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STATE OF HAWAII
HEALTH AND FUNCTIONAL ASSESSMENT (HFA)
CHILD AND ADULT

Member Name: **Medicaid ID#:** **Date of Assessment:**

Health Plan

SECTION A. ADMINISTRATIVE INFORMATION COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

A1. Member

a) Member Name b) Date of Birth c) Medicaid ID#

_____ _____ _____ __/__/____ _____

Last First MI

c) Age Cohort: ☐ Child ☐ Adult (19 and over)

d) Program Type: ☐ SHCN ☐ EHCN ☐ At Risk ☐ LTSS

A2. Assessment

a) Reason for Assessment
- ☐ i) Initial
- ☐ ii) 6-month (ONLY for CCFFH, E-ARCH, ALF)
- ☐ iii) Annual
- ☐ iv) Member Request
- ☐ v) Change of Condition/Status: _____

b) Assessment Reference Information
- i) Date: __/__/____
- ii) Time: : ☐ AM ☐ PM
- iii) Assessment Location: _____
- iv) Member's Physical Address/Location: _____
- v) Identify any safety issues that a HC may encounter during the assessment. _____

c) Assessor (Primary)
- i) Assessor Name:
- ii) Title: _____

d) Assessor (Consult)
- i) Assessor Name: _____
- ii) Title: _____

e) Additional Health Plan/Insurance (other than Medicare/Medicaid)
- i) Health Plan Name: _____
- ii) Subscriber Name: _____
- iii) Subscriber Number: _____
- iv) Are you a veteran? ☐ Yes ☐ No
- v) Are you receiving any veteran benefits? ☐ Yes ☐ No
  Identify: _____

f) Medicare
- i) Medicare ☐ Yes ☐ No ☐ N/A
  ID# _____
- ii) Medicare Advantage
  ☐ Yes ☐ No ☐ N/A
  Plan Name: _____
  ID# _____

g) Other Individual(s) Member consented to Participate in the Assessment
- i) Is there a legal guardian, or representative assisting in the assessment? ☐ Yes ☐ No
- ii) Other individuals present? ☐ Yes ☐ No
- iii) Representatives

Name	Relationship	Purpose	Attendance
_____	_____	_____	Choose an item.
_____	_____	_____	Choose an item.
_____	_____	_____	Choose an item.

h) Comments: _____

A3. Legal Information ☐ No Change from Previous Assessment

a) Legal Responsibility(ies) Health Plan Copy
- ☐ i) Self
- ☐ ii) Legal Guardian ☐ Yes ☐ No
  Name/Contact: _____
- ☐ iii) Authorized Representative ☐ Yes ☐ No
  Name/Contact: _____
- ☐ iv) Healthcare Power of Attorney ☐ Yes ☐ No
  Name/Contact: _____
- ☐ v) Individuals identified on a legal document who are NOT allowed information on the member.
  Name: _____
- ☐ vi) Rep Payee ☐ Yes ☐ No

b) Advance Directives
- i) Do you have an Advance Directive? ☐ Yes ☐ No
- ii) If yes, do you have a copy of the Advance Directive? ☐ Yes ☐ No
- iii) If you have an Advance Directive, have you given a copy to your primary care provider? ☐ Yes ☐ No
- iv) If you have an Advance Directive, have you given a copy to your health plan? ☐ Yes ☐ No
- v) If you do not have an Advance Directive, would you like more information? ☐ Yes ☐ No
- vi) Do you have a Provider Orders for Life-Sustaining Treatment (POLST)? ☐ Yes ☐ No

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Name/Contact: _____ ☐ vii) Other: _____ Name: _____	vii) Have you given a copy of your POLST to your primary care provider and/or Health Plan? ☐ Yes ☐ No viii) Location of POLST: _____ ix) Code Status: _____

c) Emergency Contact(s)

	Name	Relationship to member	Address	Phone number	Email address
Primary					
Secondary					

d) Emergency Plan **(Complete these questions for Members receiving HCBS)**

i) Describe your Fire Evacuation Plan (Attach floor plan).
ii) Location of your fuse box/circuit breaker.
iii) Location of your water turn off valve.
iv) Is your Individualized Emergency Back-up Plan Form completed? ☐ Yes ☐ No
v) If Yes, where is it located?
vi) If No, **complete ATTACHMENT for QI Individualized Emergency Back-up Plan. Attach original copy to the HAP and provide a copy to member.**

e) Comments – Identify any risk factors: _____

SECTION B. DEMOGRAPHIC INFORMATION — COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

B1. Demographics ☐ No Change from Previous Assessment

a) What sex was originally listed on your birth certificate:	b) Do you identify as:	c) Preferred Pronoun(s):	d) Relationship Status (Click on drop down to select) Choose an item.
☐ i) Male ☐ ii) Female ☐ iii) Other: _____ ☐ iv) Decline to answer	☐ i) Male ☐ ii) Female ☐ iii) Transgender man/trans man/female-to-male (FTM) ☐ iv) Transgender woman/trans woman/male-to-female (MTF) ☐ v) Gender queer/gender nonconforming neither exclusively male or female ☐ vi). Additional gender category (or other); please specify: ☐ vii) Decline to answer		Describe other_____

e) Race/Ethnicity – Check all that apply

☐ i) African, African American, or Black	☐ ii) American Indian, Alaska Native, or Indigenous
☐ iii) Asian or Asian American ☐ (1) Cambodian ☐ (2) Chinese/Taiwanese ☐ (3) Filipino ☐ (4) Indian ☐ (5) Japanese/Okinawan ☐ (6) Korean ☐ (7) Laotian ☐ (8) Vietnamese ☐ (9) Other	☐ iv) Native Hawaiian or Other Pacific Islander ☐ (1) Federated States of Micronesia ☐ (2) Native Hawaiian ☐ (3) Palauan ☐ (4) Marshallese ☐ (5) Samoan ☐ (6) Tongan ☐ (7) Other

☐ v) Hispanic or Latino/a/x	☐ vi) Middle Eastern
☐ vii) White	☐ viii) Puerto Rican
☐ ix) Other, specify: ____	

B2. Communication ☐ No Change from Previous Assessment

a) Primary Means of Communication ☐ i) Verbal ☐ iii) Written ☐ v) Other, specify:
☐ ii) Non-Verbal ☐ iv) American Sign Language

b) Primary Spoken Language (Click on drop-down to select) Choose an item.	c) Interpretation i) Do you need an interpreter? ☐ Yes ☐ No Name/Contact:
d) Primary Written Language (Click on drop-down to select) Choose an item. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ i) Never ☐ ii) Sometimes. Describe: ☐ iii) Always: Describe:	e) Translation i) Do you need a translation? ☐ Yes ☐ No Name/Contact: f) Other Assistive Communication Device(s): _____ ☐ None

g) Comments: _____

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

a) Living arrangement (Click on drop-down list to select)
Choose an item.

b) In the Past 30 days where have you lived (Select all that apply)

☐ i) Own private house/apartment	☐ ii) Rent Private house/apartment/ room	☐ iii) Houseless (with or without shelter)
☐ iv) At risk of houselessness	☐ v) Assisted Living Facility (ALF)	☐ vi) Adult Residential Care Home (ARCH)
☐ vii) Expanded Adult Residential Care Home (E-ARCH)	☐ viii) Foster Home (Children)	☐ ix) DD Adult Foster Home/DD Dom
☐ x) Community Care Foster Family Home (CCFFH)	☐ xi) Nursing Facility (NF)	☐ xii) NF transition
☐ xiii) Rehabilitation hospital/unit	☐ xiv) Psychiatric hospital/unit	☐ xv) Acute Care hospital
☐ xvi) Acute Care hospital transition	☐ xvii) Other	☐ xviii) Other/Transition e.g., Prison or State Hospital

(1) If Houseless, at risk of houselessness, NF/Acute care hospital transition, other transition is checked, **complete Section B.4 Housing Transitions for Going Home Plus (GHP)**

(2) If Houseless, at risk of houselessness, are you receiving housing navigation services? ☐ Yes ☐ No

(3) If No, have you ever been screened for CIS? ☐ Yes ☐ No

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CIS Status	DATE	Comment
Choose an item.		

