STATE OF HAWAII
Department of Human Services

Med-QUEST Division

Attachment for Individualized Emergency Back-Up Plan

Attach original copy to the HAP and give copy to the Member. ☐ MFP/GHP

Member Name (Last, First):	**Medicaid ID #:**	**Date:**

Check all that apply:

☐ CPR ☐ No CPR ☐ Comfort Measures Only (CMO)

☐ Provider Orders for Life-Sustaining Treatment (POLST) Yes ☐ No ☐ If No, explain:

Location of POLST copy in the home:

Contact list in case a worker does not show-up (Foster substitute caregivers included)

List of individuals or agencies who will provide emergency care:

Who to contact	**Contact Phone Number**	**Contact Address**

Other plans in case a critical need for personal assistance/nursing care and/or in case a worker does not show up.

Transportation back-up plan

List of people/providers who will provide transportation:

Who to contact	**Contact Phone Number**	**Medical (MED)/ Non-Medical Transportation (NMT)**
		☐ MED ☐ NMT
		☐ MED ☐ NMT
		☐ MED ☐ NMT

Other plans in case of a critical need for transportation and/or in case a transport is not available.

Emergency Contact -

QI Member has a cell phone: Yes ☐ No ☐

QI Member has Personal Emergency Alarm System (PERS): Yes ☐ No ☐

DME and life support repair/replacement back-up plan

Who to contact (Provider)	**Contact Phone Number**	**Item**

Other plans in case of a critical need for repair and/or in case repair services are not available.

Contact list for support in a health emergency

Who to contact	Contact Phone Number	Contact Address
Ambulance/Fire	911	

If you need to report abuse and/or neglect of elderly and/or disabled individuals:

Adult Protective Services (APS)	Child Protective Services (CPS)
Oahu 808-832-5115	Oahu 808-832-5300

Contact list for support in case of emergency/disaster:

(Examples: power outage, flooding, hurricane)

Who to contact	Contact Phone Number	Contact Address
		(Enter employer/work address)
		(Enter employer/work address)
		(Enter employer/work address)

Shelter in Place: Yes ☐ No ☐ Service Animal: Yes ☐ No ☐ Lives in Tsunami Evacuation Zone: Yes ☐ No ☐

Other plans for emergency/disaster preparedness:

Nearest shelter:

Special Needs listed:

Contact list of people who are authorized to help make decisions or sign documents for you:

(Examples: Legal Guardian, Rep Payee, Health Care Surrogate)

Who to contact	Contact Phone Number	Contact Address

_____ _____

Signature of QI Member or Representative Date

_____ _____

Signature of Individual Developing the Emergency Back-Up Plan Date

INSTRUCTIONS FOR QI INDIVIDUALIZED EMERGENCY BACK-UP PLAN

This attachment is completed if response to A3.d Emergency Plan question iv is "No".

1. Check the box if member is enrolled in MFP/GHP.
2. Enter Member Name, Member ID number, and date the attachment is being completed.
3. Fill in the appropriate answers.
4. Obtain signature from member or representative.
5. Obtain the signature of the individual developing the Emergency Back-up Plan.

Ensure that Individualized Emergency Back-Up Plan is updated and attached to the HAP.

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

ATTACHMENT FOR FINANCIAL WORKSHEET

ATTACH TO HFA

Member Name (Last, First):	**Member ID #**:	**Date:**

C1.a Financial Worksheet			
FINANCIAL WORKSHEET			
HOUSEHOLD INCOME (+)		HOUSEHOLD EXPENSES (-)	
Monthly Income	Amount	Monthly Expenses	Amount
Salary/Wages	$	Rent/Mortgage	$
DHS Financial Assistance	$	Electricity	$
SNAP (Food Stamps)	$	Water/Sewer	$
Social Security	$	Gas	$
Section 8/Housing Choice Voucher	$	Home Phone	$
SSI (Supplemental Security Income)	$	Cell Phone	$
SSDI (Social Security Disability Insurance)	$	Cable/Internet	$
Child Support	$	Food	$
Alimony	$	Clothing	$
Unemployment	$	Laundry	$
Veteran's Benefit	$	Car Payment	$
TDI (Temporary Disability Insurance)	$	Car Insurance	$
Other Agencies/Grants	$	Gas (car)	$
Pension/Retirement	$	Bus fare/pass	$
Child Care Subsidy	$	Car Maintenance	$
Relative's contribution	$	Medical Bills	$
Other	$	Recreation	$
		Toiletries	$
		Credit Card(s)	$
		Loans(s)	$
		Other	$
TOTAL INCOME	$	TOTAL EXPENSES	$
TOTAL INCOME – TOTAL EXPENSES:	$		
Recommendations for Financial Management:			
Housing Assistance:			
Food Stamps:			
SSI:			
Other:			
b. Comments – Identify any risk factors:			

INSTRUCTIONS FOR FINANCIAL WORKSHEET

This attachment is completed if response to C1.a Finances question vi is "Yes."

