Yes ☐ No
   Plan Name:
   ID#

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

h. Comments:

A3. Legal Information ☐ No Change from Previous Assessment

a. Legal Responsibility(ies) — Health Plan Copy
- ☐ 1. Self
- ☐ 2. Legal Guardian — ☐ Yes ☐ No
  Name:
- ☐ 3. Authorized Representative — ☐ Yes ☐ No

b. Advance Directives
1. Do you have an Advance Directive?
   ☐ Yes ☐ No
2. If yes, do you have a copy of the Advance Directive?

☐ Child ☐ Adult

Health Plan

Long Term Services and Supports (LTSS) ☐
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At Risk ☐

<table>
<tr><td>Name:
☐ 4. Healthcare Power of Attorney ☐ Yes ☐ No
Name:
☐ 5. Family Educational Rights and Privacy Act (FERPA)
☐ Yes ☐ No
☐ 6. Other:
Name:
☐ 7. Identify parents or adults who are NOT allowed information on the member, only if identified on a legal document. Name:</td><td>☐ Yes ☐ No
3. If no, would you like more information on Advance Directives?
☐ Yes ☐ No
4. Health Plan obtained copy for records?
☐ Yes ☐ No
5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST)? ☐ Yes ☐ No
6. Location of POLST:</td></tr>
</table>

c. Emergency Contact(s)

	Name	Relationship to member	Address	Phone number	Email address
Primary					
Secondary					

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.**

e. Comments – Identify any risk factors:

SECTION B. DEMOGRAPHIC INFORMATION

B1. Demographics ☐ No Change from Previous Assessment

a. Gender	b. Relationship Status	
☐ 1. Male	☐ 1. Single	☐ 4. Separated
☐ 2. Female	☐ 2. Married	☐ 5. Widowed
☐ 3. Preferred	☐ 3. Divorced	☐ 6. Other:
Gender Identity:		

☐ Child ☐ Adult

Health Plan

Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

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:

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:

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:

c. Interpretation
1. Do you need an interpreter?
   ☐ Yes ☐ No

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
- ☐ 12. Laotian
- ☐ 13. Large Format
- ☐ 14. Marshallese
- ☐ 15. Palauan
- ☐ 16. Samoan
- ☐ 17. Spanish
- ☐ 18. Tagalog
- ☐ 19. Tongan
- ☐ 20. Vietnam
- ☐ 21. Visayan
- ☐ 22. Other:

e. Translation
1. Do you need a translation?
   ☐ Yes ☐ No

f. Other Assistive Communication Device(s): ☐ None

g. Comments:

B3. Residence and Living Arrangements ☐ No Change from Previous Assessment

☐ Child ☐ Adult
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At Risk ☐

Health Plan

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:

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:

c. Type of Subsidized Housing

☐ i. Hawaiian Homestead
☐ ii. Section 8
☐ iii. Public Housing
☐ iv. Other:

d. Comments:

SECTION C. MEDICAL INFORMATION

C1. Disease Diagnosis(es) ☐ No Change from Previous Assessment

a. Disease Diagnosis(es)

List Disease Diagnosis(es)	ICD-10 Code	Date of Onset
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown
		/ / ☐ Unknown

b. Comments – Identify any risk factors:

C2. Transplant ☐ No Change from Previous Assessment

a. Transplant

1. Have you had a transplant? ☐ Yes ☐ No
2. What type of transplant?

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At Risk ☐

3. Is member compliant with transplant related medication and provider follow-up? ☐ Yes ☐ No
4. If not, document action plan.

b. Comments – 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? ☐ Yes ☐ No
2. If Yes, **attach a current Medication list and/or complete the Medication Attachment Form. Attach to assessment and service plan.**
3. Allergies: ☐ Yes ☐ No Specify:

C4. Treatments and Therapy(ies) ☐ No Change from Previous Assessment ☐ NA

Treatment/Therapy	Prescribing Provider	Provider/ Agency	Frequency	Comments/Needs

C5. Medical Equipment and Supplies ☐ No Change from Previous Assessment ☐ NA

Medical Equipment and Supplies	Type/Description /Amount	Prescribing Provider	Indicate Rent or Own	Vendor and Phone Number	Comments/Needs
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		

C6. Physician(s) and Provider(s) ☐ No Change from Previous Assessment

Physician(s)/Provider(s) Name	Specialty	Address	Phone Number	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?	☐ 0 ☐ 1-2 ☐ 3 or more
2. How many times did you go to the emergency room within the past six months?	☐ 0 ☐ 1-2 ☐ 3 or more

Services	Date	Reason

☐ Child ☐ Adult
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

Health Plan

a. LAST Primary Care Provider visit	/ /	☐ Unknown
b. NEXT scheduled Primary Care Provider visit:	/ /	☐ Unknown
c. Other Provider visit Type: NEXT scheduled visit: Other Provider visit Type: NEXT scheduled visit: Other Provider visit Type: NEXT scheduled visit:	/ / / / / /	☐ Unknown ☐ Unknown ☐ Unknown
d. Comments – Identify any risk factors:		

C8. Prevention & Immunizations ☐ No Change from Previous Assessment

a. Screening(s)

1. Breast Cancer screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
2. Cervical Cancer screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
3. Colorectal screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
4. Osteoporosis screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
5. Prostate Cancer screening in the LAST 2 YEARS ☐ Yes ☐ No ☐ Unknown ☐ N/A
6. Total Cholesterol measured in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
7. Weight/Height measured in the LAST YEAR ☐ Yes ☐ No
8. Well member visit/EPSDT screening (0 to 20 years) in the LAST YEAR ☐ Yes ☐ No
9. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
10. TB Results ☐ Negative ☐ Positive
11. Date of last TB Chest X-ray: / / ☐ Unknown
12. LAST Well Child visit: / / ☐ Unknown
13. Are your immunizations up to date? ☐ Yes ☐ No ☐ Unknown
14. Date of Pneumococcal Vaccination: / / ☐ Unknown
15. Date of LAST Influenza Vaccination: / / ☐ Unknown
16. Other:

b. Comments – Identify any risk factors:

SECTION D. GENERAL HEALTH

D1. Birth History (Complete for Children Only through Age 18) ☐ No Change from Previous Assessment

a. Birth History

1. Did your mother have any problems while she was pregnant with you? ☐ Yes ☐ No
2. If yes, describe.
3. Did you have any problems when you were born? ☐ Yes ☐ No
4. If yes, describe.
5. Did you have to stay in the Intensive Care Unit (ICU) after you were born? ☐ Yes ☐ No
6. If yes, describe.

b. Comments – Identify any risk factors:

D2. Developmental Milestones (Complete for Children, Only through Age 18) ☐ No Change from Previous Assessment

a. Developmental Milestones	YES	NO
1. Infancy (Birth – 12 months)		
i. Recognizes familiar people.	☐	☐
ii. Follows objects with eyes both in same direction.	☐	☐

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Long Term Services and Supports (LTSS) ☐
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iii. Pull to a standing position.	☐	☐
iv. Know approximately 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.	☐	☐
b. Comments – Identify any risk factors:		

D3. Cognition ☐ No Change from Previous Assessment

a. Cognition

1. Is member Comatose? ☐ Yes ☐ No **If yes, Go to Section D6**

2. Mental Status. Choose one (1)
   - ☐ Oriented: Mentally alert and aware of surroundings.
   - ☐ Disoriented: Partially or intermittently; requires supervision.
     If yes, describe.
   - ☐ Disoriented and/or disruptive.
     If yes, describe.