(4) If "Not Identified, Screened or Referred" is selected, **refer to CIS.**

c) Type of Subsidized Housing (Check all that apply)
- ☐ i) Hawaiian Homestead
- ☐ ii) Section 8
- ☐ iii) Public Housing
- ☐ iv) Other, specify: _____
- ☐ v) N/A

d) Comments: _____

B4. Housing Transitions for Going Home Plus

a) For Going Home Plus (GHP):
- i) Have you been in the nursing facility and/or acute care hospital for more than 60 continuous days? ☐ Yes ☐ No
- ii) Does the member meet nursing facility level of care? ☐ Yes ☐ No
- iii) If Yes to both, refer member to GHP. ☐ Yes ☐ Not Eligible ☐ Declined/Family Refused (for now)

SECTION C. FINANCES/SOCIAL SUPPORTS/CAREGIVER(S) COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

C1. Finances ☐ No Change from Previous Assessment

a) Finances

i) Do you have concerns about your financial situation? ☐ Yes, check all that apply ☐ No
- ☐ (1) Paying Housing/Rent/Utilities
- ☐ (2) Food and other necessities
- ☐ (3) Paying off Debts
- ☐ (4) Dependents
- ☐ (5) Other, specify: _____

ii) What income sources do you have? Check all that apply.
- ☐ (1) SSI
- ☐ (2) SSDI
- ☐ (3) DHS Financial Assistance
- ☐ (4) SNAP (food stamps)
- ☐ (5) Employment
- ☐ (6) Other, specify: _____

iii) Employment Status. Check all that apply.
- ☐ (1) Full-time work
- ☐ (2) Part-time or temporary work
- ☐ (3) Unemployed
  - ☐ (a) Seeking work
  - ☐ (b) Not seeking work (ex: student, retired, disabled, unpaid primary caregiver)

Please describe:

iv) In the past year, have you or any family members you lived with been **unable** to get any of the following when it was **really needed**? ☐ Yes ☐ No If yes, complete **ATTACHMENT for SDOH/SRF and attach to this HFA, and/or make appropriate referral.**

Check **ALL** that apply:
- ☐ (1) Food

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☐ (2) Clothing
☐ (3) Utilities
☐ (4) Childcare
☐ (5) Technology Access
☐ (a) Internet
☐ (b) Computer
☐ (c) Phone
☐ (6) Medicine or any Health Care (Medical, Dental, Mental Health, Vision)
☐ (7) Other, please describe:

v) Are you worried about losing your housing? ☐ Yes ☐ No If Yes, complete **ATTACHMENT for SDOH/SRF and attach to this HFA, and/or make appropriate referral.**

vi) Would it be helpful to review your monthly expenses? ☐ Yes ☐ No If Yes, complete **ATTACHMENT for Financial Worksheet and attach to this HFA, and/or make appropriate referral.**

vii) Have you previously applied for additional services? ☐ Yes ☐ No

viii) Are you in the process of applying for additional assistance? ☐ Yes ☐ No

ix) Referrals:
☐ (1) Housing Assistance
☐ (2) Food Stamps
☐ (3) Social Security/SSI
☐ (4) Financial Management Assistance *(e.g., Budget Assistance, Rep Payee):*
☐ (5) Other:

b) Comments – Identify any risk factors:

C2. Social Supports ☐ No Change from Previous Assessment

a) Social Supports

i) Family and/or friends living in the SAME residence? ☐ Yes ☐ No

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

ii) 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

iii) Strong and supportive relationship with family? ☐ Yes ☐ No

iv) Strong and supportive relationship with a friend or neighbor? ☐ Yes ☐ No

v) Do you prefer having family or friends accompany you or help you when you go to a medical appointment?
☐ Yes ☐ No ☐ No opinion

b) Comments – Identify any risk factors:

C3. 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		

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					☐ Yes ☐ No		

a) Primary Caregiver Name:

i) Ask the **Primary Caregiver about their current status.** Use the following bullet 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 D. TRANSPORTATION COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

*****Do not complete for NF/CCFFH/E-ARCH*****

a) Transportation

i) Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for family living? Check all that apply:

☐ (1) Yes, it has kept me from medical appointments or getting medications.
☐ (2) Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
☐ (3) No

ii) Current Mode of Medical Transportation (Select all that apply)

☐ (1) Drives own vehicle
☐ (2) Family or friends

If member selects "Drives own Vehicle" or "Family or Friends" only, you may skip to Section E.

☐ (3) Public transportation
  ☐ (a) Bus
  ☐ (b) Handi-Van
☐ (4) Van
  ☐ (i) Curb to curb
  ☐ (ii) Door to door
  ☐ (iii) Gurney
☐ (5) Taxi
☐ (6) Air Travel for specialist care
☐ (7) Other:

iii) Are you able to use public transportation or can someone regularly transport you to obtain medical services? ☐ Yes ☐ No
If No, explain.

iv) Are you able to ambulate without assistance (with or without device, includes wheelchair)? ☐ Yes ☐ No

v) Are you able to ambulate to the local bus stop? ☐ Yes ☐ No
Describe.

vi) If wheelchair bound, are you able to self-propel to curb side for pick up? ☐ Yes ☐ No

vii) If wheelchair bound, are you able to transfer in and out of vehicle without assistance? ☐ Yes ☐ No

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viii) If the member needs assistance, do you have an attendant? ☐ Yes ☐ No

ix) Do you require any medical equipment when traveling? ☐ Yes ☐ No
If yes, list medical equipment. (e.g., ventilator, suction machine, feeding pump, etc.)

x) Are you able to get to curb side alone? ☐ Yes ☐ No If No, select all that apply.
- ☐ (1) No attendant
- ☐ (2) Attendant is unable to help member to curb side.
- ☐ (3) Member is bedbound.
- ☐ (4) Member is non-ambulatory.
- ☐ (5) Member is unable to transfer or receive assistance.

b) Comments – Identify any risk factors:

SECTION E. HCBS HOME ENVIRONMENT — COMPLETE FOR AT RISK, LTSS

*****Complete for HCBS and do not complete if member is in NF/CCFFH/E-ARCH*****

a) Current Home

Check **ALL** that apply:

a1) Safety
- ☐ i) Member feels safe in the home.
- ☐ ii) Member feels safe in the neighborhood.
- ☐ iii) Building has a secured lobby. Entry code and/or entry directions.