1. Complete financial worksheet and/or refer to appropriate agency for financial planning or assistance as needed.

At any point you identify the member has financial problem(s), a new task order must be added to the HAP.

ATTACHMENT FOR SOCIAL DETERMINANTS OF HEALTH (SDOH)/SOCIAL RISK FACTORS (SRF)

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

Social Determinants of Health (SDOH)/Social Risk Factors (SRF)
A1. Housing
a. What is your living situation today? ☐ 1. I have a steady place to live. ☐ 2. I have a place to live today, I am worried about losing it in the future. ☐ 3. I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street on a beach, in a car, abandoned building, bus or train station or in a park).
A2. Food
a. Within the past 12 months, you were worried that your food would run out before you got money to buy more? ☐ 1. Often true ☐ 2. Sometime true ☐ 3. Never true
B. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more? ☐ 1. Often true ☐ 2. Sometime true ☐ 3. Never true
Year 2 TBD *
Year 3 TBD
Year 4 TBD
Year 5 TBD

INSTRUCTIONS for SDOH/SRF

This attachment is completed if response(s) to C1.a Finances questions iv and/or v is/are "Yes."

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Check all that apply.

- An answer where member is at risk:
  - a referral or Warm Hand off should be made
- A note must be made within member case file and referral should be placed and a new task order must be added to the HAP

Year 1

A1. HOUSING

If you receive a "Yes" for 2 and 3, then a referral should be made.
Possible Referral Sources:

Suggested Referral Sources

1.Shelter placement
2. Screening CIS (Housing Screening HFA Attachment B3.b)
3. VA services in applicable
4. Screening CCFFH (1148 Form)
5. Public Housing and Section 8

A2. FOOD

If you receive a "Yes" for 1 and 2, then a referral should be made.
Possible Referral Sources:

Suggested Referral Sources

1. Aloha United Way- 211
2. Area food banks, Local Neighborhood Place, or local church
3. WIC (any member with a child under 5 qualifies for WIC) and/or SNAP

Year 2 TBD (B)

Year 3 TBD (C)

Year 4 TBD (D)

Year 5 TBD (E)

ATTACHMENT FOR ASTHMA/COPD/RESPIRATORY/TRACHEOSTOMY/VENTILATOR

ATTACH TO HFA

Member Name (Last, First):	**Member ID #**:	**Date**:

F1.1 Asthma

This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).

a. Asthma

1. Briefly describe your current respiratory symptoms.
2. Are your symptoms getting better or worse in the last 12 months?
3. Do you use a peak flow meter? ☐Yes ☐ No
4. How often do you use a peak flow meter?
5. Do you have a rescue inhaler? ☐Yes ☐No
6. How often do you use your rescue inhaler?
7. Do you use a nebulizer? ☐Yes ☐ No
8. How often do you use your nebulizer?
9. Do you know what triggers your respiratory condition? ☐Yes ☐ No
10. List your respiratory triggers.
11. Are you having difficulty sleeping at night due to respiratory symptoms? ☐Yes ☐ No
12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms? ☐Yes ☐ No
    If yes, do you receive help from family or is there a plan in place for managing your respiratory condition? ☐Yes ☐ No
13. Explain your plan.

b. Comments – Identify any risk factors:

F1.1 Chronic Obstructive Pulmonary Disorder (COPD)

This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).

a. COPD

1. Briefly describe your current respiratory symptoms.
2. Are your symptoms getting better or worse in the last 12 months?
3. Do you use a peak flow meter? ☐Yes ☐ No
4. How often do you use a peak flow meter?
5. Do you have a rescue inhaler? ☐Yes ☐ No
6. How often do you use your rescue inhaler?
7. Do you use a nebulizer? ☐Yes ☐ No
8. How often do you use your nebulizer?
9. Do you know what triggers your respiratory condition? ☐Yes ☐ No
10. List your respiratory triggers.
11. Are you having difficulty sleeping at night due to respiratory symptoms? ☐Yes ☐ No
12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms? ☐Yes ☐ No
    If yes, do you receive help from family or is there a plan in place for managing your respiratory condition? ☐Yes ☐ No
13. Explain your plan.
14. Do you use supplemental oxygen? ☐Yes ☐ No
15. Oxygen Flow rate _____ LPM
16. Mode of oxygen delivery.

b. Comments – Identify any risk factors:

INSTRUCTIONS FOR ASTHMA, COPD

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. ASTHMA
    a. Answer questions 1-13.
    b. In the comments section, include all risk factors.
3. COPD
    a. Answer questions 1-16.
    b. In the comments section, include all risk factors.

At any point you identify the member has a problem, a new task order must be added to the HAP.