   If disoriented or 65+, complete the Mini-Cog Attachment

b. Comments – 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: / /

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: / / ☐ Unknown

☐ Child ☐ Adult
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

Health Plan

☐ Unknown

c. Speech	d. Communication	e. Comprehension
1. Speech pattern ☐ i. Coherent ☐ ii. Incoherent ☐ iii. No speech 2. Date of LAST Speech Evaluation: / / ☐ Unknown	1. Ability to verbally express ideas ☐ i. Adequately communicates needs/wants ☐ ii. Has difficulty communicating needs/wants ☐ iii. Unable to communicate needs/wants	1. Ability to understand others ☐ i. Understands ☐ ii. Usually understands ☐ iii. Sometimes understands ☐ iv. Rarely or never understands

f. Comments – Identify any risk factors:

D5. Mood, Behavior, and Psychological Well Being ☐ No Change from Previous Assessment

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:	None (0)	Several Days (1)	More than half the days (2)	Nearly everyday (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐
Sub Score				

b. Total Score:

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:	Never (0)	Sometimes (1)	Often (2)

☐ Child ☐ Adult

Health Plan

Long Term Services and Supports (LTSS) ☐
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At Risk ☐

1. Feels sad, unhappy	☐	☐	☐
2. Feels hopeless	☐	☐	☐
3. Dislikes themselves	☐	☐	☐
4. Worries a lot	☐	☐	☐
5. Seems to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydreams too much	☐	☐	☐
8. Distracted easily	☐	☐	☐
9. Has trouble concentrating	☐	☐	☐
10. Acts as if they have endless energy	☐	☐	☐
11. Fights with other children	☐	☐	☐
12. Does not listen to rules	☐	☐	☐
13. Does not care about others	☐	☐	☐
14. Teases others	☐	☐	☐
15. Blames others for his/her troubles	☐	☐	☐
16. Does not like to share	☐	☐	☐
17. Takes things that do not belong to him/her	☐	☐	☐
Sub Score:			
d. Total Score:			

e. Major Life Stressor(s)

1. Have you had any recent major life stressor(s)? ☐ Yes ☐ No
2. If yes, explain.

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

g. Anger

Check **ALL** that apply:

☐ 1. Angers easily
☐ 2. Have felt persistent anger with self or others. Describe.

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

☐ Child ☐ Adult

Health Plan

Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

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
- ☐ 4. Socially inappropriate or displayed disruptive behaviors
- ☐ 5. Resisting caregiving
- ☐ 6. 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.

k. Comments– 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:
   - / - _______ ☐ 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: _____

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? ☐ Yes ☐ No
3. Location:
4. Type:
5. Frequency:
6. Intensity
   - ☐ i. Numeric Rating Scale OR
   - ☐ ii. FACES Pain Rating Scale
7. Break through pain? ☐ Yes ☐ No
8. Pain management:

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Special Health Care Needs (SHCN) ☐
At Risk ☐

Health Plan

d. Substance/Drug Use

1. Smoking Use – Do you use tobacco, smokeless tobacco, or E-cigarettes? ☐ Yes ☐ No
2. Alcohol Use – Do you drink any alcohol products? ☐ Yes ☐ No
3. Other Substance/Drug Use – Do you use any other substance(s)? ☐ Yes ☐ No

If the answer is "Yes" to questions 1-3, 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.

f. Comments – Identify any risk factors:

D7. Nutrition ☐ No Change from Previous Assessment

☐ Child ☐ Adult

Health Plan

Long Term Services and Supports (LTSS) ☐
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At Risk ☐

a. Height, Weight, and Body Mass Index (BMI)