a2 Accessibility
- ☐ i) Elevator in the building.
- ☐ ii) Home accessible to wheelchairs or other assistive devices.
- ☐ iii) Locations with accessibility issues (Observe member navigating the following areas and select all areas of concern that apply)
  - ☐ (1) Interior doorways
  - ☐ (2) Bedroom
  - ☐ (3) Shared living area
  - ☐ (4) Kitchen
  - ☐ (5) Bathroom (toilet, shower, sink)
  - ☐ (6) Entrance/Exits
  - ☐ (7) Other area of concern:

a3) Electronic connectivity/communication
- ☐ i) The following forms of communication are available and member can use proficiently:
  - ☐ Cell phone
  - ☐ Home phone
  - ☐ Tablet
  - ☐ Computer
- ☐ ii) How often can member access medical care through telephone/video

If you need medical care, how often are you able to get help by telephone or video chat/ conferencing?					
	Never	Rarely	Sometimes	Often	Always
Telephone	☐	☐	☐	☐	☐
Video chat/conferencing	☐	☐	☐	☐	☐

a4) If safety, accessibility, and electronic communication concerns noted above, describe interventions to address concerns in the HAP

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	Adequate	Inadequate	N/A	Comments
b) Exterior Assessment				
Parking	☐	☐	☐	Location:
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	☐	☐	☐	
Tacked down rugs and carpets	☐	☐	☐	
Visible cords/electrical circuits	☐	☐	☐	
Telephone service and accessibility (Indicate if this is a landline)	☐	☐	☐	
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:				

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SECTION F. MEDICAL INFORMATION — COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

F1. Disease Diagnosis(es) ☐ No Change from Previous Assessment

a) Disease Diagnosis(es)

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

Complete specific disease diagnosis attachments, if applicable to member. Attach to this HFA.

b) Comments – Identify any risk factors:

F2. Transplant ☐ No Change from Previous Assessment

a) Transplant

i) Have you had a transplant? ☐ Yes ☐ No

ii) What type of transplant? _____

1) Enrollment Start: (for future)

2) Enrollment End: (for future)

iii) Is member compliant with transplant related medication and provider follow-up? ☐ Yes ☐ No
If No, document action plan. _____

b) Comments – Identify any risk factors:

F3. Medications (Prescribed and OTC) ☐ No Change from Previous Assessment

i) Are you taking any medications, including vitamins, supplements, herbal, or OTC medications? ☐ Yes ☐ No

ii) Are you taking any psychotropic medications? ☐ Yes ☐ No

iii) If Yes to i or ii above, **attach a current medication list** and/or **complete the ATTACHMENT for Medications and attach copies to this and HAP.**

iv) Do you have difficulty picking up your medications? ☐ Yes ☐ No Specify: _____

v) In the past 30 days

a. Did you miss or forget to take any of your medications as prescribed? ☐ Yes ☐ No

b. Were your medications lost or stolen? ☐ Yes ☐ No

c. Specify:

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vi) When you feel better, do you sometimes stop taking your medication? ☐ Yes ☐ No ☐ N/A

vii) If you feel worse when you take the medicine do you stop taking it? ☐ Yes ☐ No ☐ N/A

viii) Allergies
- a. Drug Allergies: ☐ Yes ☐ No
- b. Food or other Allergies: ☐ Yes ☐ No
- c. Specify:

F4. Treatments and Therapy(ies) ☐ No Change from Previous Assessment ☐ NA

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

F5. 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		

F6. Physician(s) and Provider(s) ☐ No Change from Previous Assessment

Physician(s)/Provider(s) Name	Specialty	Address	Phone Number	Fax Number

F7. Utilization of Hospital, Emergency Room, and Physician Services ☐ No Change from Previous Assessment

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a) Did you need medical attention within the past three (3) months? ☐ Yes ☐ No If yes, have you been able to get help?

by Phone ☐ Yes ☐ No
by Telehealth ☐ Yes ☐ No

b) How many times were you hospitalized within the past three (3) months?

Physical Health	Number of Days	Mental Health	Number of Days	SUD	Number of Days
☐ 0		☐ 0		☐ 0	
☐ 1-2		☐ 1-2		☐ 1-2	
☐ 3 or more		☐ 3 or more		☐ 3 or more	

c) How many times were you in the emergency room within the past three (3) months?

Physical Health	Mental Health	SUD
☐ 0	☐ 0	☐ 0
☐ 1-2	☐ 1-2	☐ 1-2
☐ 3 or more	☐ 3 or more	☐ 3 or more

d) How many times have you stayed at a crisis home or unit in the past three (3) months?

Times	Number of Days
☐ 0	
☐ 1-2	
☐ 3 or more	

e) Physician Services	Date	Reason
i) LAST Primary Care Provider visit	/ /	☐ Unknown
ii) NEXT scheduled Primary Care Provider visit	/ /	☐ Unknown
iii) MH Provider visit ☐ N/A Type: _____		☐ Unknown
iv) Next scheduled MH Provider visit		☐ Unknown
Other Provider visit. Type: _____ NEXT scheduled visit: Other Provider visit. Type: _____ NEXT scheduled visit: Other Provider visit. Type: _____ NEXT scheduled visit:	/ / / / / /	☐ Unknown ☐ Unknown ☐ Unknown

f) Comments – Identify any risk factors: _____

F8. Prevention & Immunizations ☐ No Change from Previous Assessment

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a) Screening(s)
(Children)
i) Well Child visit/EPSDT screening (0 to 20 years) in the LAST YEAR ☐ N/A ☐ Yes ☐ No If No, refer member to PCP for follow-up.
ii) LAST Well Child visit: __/__/____ ☐ Unknown ☐ N/A
(All Members)
iii) Are your immunizations up to date? ☐ Yes ☐ No ☐ Unknown
iv) Date of LAST Influenza Vaccination: __/__/____ ☐ Unknown
v) Other:

b) Required for HCBS Residential or Institutional.

i) Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
ii) TB Results ☐ Negative ☐ Positive
iii) Date of last TB Chest X-ray: __/__/____ ☐ Unknown
iv) Date of Pneumococcal Vaccination: __/__/____ ☐ Unknown
v) Have you had the Covid-19 vaccination: ☐ Yes ☐ No ☐ Prefer not to say
If Yes, select:
☐ First Shot: Specify: Date __/__/____
☐ Second Shot: Specify: Date __/__/____
☐ Last Booster shot (within 6 months): Specify: Date: __/__/____
vi) Other: Specify _____

c) Comments – Identify any risk factors: _____

SECTION G. GENERAL HEALTH COMPLETE IF APPROPRIATE FOR SHCN, EHCN, AT RISK, LTSS

G1. Cognition ☐ No Change from Previous Assessment

a) Cognition
i) Is member Comatose? ☐ Yes ☐ No If yes, Go to Section G4

ii) Mental Status. Choose one (1)
☐ (a) Oriented: To Person, Place, Time, and Situation.
☐ (b) Disoriented: Partially or intermittently; requires supervision.
If yes, describe. _____
☐ (c) Disoriented and/or disruptive.
If yes, describe. _____

If disoriented or 65+, complete the ATTACHMENT for Cognition and attach to this HFA.

b) Wandering

i) In the last 5 days, has the member wandered?
☐ (1) Yes, present 1-2 days
☐ (2) Yes, present 3 or more days
☐ (3) No

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☐ (4) Does not apply

ii) Does the wandering place the member at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of home, outside in community)?
☐ (1) Yes
☐ (3) No
☐ (3) Does not apply

iii) Does the wandering significantly intrude on the privacy of activities or others in the setting?
☐ (1) Yes
☐ (2) No
☐ (3) Does not apply

iv) How does the member's current wandering behavior compare to last assessment?
☐ (1) Same
☐ (2) Improved
☐ (3) Worse
☐ (4) Does not apply (no prior assessment)

c) Comments – Identify any risk factors:

G2. Vision/Hearing/Speech & Communication ☐ **No Change from Previous Assessment**

a) Vision

Is the member visually impaired, or do they struggle with vision loss?
☐ Yes ☐ No

Check **ALL** that apply:
☐ i) Visual impairment
Describe. _____
☐ ii) Uses corrective lenses
(1) Glasses ☐
(2) Contacts ☐
☐ iii) Able to see with the corrective lenses.
Date of LAST eye exam: __/__/____
☐ Unknown
☐ Decline

b) Hearing

Is the member hard of hearing, or hearing impaired?
☐ Yes ☐ No

Check **ALL** that apply:
☐ i) Hearing impairment.
Describe. _____
☐ ii) Uses a hearing aid or Other Devices. Describe. _____
☐ iii) Able to hear with the hearing aid or other device.
Date of LAST hearing exam: __/__/____ ☐ Unknown ☐ Decline

c) Speech
i) Speech pattern (select one):
☐ (1) Coherent
☐ (2) Incoherent
☐ (3) No speech

d) Communication
i) Ability to verbally express ideas (select one):
☐ (1) Adequately communicates needs/wants

e) Comprehension
i) Ability to understand others (select one):
☐ (1) Understands
☐ (2) Usually understands
☐ (3) Sometimes understands

Member Name: **Medicaid ID#:** **Date of Assessment:**

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ii) Date of LAST Speech Evaluation: / / ☐ Unknown	☐ (2) Has difficulty communicating needs/wants ☐ (3) Unable to communicate needs/wants	☐ (4) Rarely or never understands
f) Comments – Identify any risk factors:		

G3. Mood, Behavior, and Psychological Well Being ☐ No Change from Previous Assessment ☐ CCS Member

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, HC should refer member to PCP for further evaluation.**

a) PHQ-2 Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems:	Not at all (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
i) Little interest or pleasure doing things				
ii) Feeling down, depressed, or hopeless				
Score:				

If there is a score of three (3) or greater on PHQ-2:

1. Complete the **ATTACHMENT FOR PHQ-9 for Adults and attach to this HFA.**
2. Complete the **Depression (Pediatric Symptom Checklist)** for Children below**.**

FOR CHILDREN (b-e)

b) **Depression (Pediatric Symptom Checklist) (FOR CHILDREN)**

Note: If member scores 15 or higher on Pediatric Symptom Checklist or answer yes to c or d below, HC should refer member to their PCP or refer for a behavioral health 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)
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	☐	☐	☐

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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:			

Total Score:

c) Emotion

i) Have you observed any emotional or behavioral problems for which she/he needs help? ☐ Yes ☐ No
If yes, please explain.

d) Life Event

i) Has anything significant happened to you or your child within the last year that impacts your child's life?
☐ Yes ☐ No

ii) Have you ever been in any situation where you felt you or your child's life was in danger, or you might be or were seriously harmed/injured? ☐ Yes ☐ No
If yes, please identify.

e) ☐ Referral: Specify _____

FOR ADULTS (f-m)

f) Major Life Stressor(s)

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

g) Coping Skills

Check **ALL** that apply:

☐ i) Have difficulty at work
☐ ii) Have difficulty caring for things at home
☐ iii) Have difficulty getting along with people

h) Anger

Check **ALL** that apply:

☐ i) Angers easily
☐ ii) Have felt persistent anger with self or others. Describe. _____

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i) Anxiety
Check **ALL** that apply:
- ☐ i) Gets anxious easily or worries excessively
- ☐ ii) Suffers from panic attacks
- ☐ iii) Feels like something terrible is going to happen

j) Behavior ☐ Observed ☐ Asked
Check **ALL** that apply:
- ☐ i) Wanders
- ☐ ii) Verbally abusive to self and/or others
- ☐ iii) Physically abusive to self and/or others
- ☐ iv) Socially inappropriate or displayed disruptive behaviors
- ☐ v) Resisting caregiving
- ☐ vi) Other emotional or behavioral problems. Describe. _____

k) Social Relationships
Check **ALL** that apply:
- ☐ i) Had conflict or anger with family or friends. Explain. _____
- ☐ ii) Felt fearful of a family member or close acquaintance. Explain. _____
- ☐ iii) Felt neglected, abused, or mistreated. Explain. _____

l) Restraints

i) Does the member have a physician ordered use of physical restraints?
- ☐ Yes
- ☐ No
- ☐ Does not apply

If yes, within the last 5 days was there a use of physical restraints (any manual method, physical or mechanical device, material or equipment attached or adjacent to the member's body that the individual cannot remove easily) which restricts freedom of movement or normal access to one's body?

For ii and iii, Enter code for each limitation coding:
0. Not used
1. Used less than daily
2. Used daily

ii) Used in Beds
- ☐ (1) Bed rail (e.g., full, half, one side) - Limitation Coding: _____
- ☐ (2) Trunk restraint - Limitation Coding: _____
- ☐ (3) Limb restraint - Limitation Coding: _____
- ☐ (4) Other. Describe: _____

iii) Used in Chair or Out of Bed
- ☐ (1) Trunk restraint - Limitation Coding: _____
- ☐ (2) Limb restraint - Limitation Coding: _____
- ☐ (3) Chair prevents rising - Limitation Coding: _____

Member Name: **Medicaid ID#:** **Date of Assessment:**

Health Plan

☐ (4) Other. Describe: _____

m) Comments– Identify any risk factors**:**
☐ Referral: Specify _____

G4. Health Status ☐ No Change from Previous Assessment

a) Vital Signs (**Required for LTSS)**

1) Temperature: F
   i. Mode:
2) Pulse: bpm
   ii. 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

Does the member have problems with balance or gait, or a risk of falls?
☐Yes ☐No

Does the member have a history of falls?
☐Yes ☐No

Check **ALL** that apply:

☐ 1) Member has problems with balance or gait.

☐ 2) Member is not ambulatory, is bed ridden, immobile, is confined to chair, is a wheelchair user who is dependent on helper pushing wheelchair, is independent in wheelchair, or requires minimum help in wheelchair.

☐ 3) Member has a fear of falling

Fall(s) in the past year
# of fall(s) _____

Fall-related injury in the past year
# of injury(ies) _____

Date of Last Fall: / /

If Member is 18 or older and had one fall with injury or had at least two falls in the past year, **complete the ATTACHMENT for Fall Risk Assessment and attach to this HFA.**

Member Name: **Medicaid ID#:** **Date of Assessment:**

Health Plan

c) Pain

i) Communication of Pain

☐ (1) Member is verbal and able to answer

☐ (2) Member is non-verbal and unable to answer

☐ (3) Member is non-verbal but able to answer.
Describe.

☐ (4) Caregiver/Authorized Representative is answering based on observation

ii) Current pain? ☐ Yes ☐ No

(1) Location:

(2) Type:

(3) Frequency:

(4) Intensity

☐ i. Numeric Rating Scale OR

☐ ii. FACES Pain Rating Scale

(5) Break through pain? ☐ Yes ☐ No

(6) Pain management:

d) Substance/Drug Use

i) Smoking Use – Do you use tobacco, smokeless tobacco, vape, or E-cigarettes? ☐ Yes ☐ No

ii) Alcohol Use – Do you drink any alcohol products? ☐ Yes ☐ No

If yes, over the past 2 weeks, on how many occasions have you had [5 (male)/4 (female)] or more drinks in a row?