Member Name:	**Member ID #**:	**Date**:

F1.1 and/or G4.f Respiratory/Tracheostomy/Ventilator

This attachment is completed if:

a. it has been identified in Section F1. Disease Diagnosis(es), and/or
b. in Section G4.f, box x is checked

a. Respiratory/Tracheostomy/Ventilator

1. Do you have a tracheostomy? ☐Yes ☐ No
   If yes, do you use a ventilator? ☐Yes ☐ No
   If yes, be sure to document the settings on the health action plan.
2. Do you use supplemental oxygen? ☐Yes ☐ No
   If yes, check appropriate box: ☐ Continuous ☐ As needed
3. Is your oxygen level monitored by pulse oximeter? ☐Yes ☐ No
   If yes, what are the orders for calling the doctor or using oxygen?
4. Do you require? ☐CPAP ☐ BIPAP ☐ N/A
5. How many hours each day or night do you use CPAP or BiPAP?
6. Do you see a pulmonologist? ☐Yes ☐ No
   If yes, how long has it been since you had a checkup with the pulmonologist?
7. If you require life sustaining equipment, is there a back-up plan? ☐Yes ☐ No

(Note: If member has not seen a pulmonologist, assist the member to make an appointment. If member refuses, document along with any barriers, such as transportation, that need problem solving. May require a call to the PCP to check and see if pulmonology consult is needed.)

b. Comments - Identify any risk factors:

INSTRUCTIONS FOR RESPIRATORY/TRACHEOSTOMY/VENTILATOR

1. RESPIRATORY/TRACHEOSTOMY/VENTILATOR
   a. Enter Member Name, Member ID number, and date the attachment is being completed.
   b. Answer questions 1-16.
   c. In the comments section, include all risk factors.

At any point you identify the member has a problem, a new task order must be added to the HAP.

ATTACHMENT FOR CANCER

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

F1.2 Cancer ***This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).***
a. Cancer 1. Are you currently being treated for cancer? ☐Yes ☐ No 2. Type of Cancer. 3. Describe your current status.
b. Comments - Identify any risk factors:

INSTRUCTIONS FOR CANCER

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-3.
3. In the comments section, include any risk factors.

At any point you identify the member has a problem, a new task order must be added to the HAP.

STATE OF HAWAII
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Med-QUEST Division

ATTACHMENT FOR DIABETES

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

F1.3 Diabetes

This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).

a. Diabetes

1. Briefly describe your current symptoms related to your diabetes.
2. Do you currently monitor your blood sugar levels? ☐Yes ☐ No
3. How often is blood sugar being monitored?
4. What is your usual blood sugar range? _____-_____
5. What is your Glycohemoglobin or A1C level?
6. Has your doctor set a goal for your blood sugar range? ☐Yes ☐ No
7. What is your doctor's recommended blood sugar range? _____-_____
8. Is there a plan in place for managing blood sugar levels? ☐Yes ☐ No
   If Yes, explain.
9. Are you on insulin? ☐Yes ☐ No
   If Yes, how do you administer your insulin, e.g., Injections, pump?
10. Do you sense when your blood sugar levels are low? ☐Yes ☐ No
    If Yes, what are your symptoms?
11. Do you sense when your blood sugar levels are high? ☐Yes ☐ No
    If Yes, what are your symptoms?
12. How do you manage your low blood sugar levels?
13. Do you have blood pressure, heart, kidney, or circulatory problems? ☐Yes ☐ No
    If Yes, explain.
14. Have you had an eye exam in the last 12 months? ☐Yes ☐ No
15. Do you regularly check your feet for any open cuts, sores, swelling, tingling or discoloration? ☐Yes ☐ No
16. Are your feet regularly checked by a doctor? ☐Yes ☐ No
17. Do you have any amputations? ☐Yes ☐ No
    If Yes, describe location(s).

b. Comments - Identify any risk factors:

INSTRUCTIONS FOR DIABETES

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-17.
3. In the comments section, include any risk factors.

At any point you identify the member has a problem or is at Risk for diabetes, a new task order must be added to the HAP.

STATE OF HAWAII
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ATTACHMENT FOR End-Stage Renal Disease (ESRD)

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

F1.4 End-Stage Renal Disease (ESRD)

This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).

a. ESRD

1. When were you diagnosed with renal failure? / /
2. Are you currently receiving dialysis? If Yes, complete the following questions: ☐Yes ☐ No
   i. Facility Name:
   ii. Location:
   iii. Telephone:
3. What type of dialysis is currently being used?
   ☐i. Peritoneal dialysis
   ☐ii. Hemodialysis
   ☐iii. Other:
4. If peritoneal dialysis, who is assisting with your dialysis?
5. Dialysis frequency:
   ☐i. Daily
   ☐ii. Three times per week
   ☐iii. Other:
6. Current access type for dialysis:
   ☐i. AV Fistula
   ☐ii. AV Graft
   ☐iii. Vas Cath
7. Site most used:
   ☐i. AV Fistula
   ☐ii. AV Graft
   ☐iii. Vas Cath
8. Have you missed 1 or more dialysis appointments in the last 30 days? ☐Yes ☐ No
   If Yes, explain.
9. How do you get to your dialysis appointments?
10. Do you have help after your dialysis treatments?
11. Do you experience any problem(s) with your dialysis treatments? ☐Yes ☐ No
    If Yes, explain.

b. Comments - Identify any risk factors:

INSTRUCTIONS FOR ESRD

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-13.
3. In the comments section, include any risk factors.