1. Height _____ feet _____ inches
   ☐ Unknown
   i. Date of height measurement:
      / /
      ☐ Unknown
2. Weight _____lbs ☐ Unknown
   i. Date of weight measurement:
      / / ☐ Unknown
3. BMI: _______ ☐ Unknown
   i. Date BMI calculated:
      / / ☐ Unknown

b. Dental

1. Do you have any broken, fragmented, loose, or non-intact natural teeth?
   ☐ Yes ☐ No
2. Do you have dentures?
   ☐ Yes ☐ No ☐ NA
3. Do you use your dentures?
   ☐ Yes ☐ No ☐ NA
   If no, reason:
4. Are you currently experiencing any toothaches or pain?
   ☐ Yes ☐ No
5. Date of LAST Dental Exam:
   / / ☐ 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? ☐ Yes ☐ No
3. If yes, explain.
4. Has a physician or provider counseled you for weight loss or weight gain? ☐ Loss ☐ Gain ☐ NA
5. Is there a plan for managing your weight? ☐ Yes ☐ No
6. If yes, describe plan.

d. Nutritional Intake

1. Are you able to eat by mouth? ☐ Yes ☐ No
2. Are you able to feed yourself independently?
   ☐ Yes ☐ No
3. If no, explain.
4. Do you have difficulty chewing and/or swallowing?
   ☐ Yes ☐ No
5. Do you cough or choke during meals or when swallowing medications? ☐ Yes ☐ No
6. Do you hold food in your mouth/cheek instead of swallowing? ☐ Yes ☐ No
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? ☐ Yes ☐ No
   ☐ i. Nasogastric (NG) Tube
   ☐ ii. Gastrostomy Tube (GT)
   ☐ iii. Gastrojejunostomy (G/J) Tube
10. Do you require parenteral feedings? ☐ Yes ☐ No
   ☐ i. Total Parenteral Nutrition (TPN)
   ☐ ii. Other, parenteral feeding:

e. Comments – 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

b. Do you use incontinence products?
   ☐ Yes ☐ No

☐ Child ☐ Adult

Health Plan

Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

c. Comments – Identify any risk factors:

D9. Skin ☐ No Change from Previous Assessment

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).

b. Comments – 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.
☐ 3. Had a bone, muscle, or joint surgery or procedure. Date of Surgery/Procedure: / / Type:

b. Comments – Identify any risk factors:

D11. Family Planning ☐ No Change from Previous Assessment ☐ NA

a. Reproductive Health

1. Prescreening for children only: Are you sexually active? ☐ Yes ☐ No
   If "No", go to section D12 below.
2. Are you Pregnant? ☐ Yes ☐ No ☐ NA
3. If yes, complete ATTACHMENT for Pregnant Female
4. (For Females) Would you like to become pregnant in the next year?
   ☐ Yes
   ☐ I'm okay either way
   ☐ I don't know
   ☐ No
5. (For Males) Would you like your partner to become pregnant in the next year?
   ☐ Yes
   ☐ I'm okay either way
   ☐ I don't know
   ☐ No
6. Are you currently using birth control? ☐ Yes ☐ No Type:
7. If yes, are you satisfied with your method of birth control? ☐ Yes ☐ No
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? ☐ Yes ☐ No
10. Do you need help finding a family planning provider to help with your reproductive health? ☐ Yes ☐ No

b. Comments – Identify any risk factors:

D12. Functional Status ☐ No Change from Previous Assessment

a. Long Term Services and Supports (LTSS)

1, Do you have concerns about taking care of yourself? ☐ Yes ☐ No. Describe in Comments.
2. Do you currently have a caregiver who assist with these activities? ☐ Yes ☐ No
3. Is there assistance and/or services that you need to remain in your home? ☐ Yes ☐ No
4. Complete Functional Assessment Below.