☐ None
☐ Once
☐ Twice
☐ 3 to 5 times
☐ 6 to 9 times
☐ 10 or more times

iii) Other Substance/Drug Use – Have you used any other substance(s) in the past year? ☐ Yes ☐ No

How often have you used illegal drugs?

☐ Never
☐ Once every couple weeks
☐ A couple times a week
☐ Everyday

If using illegal drugs, please list the drugs used in the last 30 days

☐ Methamphetamine
☐ Opioids/heroin
☐ Marijuana/hashish
☐ Synthetic marijuana/K2
☐ Cocaine
☐ Other

Member Name: **Medicaid ID#:** **Date of Assessment:**

Health Plan

If the answer is "Yes" to questions i-iii, complete **ATTACHMENT for Tobacco and/or CAGE-AID and attach to this HFA.**

e) Comments– Identify any risk factors**:**

☐ Referral: Specify _____

f) Cardiac/Respiratory

Check **ALL** that apply:

Have you experienced any of the following:

- ☐ i) Palpitations (feels like butterflies, pounding, skipping a beat, racing)
- ☐ ii) Faster than normal heart rate (tachycardia)
- ☐ iii) Slower than normal heart rate (bradycardia)
- ☐ iv) Missing or skipping a heartbeat (irregular heart rhythm)
- ☐ v) Swelling below the knee or feet
- ☐ vi) Dizziness or feel like passing out (syncope)
- ☐ vii) Chest pain
- ☐ viii) Lack of color or discoloration of hands, feet, or lips
- ☐ ix) Excessive tiredness, decreased energy
- ☐ x) Shortness of breath or difficulty breathing
  - (1) If yes, how would you describe your shortness of breath?
    - ☐ mild (has minimal to no impact on day-to-day activities)
    - ☐ moderate (makes it difficult to complete some activities)
    - ☐ severe (are unable to do some activities and/or it reduces their quality of life)
  - (2) When do you experience shortness of breath?
  - (3) What relieves your shortness of breath?

If any of the boxes above from i-x are checked, **complete ATTACHMENT for Heart Disease and attach to this HFA.**

If box x is checked in addition to any of the boxes i to ix, or if box x is the only box checked, complete **ATTACHMENT for Asthma/COPD/Respiratory/Tracheostomy/Ventilator** and **attach to this HFA.**

g) Comments – Identify any risk factors:

G5. Nutrition ☐ No Change from Previous Assessment

Member Name: **Medicaid ID#:** **Date of Assessment:**

Health Plan

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

i) Height feet inches ☐ Unknown
   a. Date of height measurement: / /
   ☐ Unknown

ii) Weight _____lbs. ☐ Unknown
   a. Date of weight measurement: / / ☐ Unknown

iii) BMI: _____ ☐ Unknown
   a. Date BMI calculated: / / ☐ Unknown

b) Dental

i) Do you have any broken, fragmented, loose, or non-intact natural teeth? ☐ Yes ☐ No

ii) Do you have dentures? ☐ Yes ☐ No ☐ NA
   ☐ Full
   ☐ Partial

iii) Do you use your dentures? ☐ Yes ☐ No ☐ NA
   If No, reason:

iv) Are you currently experiencing any toothaches or pain?
   ☐ Yes ☐ No

v) Date of LAST Dental Exam:
   / / ☐ Unknown

c) Weight Loss or Gain

i) Describe the foods or meals that you normally eat.

ii) Has a physician or provider recommended a special diet for you? ☐ Yes ☐ No
   If Yes, explain.

iii) Does the Member show any signs and symptoms of possible chewing and/or swallowing disorder or difficulty?
   ☐ Yes ☐ No
   If yes, check all that apply:
   ☐ Loss of liquids/solids from mouth when eating or drinking
   ☐ Do you cough or choke during meals or when swallowing medications?
   ☐ Do you hold food in your mouth/cheek instead of swallowing?
   ☐ Date of swallow evaluation , if applicable

iv) Was there a weight **loss** of 5% or more in the last month or loss of 10% or more in last 6 months?
   ☐ a. No or unknown
   ☐ b. Yes, on physician-prescribed weight-loss regimen
   ☐ c. Yes, not on physician-prescribed weight-loss regimen

v) Was there a weight **gain** of 5% or more in the last month or gain of 10% or more in last 6 months?
   ☐ a. No or unknown
   ☐ b. Yes, on physician-prescribed weight-gain regimen
   ☐ c. Yes, not on physician-prescribed weight-gain regimen.

vi) Has a physician or provider counseled you for weight loss or weight gain? ☐ Loss ☐ Gain ☐ NA

vii) Is there a plan for managing your weight? ☐ Yes ☐ No
   If Yes, describe plan.

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Health Plan

d) Nutritional Intake

i) Are you able to eat by mouth? ☐ Yes ☐ No

ii) Are you able to feed yourself independently?
☐ Yes ☐ No
If No, explain.

iii) Dietary Modifications

a) Food
☐ (1) Regular
☐ (2) Chopped
☐ (3) Minced
☐ (4) Pureed

b) Liquid
☐ (1) Nectar
☐ (2) Honey
☐ (3) Pudding

iv) Do you require enteral feedings? ☐ Yes ☐ No
☐ (1) Nasogastric (NG) Tube
☐ (2) Gastrostomy Tube (GT)
☐ (3) Gastrojejunostomy (G/J) Tube

v) Do you require parenteral feedings? ☐ Yes ☐ No
☐ (1) Total Parenteral Nutrition (TPN)
☐ (2) Other, parenteral feeding:

e) Comments – Identify any risk factors:

G6. Continence ☐ No Change from Previous Assessment

a) Continence

i) Bladder Continence
☐ (1) Continent
☐ (2) Control with catheter or ostomy. Type:
☐ (3) Incontinent

ii) Bowel Continence
☐ (1) Continent
☐ (2) Control with ostomy Type:
☐ (3) Incontinent

b) Do you use incontinence products?
☐ Yes ☐ No
If yes, describe:

c) Comments – Identify any risk factors:

G7. Skin ☐ No Change from Previous Assessment

a) Skin
Check **ALL** that apply:
☐ i) History of skin breakdown or pressure sores. If yes, describe:
☐ ii) Have any skin break down, tears, or open sores. If yes, describe:
☐ iii) Have any blood, drainage, or odor from a wound. Describe the wound(s) and location(s).

b) Comments – Identify any risk factors:

G8. Musculoskeletal ☐ No Change from Previous Assessment

a) Bones, Muscles, or Joints
Check **ALL** that apply:
☐ i) Have any history of bone, muscle, or joint abnormalities or complications. Describe:
☐ ii) Have any current bone, muscle, or joint abnormalities or complications. Describe:
☐ iii) Had a bone, muscle, or joint surgery or procedure. Date of Surgery/Procedure: / / Type:

b) Comments – Identify any risk factors:

G9. Family Planning ☐ No Change from Previous Assessment ☐ NA

a) Reproductive Health

i) Are you sexually active? ☐ Yes ☐ No

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Health Plan

ii) Are you Pregnant? ☐ Yes ☐ No ☐ NA
If Yes, **complete ATTACHMENT for Pregnancy and attach to this HFA.**

iii) Would you like to become pregnant in the next year?
☐ (1) Yes
☐ (2) I'm okay either way
☐ (3) I don't know
☐ (4) No

iv) Are you currently using birth control? ☐ Yes ☐ No Type:
If yes, are you satisfied with your method of birth control? ☐ Yes ☐ No
☐ N/A If no, why?