At any point you identify the member has a problem, is at risk or needs a referral, a new task order must be added to the HAP.

ATTACHMENT FOR HEPATITIS B and C

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

F1.5 Hepatitis ***This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).***
a. Hepatitis 1. Briefly describe your current symptoms related to your condition. 2. Are you experiencing any side effects from the medications? ☐Yes ☐ No 3. Do you know which type of Hepatitis (A, B, or C) you have? ☐A ☐ B ☐ C 4. If you have Hepatitis B or Hepatitis C, have you received treatment? ☐Yes ☐ No
b. Comments - Identify any risk factors:

<u>INSTRUCTIONS FOR HEPATITIS B and C</u>

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-4.
3. In the comments section, include any risk factors.

At any point you identify the member has a problem, a new task order must be added to the HAP.

STATE OF HAWAII
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ATTACHMENT FOR HIGH BLOOD PRESSURE

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

F1.6 High Blood Pressure

This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).

a. High blood pressure

1. Briefly describe your current symptoms related to your high blood pressure.
2. List symptoms that would indicate you need immediate help for high blood pressure. (i.e., chest pressure/discomfort, shortness of breath, headache etc.)
3. Do you currently monitor your blood pressure levels? ☐Yes ☐ No
4. How often is blood pressure being monitored?
5. Has your doctor set a goal for your blood pressure range? ☐Yes ☐ No
6. What is your doctor's recommended blood pressure range _____-_____
7. Is there a plan in place for managing blood pressure? ☐Yes ☐ No
   If yes, explain.
8. Do you have high blood sugar, kidney, or circulatory problems? ☐Yes ☐ No
   If yes, explain.

b. Comments - Identify any risk factors:

INSTRUCTIONS FOR HIGH BLOOD PRESSURE

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-8.
3. In the comment section, include all risk factors.

At any point you identify the member has a problem, a new task order must be added to the HAP.

STATE OF HAWAII
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Med-QUEST Division

ATTACHMENT FOR HEART DISEASE

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

F1.1 and/or G4.f. Heart Disease

This attachment is completed if:

a. it has been identified in Section F1. Disease Diagnosis(es), and/or

b. in Section G4.f, any of the boxes i-x is/are checked

a. Heart Disease

1. Do you have a heart condition? ☐Yes ☐ No
   If Yes, explain.
2. Have you had any heart surgeries? ☐Yes ☐ No
   If Yes, what are the type(s) and dates of your heart procedure(s), e.g., valve surgery, catheterization.
   Heart Procedure: Date: / /
   Heart Procedure: Date: / /
3. If positive for history of chest pain, answer the following:
   How would you describe your chest pain?
   When do you experience the chest pain?
   What relieves your chest pain?
4. Do you get tired easily when walking short distances or walking up or down stairs? ☐Yes ☐ No
5. How do you know that your heart condition is getting worse (i.e., weight gain, shortness of breath, swelling of lower extremities, angina, lightheadedness, etc.)
6. Do you regularly check your weight? ☐Yes ☐ No
7. Do you regularly check your blood pressure? ☐Yes ☐ No
8. Do you regularly check your pulse? ☐Yes ☐ No

b. Comments - Identify any risk factors:

INSTRUCTIONS FOR HEART DISEASE

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-8.
3. In the comments section, include all risk factors.

At any point you identify the member has had a problem, a new task order must be added to the HAP.

STATE OF HAWAII
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Med-QUEST Division

ATTACHMENT FOR HIV/AIDS

ATTACH TO HFA

Member Name:	**Member ID #:**	**Date:**

F1.8 HIV/AIDS ***This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).***
a. HIV/AIDS 1. Identify the current stage of your disease (HIV/AIDS) ☐i. Acute Infection ☐ii. Clinical latency (inactivity or dormancy) ☐iii. AIDS ☐iv. Unknown 2. Briefly describe your current symptoms related to your condition. 3. Experiencing any side effects from the medications? ☐Yes ☐ No
b. Comments - Identify any risk factors:

INSTRUCTIONS FOR HIV/AIDS

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Please select the stage of disease. If a referral is needed, it can be dictated by the stage of disease and/or symptoms.
   Below are referral suggestions:
   - Behavioral Health
   - Case Management
   - Nutrition
   - Peer Support
   - Primary care and/or Infectious Disease
   - Health Coordinator and/or Social Worker
   - Substance Abuse Screening and/or Counseling
   - Legal Aid Society
   - Hawaii Health and Harm Reduction Center

2. Members who report symptoms should be referred to a medical provider for evaluation.

3. Members who report medication side effects should be referred to a medical provider for evaluation.

4. In the comments section, risk factors include conditions that can lead to:
   1. Deterioration of disease condition.
   2. Exposure to vulnerabilities in social determinants of health (SDOH) which can impact the member's well-being.