☐ Child ☐ Adult
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

Health Plan

b. Instrumental Activities of Daily Living (IADLs) (COMPLETE IADLs FOR ADULTS ONLY)	Independent	Minimal	Moderate	Total
1. Routine house cleaning	☐	☐	☐	☐
2. Laundry (washing, drying, ironing, mending)	☐	☐	☐	☐
3. Shopping/Errands	☐	☐	☐	☐
4. Transportation/Escort	☐	☐	☐	☐
5. Meal Preparation	☐	☐	☐	☐
6. Other: ☐ NA	☐	☐	☐	☐
c. Activities of Daily Living (ADLs)	**Independent**	**Minimal**	**Moderate**	**Total**
1. Eating/Feeding	☐	☐	☐	☐
2. Bathing	☐	☐	☐	☐
3. Dressing upper body	☐	☐	☐	☐
4. Dressing lower body	☐	☐	☐	☐
5. Grooming/Personal hygiene	☐	☐	☐	☐
6. Toileting	☐	☐	☐	☐
7. Walks with or without assistive device. Identify assistive device(s):	☐	☐	☐	☐
8. Do you have difficulty accessing areas of your house? ☐ Yes ☐ No	If yes, explain:			
9. Bed Mobility/Transfers	☐	☐	☐	☐
10. Manual Wheelchair mobility ☐ NA	☐	☐	☐	☐
11. Medication assistance ☐ NA	☐	☐	☐	☐
12. Other: ☐ NA	☐	☐	☐	☐

d. Activity/Mobility/Exercise. Document your observations of member, e.g. able to walk, uses assistive device, etc.

e. Comments – Identify any risk factors:

SECTION E. PSYCHOSOCIAL HISTORY

E1. Member's Perspective

a. Personal History/Lifestyle/Goals

1. Ask about **Family Life** and use the bulleted points to start the conversation.
   - Where did you grow up? Can you tell me about where you grew up?
   - Describe Family.

   What was member's response:

2. Ask about **Education/Work/Occupation** and use the bulleted points to start the conversation.
   - What was the highest level of education you completed?
   - What kind of work do you do or did you do?
   - Do you want to volunteer/work now?
   - What kind of work/volunteer did you do or do you want to do?

   What was member's response:

3. Ask about **Recreation/Fun/Relaxation** and use the bulleted points to start the conversation.
   - What are some things you enjoy doing? Tell me about some of the things you enjoy doing.
   - Identify some people you enjoy spending time with and list their relationship.

   What was member's response:

4. Ask about **Strengths/Accomplishments** and use the bulleted points to start the conversation.
   - What are some of the things you feel you are good at doing?
   - What are some things you have done that you feel proud of?

   What was member's response:

5. Ask about **Traditions/Rituals** and use the bulleted points to start the conversation.
   - Do you have any cultural, personal, or religious beliefs?
   - Do these beliefs impact service expectations and delivery?
   - If yes, describe.
   - Are you able to attend religious services or engage in spiritual practices as often as you like?
   - If no, explain.

   What was member's response:

6. Ask about **Home** and use the bulleted points to start the conversation.
   - Did you choose the place where you live?
   - Do you like where you live now?
   - If no, explain.
   - Would you prefer to live somewhere else?
   - If yes, explain.
   - What other HCBS settings did you consider?

   What was member's response:

7. Ask about **Routines** and use the bulleted points to start the conversation.
   - What is a typical day like for you - - what is your daily routine from the time you get up until you go to bed?
   - What are the things you like about your routine?
   - What are the things you don't like about your routine?

   What was member's response:

8. Ask about **Care Needs** and use the bulleted points to start the conversation.
   - What are your thoughts/feelings about your disability/illness?
   - What are your current concerns/needs and how are you handling them?
   - Are you able to direct your care?
   - If no, explain.
   - Do you have any specific end of life wishes or arrangements?
   - If yes, describe.

   What was member's response:

b. Comments – Identify any risk factors:

E2. Finances

a. Finances

1. Do you have concerns about your financial situation? ☐ Yes ☐ No

☐ Child ☐ Adult

Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

a. ☐ Housing/Rent
b. ☐ Monthly Expenses due to:
c. ☐ Dependents
d. ☐ Other:

2. What income sources do you have?
   - ☐ SSI
   - ☐ SSDI
   - ☐ DHS Financial Assistance
   - ☐ SNAP (food stamps)
   - ☐ Employment
   - ☐ Other
3. Employment Income:
   - ☐ Full-time work
   - ☐ Part-time or temporary work
   - ☐ Unemployed
     - ☐ Seeking Work
     - ☐ Not seeking work (ex: student, retired, disabled, unpaid primary caregiver)