(1) Would you like basic information on contraceptive options available. ☐ Yes ☐ No

(2) Are you comfortable discussing your reproductive health with your PCP or family planning provider? ☐ Yes ☐ No

(3) Do you need help finding a family planning provider to help with your reproductive health? ☐ Yes ☐ No

b) Comments – Identify any risk factors:

G10. Functional Status ☐ No Change from Previous Assessment **COMPLETE FOR AT RISK, LTSS**

a) Long Term Services and Supports (LTSS)

i) Do you have concerns about taking care of yourself? ☐ Yes ☐ No. Describe within **the ATTACHMENT for IADLs and ADLs.**

ii) Do you currently have a caregiver who assist with these activities? ☐ Yes ☐ No

iii) Is there assistance and/or services that you need to remain in your home? ☐ Yes ☐ No

iv) Complete the **ATTACHMENT for IADLs and ADLs and attach to this HFA and to the HAP.**

G11. Self-Reported Health ☐ No Change from Previous Assessment

a) Would you say that in general, your health is:
☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

If "Fair" or "Poor"

b) Now thinking about your physical health, which includes physical illness and injury, for **how many days during the past 30 days** was your **physical health** not good?
Member's Response:

c) Now thinking about your mental health, which includes stress, depression, and problems with emotions, for **how many days during the past 30 days** was your **mental health** not good?
Member's Response:

d) During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreations?

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Member's Response:

SECTION H. PSYCHOSOCIAL HISTORY COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

H1. Member's Perspective ☐ No Change from Previous Assessment

Personal History/Lifestyle/Goals

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

What was member's response:

b) Ask about **Education/Work/Occupation** and use the bulleted points to start the conversation.
- i) What was the highest level of education you completed?
- ii) What kind of work do you do, or did you do?
- iii) Do you want to volunteer/work now?
- iv) What kind of work/volunteer did you do, or do you want to do?
- v) What was member's response:

c) Ask about **Recreation/Fun/Relaxation** and use the bulleted points to start the conversation.
- i) What are some things you enjoy doing? Tell me about some of the things you enjoy doing.
- ii) Identify some people you enjoy spending time with and list their relationship.
- iii) 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)?
- iv) Can you tell me about any things that help create a positive experience and a good day for you (i.e., things that make your day great, made you happy, people who made it enjoyable, or comfortable or made it fun)?
- v) What was member's response:

d) Ask about **Strengths/Accomplishments** and use the bulleted points to start the conversation.
- 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?
- iii) Can you tell me what is important TO you to be satisfied, content, comforted, fulfilled, and happy?
- iv) What was member's response:

e) Ask about **Traditions/Rituals** and use the bulleted points to start the conversation.
- 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.
- vi) What was member's response:

f) Ask about **Home** and use the bulleted points to start the conversation.
- 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?

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v) If yes, explain.
vi) What other HCBS settings did you consider?
vii) What was member's response:

g) Ask about **Routines** and use the bulleted points to start the conversation.
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?
iv) 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?
v) What was member's response:

h) Ask about **Care Needs** and use the bulleted points to start the conversation.
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?
iv) If no, explain.
v) Do you have any specific end of life wishes or arrangements?
vi) If yes, describe.
vii) Can you tell me what is important FOR you to be healthy, safe, and valued in your community?
viii) What was member's response:

i) **Complete ATTACHMENT for One Page Description (MY PROFILE) and attach to the HAP.**

j) Comments – Identify any risk factors:

SECTION I. CURRENT SERVICES AND SUPPORTS COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

I1. Home and Community Based Services (HCBS) COMPLETE FOR AT RISK, LTSS
☐ No Change from Previous Assessment ☐ NA

a) List HCBS Services

HCBS Service	Provider/Agency	Frequency/Amount	Comments/Needs

b) Comments:

I2. Institutional Services COMPLETE FOR LTSS
☐ No Change from Previous Assessment ☐ NA

a) List Institutional Services

Institutional Service	Provider	Comments/Needs (include start date)

b) Comments to include dates:

I3. Additional Support Services COMPLETE FOR SHCN, EHCN, AT RISK, LTSS
☐ No Change from Previous Assessment ☐ NA

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a) State Program(s)					
i) Are you currently receiving services from any State Program(s)? ☐ Yes ☐ No ii) Name of School Attending: ☐ N/A					
	State Program	Contact Name	Phone Number and Email Address	Agency	Additional Information
Provided by DHS					
☐	CCS ☐ ITP Obtained Referral Date: __/__/____ Enrollment Start: __/__/____				
☐	GHP Enrollment Start: __/__/____ Enrollment End: __/__/____				
☐	CCFFH or E-ARCH Case Manager Enrollment Date: __/__/____ Name of Caregiver and Contact Number Number of moves within the last year				
☐	CIS ☐ Pre-Tenancy ☐ Tenancy Enrollment Date: __/__/____				
☐	SHOTT Anticipated Enrollment Start: __/__/____				
☐	DD Waiver Enrollment Date: __/__/____ Case Manager/Contact ☐ Living at Home ☐ Other Residence				
☐	DHS/CWS				
☐	DHS/APS				
☐	Other:				
☐	Unknown				
Provided by DOE					
☐	DOE/Special Education ☐ Individual Educational Plan (IEP) Provided to HP				
☐	DOE/Physical, Occupational or Speech Therapy, Applied Behavioral Analysis (ABA) ☐ Individual Educational Plan (IEP) Provided to HP				
☐	Other:				
☐	Unknown				
Provided by DOH					
☐	DOH/Early Intervention				
☐	DOH/CAMHD				

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☐	DOH/AMHD				
☐	DOH/DDD ☐ Individual Service Plan (ISP) Provided to HP				
☐	DOH/Hawaii State Hospital (box for future use)				
☐	Other:				
☐	Unknown				
Provided by PSD					
☐	PSD/Jail or Prison (box for future use)				
☐	Other:				
☐	Unknown				

b) Comments:

c) Non-State Program(s)

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

d) Referrals

Type of Referral	Contact Name	Phone Number	Services/Hours
Social			
Health			
Behavior			
Housing			
Spiritual Needs			
Transportation			
Other			

e) Comments

SECTION J. ATTACHMENTS COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

The following are attachments triggered by certain questions. Attach the completed documents to this HFA.

☐ **A3.d ATTACHMENT For QI Individualized Back-Up Plan**
☐ **B3.b ATTACHMENT For Housing Screener**
☐ **C1.a ATTACHMENT For SDOH/SRF**
☐ **C1.a ATTACHMENT For Financial Worksheet**
☐ **F3.3 ATTACHMENT For Medications**
☐ **G1.a ATTACHMENT For Cognition**
☐ **G3.a ATTACHMENT For PHQ-9**
☐ **G4.b ATTACHMENT For Fall Risk Assessment**
☐ **G4.d ATTACHMENT For Tobacco and/or CAGE-AID**
☐ **G4.f ATTACHMENT For Heart Disease**

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☐ **G4.f ATTACHMENT For Asthma, Chronic Obstructive Pulmonary Disease (COPD), Respiratory/Tracheostomy/ Ventilator**
☐ **G9.a ATTACHMENT For Pregnancy**
☐ **G10.a ATTACHMENT For IADLs and ADLs**
☐ **H1.j ATTACHMENT For One Page Description – MY PROFILE**

Instructions: Complete disease specific questions for those that have been identified in Section F1.a. Disease Diagnosis(es). HC will ask relevant questions appropriate to the member to gather information for the HAP.