At any point you identify the member has a problem, is at risk or needs a referral, a new task order must be added to the HAP.

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

ATTACHMENT FOR SEIZURES

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

F1.9 Seizures

This attachment is completed if it has been identified in Section F1. Disease Diagnosis(es).

a. Seizures

1. Describe what happens when you have seizure(s):
2. How often do you have seizures?
3. When did you last see a doctor about your seizures?
4. Have you had any change in your symptoms or seizures that your doctor is not aware of? ☐Yes ☐ No
5. Are there things that can cause your seizures such as fever, bright lights, not taking medicines on time, and certain illnesses? ☐Yes ☐ No
   If yes, describe.
6. Do you usually know when a seizure is going to happen? ☐Yes ☐ No
   If yes, describe.
7. When was the last time you had a seizure?
8. How long does the seizure usually last?
9. Do others living with you know what to do to keep you safe when you have a seizure? ☐Yes ☐ No
   If yes, describe.
10. Have you been told by your doctor when to call 911? ☐Yes ☐ No
    If yes, describe.
11. Have others living with you been trained in CPR? ☐Yes ☐ No

b. Comments – Identify any risk factors:

INSTRUCTIONS FOR SEIZURES

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-15.
3. In the comments section, include all risk factors.

At any point you identify the member has a problem, a new task order must be added to the HAP.

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

ATTACHMENT FOR MEDICATIONS

ATTACH TO HFA AND HAP

Member Name (Last, First):	**Member ID #:**	**Date:**

F3.3 Medications

This attachment is completed if response to F3 Medications question iii is "Yes."

Pharmacy: Address: Phone:

Delivered: Yes ☐ No ☐ Mailed: Yes ☐ No☐

1. If taking anti-psychotics, anti-anxiety, or anti-depressants, how often do you take these prescribed medications in the past seven (7) days?
   - ☐ Routine
   - ☐ PRN
   - ☐ Routine and PRN

2. Did you take more than what is prescribed by your doctor?
   - ☐ Yes
   - ☐ No
   - ☐ No response

3. Are you taking these medications to manage your behavioral symptoms?
   - ☐ Yes
   - ☐ No
   - ☐ No response

4. What types of non-pharmacological interventions do you do before you take this medication to manage behavior symptoms?

5. Has there been an attempt to reduce the dose of the medication?
   - ☐ Yes. Date of last attempted dose reduction:
   - ☐ No. Doctor documented dose reduction as clinically contraindicated, date:

Prescription Medication

Medication Name	Reason	Dose	Route	Frequency	Prescribing Provider	Compliant		Comments/Barriers
						Yes	No	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	

						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	

Over The Counter (OTC) List vitamins, supplements, herbal or OTC medications								
OTC Name	Reason	Dose	Route	Frequency	Prescribing Provider	Compliant		Comments/Barriers
						Yes	No	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	

INSTRUCTIONS FOR MEDICATIONS

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-5.
3. List all prescribed and OTC medications, herbal, supplements, vitamins and complete the table provided.

At any point you identify the member has a medical problem, a new task order must be added to the HAP.

ATTACHMENT FOR COGNITION

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

G1.a Cognition Assessment

This attachment is completed if Member is identified as disoriented or 65+ in G1.a Cognition.

a. Word Registration

1. Ability to repeat:

_____
_____
_____

☐ i. None
☐ ii. One Correct
☐ iii. Two Correct
☐ iv. Three Correct

Version 1 Banana Sunrise Chair	Version 2 Leader Season Table
Version 3 Village Kitchen Baby	Version 4 River Nation Finger
Version 5 Captain Garden Picture	Version 6 Daughter Heaven Mountain

b. Clock Drawing

1. Draw a clock
2. Place numbers where they go
3. Set hands to 10 past 11

c. Word Recall

1. Ability to recall:

_____
_____
_____

☐ i. None
☐ ii. One Correct
☐ iii. Two Correct
☐ iv. Three Correct

b. Comments - Identify any risk factors:

INSTRUCTIONS FOR MINI-COG ASSESSMENT

a. Ask member to repeat three (3) words from the versions listed on the left. Ask member to remember the words as s/he will be asked to repeat them later in assessment. Assessor must document words used and how many words member was able to repeat. If member is unable to repeat the words after three attempts, move on to step b. clock drawing.

b. HC to draw a circle on paper, then asks member to draw a clock and place the numbers where they go. Tell member to draw the hands of the clock to 10 past 11. If member is unable to complete within 3 minutes, move on to step c. word recall. Repeat instructions as needed as this is not a memory test.