   Please write:
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:
   - ☐ Food
   - ☐ Clothing
   - ☐ Utilities
   - ☐ Child Care
   - ☐ Phone
   - ☐ Medicine or any Health Care (Medical, Dental, Mental Health, Vision)
   - ☐ Other. Please describe:
5. Are you worried about losing your housing?
   - ☐ Yes
   - ☐ No
6. Would it be helpful to review your monthly expenses? ☐ Yes ☐ No **If yes, complete ATTACHMENT for Financial Worksheet and/or make appropriate referral.**
7. Have you previously applied for additional services?

   ☐ Yes ☐ No
8. Are you in the process of applying for additional assistance?

   ☐ Yes ☐ No
9. Referrals:
   - ☐ Housing Assistance
   - ☐ Food Stamps
   - ☐ Social Security/SSI
   - ☐ Financial Management Assistance *(e.g. Budget Assistance, Rep Payee):*
   - ☐ Other:

b. Comments – Identify any risk factors:

E3. Social Supports ☐ No Change from Previous Assessment

☐ Child ☐ Adult
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

Health Plan

a. Social Supports

1. Family and/or friends living in the SAME residence? ☐ Yes ☐ No

Name (*Primary Caregiver)	Age	Relationship	Contact Number	Type of Support

2. Family and/or friends NOT living in the same residence and providing support to member? ☐ Yes ☐ No

Name	Age	Relationship	Contact Number	Type of Support

3. Strong and supportive relationship with family? ☐ Yes ☐ No

b. Comments – Identify any risk factors:

E4. Caregiver(s) ☐ No Change from Previous Assessment ☐ NA

Name	Age	Relationship	Phone C = Cell, H = home, W = Work	Type of help	Outside Employment	Employer Name	Work hours/week
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		

a. Primary Caregiver Name:

1. Ask about the **Primary Caregiver Status** and use the bulleted points to start the conversation.
   - How do you feel about being a caregiver?
   - What do you do to care for yourself and your own needs?
   - Do you need help caring for member? If yes, describe.
   - What are your plans if you are no longer able to care for member?
   - Have you discussed your plans with member?
   - If yes, how does member feel about your plans?
   - Do you have any other caregiving demands or responsibilities?
   - If yes, explain.
   - Do you have any concerns/needs? What was Primary Caregiver's response?

b. Comments – Identify any risk factors:

SECTION F. DISEASE SPECIFIC QUESTIONS

The following are attachments triggered by certain questions.

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

STATE OF HAWAII
HEALTH AND FUNCTIONAL ASSESSMENT
CHILD AND ADULT

☐ Child ☐ Adult

Health Plan

Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

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 questionnaire. Attach to this assessment.

☐ **F1. Asthma, Chronic Obstructive Pulmonary Disease (COPD), Respiratory/Tracheostomy/Ventilator**
☐ **F2. Cancer**
☐ **F3. Diabetes**
☐ **F4. End Stage Renal Disease (ESRD)**
☐ **F5. Heart Disease**
☐ **F6. Hepatitis B/C**
☐ **F7. High Blood Pressure**
☐ **F8. HIV/AIDS**
☐ **F9. Seizures**

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

☐ NA

a. List HCBS Services

HCBS Service	Provider/Agency	Frequency/Amount	Comments/Needs

b. Comments:

G2. Institutional Services ☐ No Change from Previous Assessment

a. List Institutional Services

Institutional Service	Provider	Comments/Needs

b. Comments:

G3. Programs ☐ No Change from Previous Assessment

a. State Program(s)

1. Are you currently receiving services from any State Program(s)? ☐ Yes ☐ No
2. Name of School Attending:
3. Identify State Program(s)