Check ALL that apply and complete the ATTACHMENT questionnaire. Attach to this HFA.

☐ **F1.1 ATTACHMENT For Asthma, Chronic Obstructive Pulmonary Disease (COPD), Respiratory/Tracheostomy/ Ventilator**
☐ **F1.2 ATTACHMENT For Cancer**
☐ **F1.3 ATTACHMENT For Diabetes**
☐ **F1.4 ATTACHMENT For End Stage Renal Disease (ESRD)**
☐ **F1.5 ATTACHMENT For Hepatitis B and C**
☐ **F1.6 ATTACHMENT For High Blood Pressure**
☐ **F1.7 ATTACHMENT For Heart Disease**
☐ **F1.8 ATTACHMENT For HIV/AIDS**
☐ **F1.9 ATTACHMENT For Seizures**

SECTION K. SUMMARY/NARRATIVE OF VISIT COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

a) Provide a summary of visit.
Document, at a minimum, the following:

i) For initial visit, provide a brief summary of each need identified in the health action plan. Describe any assessed barriers which may prevent attainment of member's desired goals.
ii) For subsequent visits, describe the changes identified in the HFA that resulted in a modification of the health action plan and summarize any new need(s) added to the health action plan.
iii) Any issues/changes related to emergency planning.
iv) Any issues/changes related to transportation.

SECTION L. VERIFICATION OF HFA COMPLETION COMPLETE FOR SHCN, EHCN, AT RISK, LTSS

L1. Signature of Persons Completing the HFA

Member Name: **Medicaid ID#:** **Date of Assessment:**

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I certify that the accompanying information accurately reflects member assessment information and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicaid requirements. I further understand that this information is used to ensure that member receives appropriate services and quality care, is a basis for payment, and may be used as supporting evidence in the event there is a grievance, appeal, or lawsuit on the care and the services in which member has been deemed eligible. I also certify that I am authorized to submit this information by this **(HEALTH PLAN NAME)** on its behalf.

Printed Name	Signature	Title	Sections	Date Section Completed
				__/__/____
				__/__/____
				__/__/____
				__/__/____

L2. Signature of Health Coordination Licensed Clinical Staff

I certify that I reviewed the member information, collected on the dates specified by the clinical and unlicensed/non-clinical staff, confirmed the information and/or obtained any additional information from the Member and made the final recommendation(s) included on the HFA. To the best of my knowledge, this information was collected in accordance with applicable Medicaid requirements. I further understand that this information is used to ensure that member receive appropriate services and quality care, is a basis for payment, and may be used as supporting evidence in the event there is a grievance, appeal, or lawsuit on the care and the services in which member has been deemed eligible.

I also understand as the Health Coordination Licensed Clinical Staff for **(HEALTH PLAN NAME)** I am required to ensure that all information collected in the Health and Functional Assessment is accurate and correct to the best of my knowledge and ability. I also certify that I am authorized to submit this information by this **(HEALTH PLAN NAME)** on its behalf.

		__/__/____
Printed Name	Signature	DATE: (MM/DD/YYYY)

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Age Cohort: ☐ Child ☐ Adult (19 and over)

Program Type: Choose an item.
☐ Special Health Care Needs (SHCN)
☐ Expanded Health Care Needs (EHCN)
☐ Long Term Services and Supports (LTSS)
☐ At Risk

SECTION A. AUTHORIZATION OF MY SUPPORT SERVICES

A1. MEMBER/AUTHORIZED REPRESENTATIVE

I have signed this document because I agree that: I/We have directed this HAP meeting as much as possible; Information about all my available choices was provided and I/we made my/our own choices and decisions in this meeting; I/we reviewed and agree to the support services written in this HAP.

		_____/ _____/ _____
Print Member Name	**Signature**	**Date**
		_____/ _____/ _____
Print Authorized Representative Name	**Signature**	**Date**

Indicate who directed the meeting. If someone other than the member directed the health action plan meeting, explain why.

A2. HEALTH COORDINATOR(S)

		_____/ _____/ _____
Print Lead Health Coordinator Name	**Signature and Title**	**Date**
		_____/ _____/ _____
Print Consulting Health Coordinator Name	**Signature and Title**	**Date**

A3. COPY OF HAP GIVEN TO

Primary Care Provider (PCP):

Support Provider(s):

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MY CAREGIVERS (INTERDISCIPLINARY TEAM (IDT))

Designated Point of Contact for all IDT members:

List below all caregivers and other providers who are involved in the Member's care. Indicate whether these individuals attend the IDT meetings.

Caregivers	Attends IDT meetings			Providers	Attends IDT meetings			Providers	Attends IDT meetings		
	Yes	No	N/A		Yes	No	N/A		Yes	No	N/A
Natural Supports (List all):				Health Plan Name:	☐	☐	☐	Other DHS programs	☐	☐	☐
	☐	☐	☐	HC Manager:	☐	☐	☐	CCS CBCM:	☐	☐	☐
	☐	☐	☐	HC (RN/LSW):	☐	☐	☐	CCS CM:	☐	☐	☐
	☐	☐	☐	Assistant HC:	☐	☐	☐	CCS Peer Support Specialist:	☐	☐	☐
	☐	☐	☐	CHW:	☐	☐	☐	CSAC:	☐	☐	☐
				BH Manager:	☐	☐	☐	CIS CM:	☐	☐	☐
				MCSA:	☐	☐	☐	Housing Coordinator:	☐	☐	☐
				Others, specify name and role:	☐	☐	☐	CWS Case Worker:	☐	☐	☐
					☐	☐	☐	APS Case Worker:	☐	☐	☐
								Others, specify name and role:	☐	☐	☐
									☐	☐	☐
Self-Directed caregiver:	☐	☐	☐	Primary Care Physician (PCP):	☐	☐	☐	Other state agencies			
CCFFH:				Psychiatrist:	☐	☐	☐	DOH-DD Waiver CM:	☐	☐	☐
E-ARCH:				Psychologist/Therapist:	☐	☐	☐	DOH Early Intervention:	☐	☐	☐
Primary caregiver:	☐	☐	☐	Pharmacist:	☐	☐	☐	DOH CAMHD:	☐	☐	☐
Secondary caregiver:	☐	☐	☐	Cardiologist:	☐	☐	☐	DOH AMHD:	☐	☐	☐
Other substitute caregiver(s):	☐	☐	☐	Pulmonologist:	☐	☐	☐	DOE Special Education:	☐	☐	☐
CCMA:				OB-GYN:	☐	☐	☐	DOE PT:	☐	☐	☐
Case Manager:	☐	☐	☐	Others, specify name and role:	☐	☐	☐	DOE OT:	☐	☐	☐
								DOE ST	☐	☐	☐
Hospice Care Agency:								Others, specify name and role:			
Hospice Nurse:	☐	☐	☐	Office of the Public Guardian:	☐	☐	☐				
Hospice CNA:	☐	☐	☐	Interpreter/Translator:	☐	☐	☐				
Palliative Care Agency:											
Palliative Care Nurse:	☐	☐	☐								
Palliative Care CNA:	☐	☐	☐								

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SPECIAL INSTRUCTIONS

Advance Directives Completed ☐ Yes ☐ No If Yes, copy attached to HAP ☐ Yes ☐ No	Provider Orders for Life-Sustaining Treatment (POLST) Completed ☐ Yes, identify location: _____ ☐ No Select one: ☐ Yes CPR ☐ No CPR Select one: ☐ Comfort Measures Only (CMO) ☐ Limited Additional Interventions ☐ Full Treatment

Check the boxes if these documents have been completed

☐ Emergency Contact List (Section A3c of HFA)	☐ Individualized Emergency Back Up Plan (Attachment of HFA)	☐ Infection Control Guidelines

List all Allergies (drug, food, and other allergies):

Health and Functional reassessment may be needed if one of these events occurred. Select Yes or No.