A normal clock = two (2) points, has all numbers in correct sequence, with appropriate correct positions, with no missing or duplicate numbers, and hands pointing to 11 and 2. The hand length is not scored. Inability or refusal to draw clock = (abnormal = 0 points).

c. Ask member to repeat three (3) words that they were asked to remember. One (1) point for each word spontaneously recalled without cueing. None- Zero (0) points = Demented, symptoms of dementia, 3 points = no symptoms of dementia.

d. Interpretation of Score: Maximum score is five (5). PASS ≥ 4; FAIL = 3 or less.

Note: If concerns are identified through this assessment, and the member does not have a cognitive impairment diagnosis, HC should refer member to PCP for further evaluation.

At any point you identify the member has a cognitive problem or you suspect cognitive impairment diagnosis is needed, a new task order must be added to the HAP.

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

ATTACHMENT FOR PHQ-9

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

G3.a PHQ-9

This attachment is completed if responses to Section G3. Mood, Behavior, and Psychological Well-Being Member question a. PHQ-2 scored 3 or greater.

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 every day (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				

TOTAL SCORE:

Are there concerns identified through this assessment and the member does not yet have a Behavioral Health diagnosis?
☐ Yes ☐ No

If Yes, check below.

☐ Refer member to a Primary Care Physician (PCP) for further evaluation.

☐ Member declined referral.

Comments:

INSTRUCTIONS FOR PHQ-9

1. Enter Member Name, Member ID number, and date the attachment is being completed.

2. Code items 1-9 following the guideline below:
   Not at all – No problems.
   Several days – Has been bothered at least 1-6 days.
   More than half the days – Has been bothered at least 7-11 days.
   Nearly every day – Has been bothered at least 12-14 days.

3. For scoring: 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

4. Interpretation of score: Any score greater than or equal to 5, refer member to PCP for further evaluation.

At any point you identify the member has Behavioral Health need as indicated within the PHQ-9 Attachment, a new task order must be added to the HAP.

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ATTACHMENT FOR FALL RISK ASSESSMENT

ATTACH TO HFA

Member Name (Last, Name):	**Member ID #:**	**Date:**

G4.b Fall History

This attachment is completed if Member is 18 or older and had one fall with injury or had at least 2 falls in the past year as identified in Section G4.b Fall History.

Definition: A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Note: All components do not need to be completed during a single encounter but should be documented in the Member record as having been performed

FALL RISK ASSESSMENT	
☐ Member refuses to participate in the fall risk assessment. Stop here.	
1. Balance/gait assessment i) Documentation of observed transfer and walking.	Please refer to HFA G4.b: Fall history: ☐ Impaired balance/gait identified and documented. ☐ Yes. ☐ No.
2. Vision assessment i) Documentation that member is functioning well with vision or not functioning well with vision based on discussion with the Member	Please refer to HFA G2.a: Vision: Impaired vision identified and documented. ☐ Yes. ☐ No.
3. Home fall hazards assessment i) Documentation of inquiry of home fall hazards.	Please refer to HFA Section E: Home hazards: Home hazards identified and documented. ☐ Yes. ☐ No.
4. Medication assessment i) Documentation on whether or not medications are a contributing factor to falls.	Please refer to HFA Section F3.vii: Medications: Medications are documented as contributing factor to falls. ☐ Yes ☐ No

INSTRUCTIONS FOR FALL RISK ASSESSMENT

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-4.

At any point you identify the member has had or is at Risk for a fall, follow special instructions on the HAP.

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ATTACHMENT FOR TOBACCO AND/OR CAGE AID

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

Tobacco Screening Tool

Question	Answer
Have you ever used Tobacco/Nicotine products?	Choose an item.
Tobacco/ Nicotine Use Status	Choose an item.
At what age did you first use tobacco/ Nicotine product(s)?	Choose an item.
In the past 30 days, what tobacco/ Nicotine products did you use most frequently?	Choose an item.
Other (Please Describe)	
In the past 30 days, how often did you use tobacco/ Nicotine products per week?	Choose an item.
In the past 30 days, how many times did you use (smoke) tobacco/ Nicotine products per week?	
Have you ever tried to quit or thought about quitting?	Choose an item.
Do you want to quit?	Choose an item.

INSTRUCTIONS for Clinical Staff

- If member indicates that they have been using or want/tried to quit, a Referral to Plans Tobacco Cessation program should be offered.
- Please note that those that are within the **Priority Group** must receive a Tobacco screening and Educational Information from either inhouse Tobacco Cessation program.
- A note must be found within member case file.
- **At any point you identify the member has a problem with Tobacco, a new task order must be added to the HAP.**

Who is in the **Priority Group**?

1. Pregnant, Breast-Feeding Woman, and Parent's with child/children under the age of 5 years old.
2. Any member with a major medical condition that if they continue to use, they are either at risk or it is life or death to continue to use. These people are those who have diagnosis of:
    a. Lung Diseases (COPD, Asthma, Emphysema)
    b. Cancer

3. Any other medical issues that continue uses of Tobacco products will result in risk of death, serious injury or further serious medical complications.