State Program	Contact Name	Phone Number	Services/Hours
☐ DOE/Special Education			
☐ DOE/Physical, Occupational or Speech Therapy			
☐ DOH/Early Intervention			

☐ Child ☐ Adult	Health Plan
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

☐ DOH/CAMHD			
☐ DOH/AMHD			
☐ DOH/DDID			
☐ DHS/CCS			
☐ DHS/CWS			
☐ DHS/APS			
☐ Other:			
☐ Unknown			

b. Comments:

c. Non-State Program(s)

Non-State Program	Contact Name	Phone Number	Services/Hours
☐ Unknown			

d. Comments:

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 family living? Check all that apply:
   ☐ Yes, it has kept me from medical appointments or getting medications.
   ☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
   ☐ No (Skip to Section I)

2. Current Mode of Medical 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?
   ☐ Yes ☐ No
4. If no, explain.
5. Are you able to ambulate without assistance (with or without device, includes wheelchair)? ☐ Yes ☐ No

☐ Child ☐ Adult
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

Health Plan

6. Are you able to ambulate to the local bus stop? ☐ Yes ☐ No
7. Describe.
8. If wheelchair bound, are you able to self-propel to curb side for pick up? ☐ Yes ☐ No
9. If wheelchair bound, are you able to transfer in and out of vehicle without assistance? ☐ Yes ☐ No
10. If the member needs assistance, do you have an attendant? ☐ Yes ☐ No
11. Do you require any medical equipment when traveling? ☐ Yes ☐ No
12. If yes, list medical equipment. (e.g., ventilator, suction machine, feeding pump, etc.)
13. Are you able to get to curb side alone (If No, select all that apply) ☐ Yes ☐ No
    - ☐ 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

b. Comments – 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. Accessible Locations: (Select all that apply)
    - ☐ i. Doorways
    - ☐ ii. Hallway
    - ☐ iii. Bathroom
    - ☐ iv. Exits

	Adequate	Inadequate	N/A	Comments
b. Exterior Assessment				
Walkways free of clutter	☐	☐	☐	
Ramps/handrails	☐	☐	☐	#Exits: Locations:
Stairs	☐	☐	☐	#steps: Locations:
Water source	☐	☐	☐	Water catchment location:
Other:	☐	☐	☐	
c. Interior Assessment				
Clear pathway to exit/entry	☐	☐	☐	
Sturdy floors (other structural)	☐	☐	☐	
Handrails	☐	☐	☐	
Stairs	☐	☐	☐	#steps: Locations:
Free of trash accumulation/Trash Disposal	☐	☐	☐	
Lighting	☐	☐	☐	

☐ Child ☐ Adult
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

Tacked down rugs and carpets	☐	☐	☐	
Visible cords/electrical circuits	☐	☐	☐	
Telephone service and accessibility	☐	☐	☐	
Smoke/fire detector or fire extinguisher operational	☐	☐	☐	Locations:
Grab bars/support structures	☐	☐	☐	Locations:
Bathing/hand washing facilities ☐ Hot water ☐ Running water	☐	☐	☐	
Food preparation areas clean	☐	☐	☐	
Kitchen appliances ☐ Stove ☐ Refrigerator ☐ Freezer ☐ Microwave Oven	☐	☐	☐	
Food storage	☐	☐	☐	
Pets in house (cats, dogs, etc.) secured	☐	☐	☐	
Laundry ☐ Washer ☐ Dryer	☐	☐	☐	
Insects/other pests or rodents	☐	☐	☐	
Safe environment for oxygen use	☐	☐	☐	
Guns/weapons (locked/unlocked)	☐	☐	☐	If present, who is responsible?
Sufficient space for equipment/supplies	☐	☐	☐	
Home ventilation ☐ Too Hot ☐ Too Cold	☐	☐	☐	
Other:	☐	☐	☐	
d. Comments– Identify any risk factors:				

SECTION J. SUMMARY/NARRATIVE OF VISIT

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.