ATTACHMENT FOR TOBACCO AND/OR CAGE AID

C.A.G.E.-A.I.D. +

Cut, Annoyed, Guilty & Eye Opener-Adapted to Include Drugs

Instructions: Answer Yes or No to each of the following questions as it related to the last 12 months of your life.

Questions	Type	Answer	Score
1. Have you ever felt you ought to cut down on your drinking or drug use?	Choose an item.	Choose an item.	
• **Notes (List Name of Other Substances Used)**			
2. Have people annoyed you by criticizing your drinking or drug use?	Choose an item.	Choose an item.	
• **Notes (List Name of Other Substances Used)**			
3. Have you ever felt bad or guilty about your drinking or drug use?	Choose an item	Choose an item.	
• **Notes (List Name of Other Substances Used)**			
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?	Choose an item.	Choose an item.	
• **Notes (List Name of Other Substances Used)**			
		Total Score:	

ATTACHMENT FOR TOBACCO AND/OR CAGE AID

Instructions for Scoring
• Item responses on the CAGE-AID questions are scored **0 for "no"** and **1 for "yes"** answers. • Place Sore in score box with total score in the bottom. • A total score of two (2) or greater is considered clinically significant. Unless member is a part of the **Priority group**, which makes a score of one (1) or greater. • Type: Please select all types of substance used as it relates to the question being asked. • If member reports using a drug that is not listed, please write this down on the gray "Notes" section ****** Motivation Interviewing skills are necessary to complete this tool. ******
INSTRUCTIONS for Clinical Staff
• A score of 2 or more may indicate clinically significant alcohol or drug problems a referral needs to be made to either inhouse SUD treatment services or to HAWAII CARES for a complete screen and determination if member needs SUD services • Please note that those that are within the **Priority Group** must receive a SUD screening from either inhouse SUD treatment services or to HAWAII CARES at score of 1 or more • A note must be found within member case file • **At any point you identify the member has a problem with Substances, a new task order must be added to the HAP.**
Who is in the **Priority Group**?
1. Pregnant, Breast-Feeding Woman, and Parent/s (single parent or both parents) are using substances and have child/children under the age of 5 years old and are the primary caretaker. 2. HIV/AIDS positive member 3. Any member with a major medical condition that if they continue to use, they are either at risk or it is life or death to continue to use. These people are those who have diagnosis of a. Liver Failure (Cirrhosis) b. Kidney Diseases c. Any other medical issues that continue uses of Alcohol or Other Substance use will result in risk of death, serious injury or further serious medical complications.

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ATTACHMENT FOR PREGNANCY

ATTACH TO HFA

Member Name (Last, First):	**Member ID #:**	**Date:**

G9.a Pregnancy

This attachment is completed if response in Section G9.a Reproductive Health question i is "Yes".

a. Pregnancy Only	
1. Expected Date of Delivery / /	
2. Is this a planned pregnancy?	☐ Yes ☐ No
3. Would you like information or resources regarding your options?	☐ Yes ☐ No
4. Would you like information or resources regarding pregnancy or parenting?	☐ Yes ☐ No
5. Date of Last Menstrual Period / /	
6. Are you receiving prenatal care?	☐ Yes ☐ No. If No, refer to prenatal provider and maternity program
7. Date of First Prenatal Visit / /	
8. Date of Most Recent Prenatal Visit / /	
9. Identify your prenatal care provider(s) ☐ i. OB/GYN ☐ ii. Midwife ☐ iii. Other	
10. How do you get to your scheduled appointments?	
11. If appointments are missed, describe the barriers/difficulties related to this?	
12. Total number of pregnancies:	
13. Total number of births:	
14. Any history of pregnancy/delivery complications? If yes, explain.	☐ Yes ☐ No
15. Any current complications or is considered a high risk pregnancy? If yes, explain.	☐ Yes ☐ No
16. What are your plans for delivery?	
17. What are your plans **after** delivery?	
18. Are you planning on breast feeding?	☐ Yes ☐ No
19. Are there other help after delivery? If yes, explain.	☐ Yes ☐ No
20. Do you have plans for use of birth control after delivery?	☐ Yes ☐ No ☐ Unknown

b. Comments - Identify any risk factors:

INSTRUCTIONS FOR PREGNANCY ATTACHMENT

1. Enter Member Name, Member ID number, and date the attachment is being completed.
2. Answer questions 1-20.
3. In the comment section, include all risk factors.

At any point you identify the member has a problem or falls into a HIGH-RISK, a new task order must be added to the HAP.

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ATTACHMENT FOR IADLs and ADLs

ATTACH TO HFA and HAP

Member Name (Last, First):	**Member ID #:**	**Date:**

G10.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. Companion	☐	☐	☐	☐
7. Other: ☐ NA	☐	☐	☐	☐
c. Activities of Daily Living (ADLs) (Complete for Adults and Children)	**Independent**	**Minimal**	**Moderate**	**Total**
1. Eating/Feeding	☐	☐	☐	☐
2. Bathing	☐	☐	☐	☐
3. Dressing upper body	☐	☐	☐	☐
4. Dressing lower body	☐	☐	☐	☐
5. Grooming/Personal hygiene	☐	☐	☐	☐
6. Hair and skin care				
7. Toileting (do not include transfer and ambulation)	☐	☐	☐	☐
8. Walks with or without assistive device. Identify assistive device(s):	☐	☐	☐	☐
9. Do you have difficulty accessing areas of your house? ☐ Yes ☐ No	☐	☐	☐	☐
10. Bed Mobility/Transfers	☐	☐	☐	☐
11. Manual wheelchair mobility ☐ NA	☐	☐	☐	☐
12. Medication assistance ☐ NA	☐	☐	☐	☐
13. Other: ☐ NA	☐	☐	☐	☐

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

e. Comments – Identify any risk factors

INSTRUCTIONS FOR IADLs and ADLs

For G10.a - - IADLs: Complete for Adults only

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.

1. Routine House Cleaning – How routine house cleaning (bathroom, kitchen, bedroom, change linen, make bed, and empty trash can) 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. Companion – Accompanying member on daily task that helps to accomplish daily living skills/task. Check appropriate box to indicate degree of assistance needed.
7. Document other functions not described above, e.g., light yard work, simple home repairs. If not applicable, check "NA".

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 tasks but needs assistance with most of task to complete the task.
iv. **Total** – Unable to complete the task and needs total assistance to complete the task.

For G10.a - - ADLs: Complete for Adults and Children

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.
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"

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 total assistance to complete the task

For G10.a - - Activity/Mobility/Exercise: Assess and document physical activity. HC and provider(s) must be able to identify progress or decline of physical activity/exercise. Document your observations of member, e.g., able to walk, uses assistive device, etc.

For G10.a - - Enter additional comments as needed and identify any risk factors.

At any point you identify the member has IADLs and ADLs need, all items must be added to the HAP.

Member's Name

What People Like and Admire About

_____(Name)_____

What is Important TO
_____(Name)_____

Supports _(Name)__ Needs to be Happy, Healthy, and Safe

____(Name)__ Picture of a Life

Member's Name

a. Can you tell me what is important TO you to be satisfied, content, comforted, fulfilled, and happy?

b. Can you tell me what is important FOR you to be healthy, safe, and valued in your community?

c. Can you tell me about any daily rituals that help create a positive experience and a good day for you (i.e., morning or nighttime rituals, arriving at work, school, or training rituals, arriving at home rituals, Sunday or regular weekly rituals, birthday, holiday or celebration rituals, or comfort rituals)?

d. Can you tell me about any things that do not help create a positive experience and a bad day for you (i.e., things that throw your day off, made you frustrated, people who made it challenging, or was boring or took the fun out of it)?

Or, this:

d. Can you tell me about any things that create a negative experience and a bad day for you (i.e., things that throw your day off, made you frustrated, people who made it challenging, or was boring or took the fun out of it)?

INSTRUCTIONS FOR ONE PAGE DESCRIPTION

This attachment is completed for all Members.

Document member's response to the questions. Member, family, caregivers, and HC to create this one-page profile of member.

1. Answer questions a to d below.
2. What people like and admire about member.
3. What is important to member.
4. Supports member needs to be happy, healthy, and safe.
5. Member's picture of a life.

Ensure that One Page Description is updated and attached to the HAP.

EXAMPLE OF ONE PAGE DESCRIPTION

(Member Name)

What People Like and Admire About

(Member Name)

- Is always smiling
- Totally accepts people
- WONDERFUL personality
- Stylish
- Accepting and forgiving
- Resilient
- Great sense of humor
- Friendly and social

What is Important to
(Member Name)

- Being a part of things
- Having eye contact with everyone
- Looking stylish and having her hair and nails done
- Being comfortable and not having her tubes underneath her
- No roughness in personal care

Supports (Member Name) Needs to be Happy, Healthy, and Safe

- Always have her head elevated
- To be suctioned frequently (5-6 times per shift), Gurgling noises means she needs to be suctioned
- To have people be kind, sensitive, loving and a gentle touch
- Be gentle with brushing her hair (she doesn't like it, but wants it to always look nice)
- Always make sure her clothes match and make sure it's not sweat clothes
- Tammy needs to be repositioned every two hours
- Always follow through with a promise or give an explanation of what is going on and when you can keep the promise if something comes up
- Be sure to have Tammy use her body to keep flexible
- Check amount of color of urinary output at every change

(Member Name)'s Picture of a Life

Live in a big wheelchair accessible home with extra wide doors, close to her family

- Have a fun and social housemate
- Have a beautician she can go to regularly
- Have a social medical day program close to home
- Have specialized medical services and medical equipment (including backup generator)