Recent (within 90 days) Hospitalization ☐ Yes ☐ No

Recent (within 90 days) ER visit ☐ Yes ☐ No

☐ Fall Risk (Check this box if member is 18 years or older and had one fall with injury or had at least two falls in the past year) ☐ N/A

Follow-up on members with a history of falls in the past year and/or answered 'yes' to the Fall Risk Assessment Tool:

Proceed with plan of care in Section B-J: My Goals and My Actions with a goal to prevent future falls. Action must include at a minimum exercise therapy or referral to exercise. Documentation of exercise therapy may include any of the following:

1. Documentation of exercise provided or referral to an exercise program.
2. Balance/gait training or instructions provided or referral for balance/gait training.
3. Physical therapy provided or referral to physical therapy.
4. Occupational therapy provided or referral for occupational therapy.

☐ Check this box if member refuses to participate in the development of plan of care.

Other:

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SECTION B to J. MY GOALS AND MY ACTIONS			
Important TO me (My Goal) #: 1 _____ Start Date: _____/ _____/ _____ Modified Date: _____/ _____/ _____ Next Review Date: _____/ _____/ _____ **☐ Please check this box when member has attained this goal.**			
My strengths and great things about me	**My Preferences/Choices**	**Barriers**	**Past Efforts to Meet Goal (Include successful & unsuccessful efforts**
What is important FOR me (My Actions)	**Who Will Help Me**	**Action Progress**	**Progress Note**
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	
Important TO me (My Goal) #: 2 _____ Start Date: _____/ _____/ _____ Modified Date: _____/ _____/ _____ Next Review Date: _____/ _____/ _____ **☐ Please check this box when member has attained this goal.**			
My strengths and great things about me	**My Preferences/Choices**	**Barriers**	**Past Efforts to Meet Goal (Include successful & unsuccessful efforts**
What is important FOR me (My Actions)	**Who Will Help Me**	**Action Progress**	**Progress Note**
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	

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		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	
What is important TO me (My Goal) #: 3 _____ Start Date: _____/ _____/ _____ Modified Date: _____/ _____/ _____ Next Review Date: ____/ _____/ _____ **☐ Please check this box when member has attained this goal.**			
My strengths and great things about me	**My Preferences/Choices**	**Barriers**	**Past Efforts to Meet Goal (Include successful & unsuccessful efforts**
What is important FOR me (My Actions)	**Who Will Help Me**	**Action Progress**	**Progress Note**
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	
		☐ Not Started ☐ In Progress ☐ Completed ☐ Member declined	

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SECTION F. DISEASE MANAGEMENT/EDUCATION			
Learning Needs (Disease Diagnoses)	**Provider Name and Contact Information**	**Frequency/Amount and Duration**	**Comments**

SECTION F-G. MY SUPPORT PLAN DETAILS *(Select all that apply) *Skilled Nursing RN/LPN only*

F3. MEDICATIONS (Prescribed and OTC)	**Frequency/Amount**	**Special Instructions**
☐ See Medication Sheet and administer as ordered by physician* (0700)		
☐ Update medication list (0705)		
☐ Blood glucose monitoring (0710)		
☐ Other:		
G4. VITAL SIGNS		
☐ Temperature (0100) ☐ Pulse (0105) ☐ Respiration (0110 ☐ Blood Pressure (0115) ☐ Oxygen Saturation (0120) ☐ Height and Weight (0125) ☐ Other:		
G4f. CARDIAC/RESPIRATORY CARE		
☐ Oxygen* (0500) Oxygen Orders:		
☐ Oral Suctioning (0505)		
☐ Suctioning non-oral* (0510)		Every _____ hour(s) or as needed to maintain clear airways
☐ Nebulizer/Aerosol Treatments* (0515)		
☐ Check Humidifier (0520)		
☐ Check Apnea Monitor (0525)		
☐ Check Pulse Oximeter (0530)		
☐ Tracheostomy Care* (0535)		
☐ Ventilator Care (540) ☐ Check Ventilator Settings (0545) Type:		FIO2 _____%, Vt _____, Peep _____, Rate _____, PS _____
☐ Check Oxygen Concentrator (0550)		_____ L/min

Member's Name:	**Medicaid #:**	**HAP Date: ____/____/____**
☐ Check Resuscitator/Ambu Bag (0555)		
☐ Chest Physiotherapy (0560)		
☐ Cough Stimulator (0565)		
☐ See manuals/information provided by equipment vendors for specific instructions about respiratory equipment		
☐ Other:		
G6. CONTINENCE (BLADDER AND BOWEL ELIMINATION)		
☐ Brief/Diaper change and check site and skin daily (0800)		
☐ Bedpan (0805) ☐ Urinal (0810) ☐ Condom care (0840)		
☐ Toilet (0820)		
☐ Urinary Catheterization* (0825) ☐ Catheter Care (0830 ☐ Catheter Irrigation* (0835) ☐ Condom care (0840)		☐ Empty Urine Drainage Bag (845) ☐ Record Output (850) ☐ Drain bag: Empty ½ full or more often (855)
☐ Check for bowel movement (BM) (0860)		
☐ Digital Stimulation (0865) ☐ Suppository (0870)		
☐ Enema (0875) ☐ Fleet Enema* (0880)		
☐ Other:		
G7. SKIN (WOUND CARE)		
☐ Decubitus Care (0600) ☐ Dressing (0605) ☐ Clean (0610) ☐ Sterile		
☐ Other:		
G10. PERSONAL ASSISTANCE LEVEL I Chore (Based on iADL/ADL Attachment)		
Routine House Cleaning ☐ Bathroom (0200) ☐ Kitchen (0205) ☐ Bedroom (0210) ☐ Changing Linen (0215) ☐ Make bed (0220) ☐ Empty Trash (0225) ☐ Other:		
Laundry ☐ Washing (0230) ☐ Drying (0235) ☐ Ironing (0240) ☐ Mending (0245)		
☐ Shopping/Errands (0250)		

Member's Name:	**Medicaid #:**	**HAP Date: ____/____/____**
☐ Transportation/Escort (0255)		
☐ Meal preparation (0260)		
☐ Companion (0265)		
☐ Other:		
G10. PERSONAL ASSISTANCE LEVEL II Personal Care (Based on iADL/ADL Attachment)		
Eating/Feeding ☐ Prepare/Serve (0300) ☐ Assist/Feed (0305) ☐ Record Oral Intake (0310)		
Bathing ☐ Bed Bath (0315) ☐ Shower (0320) ☐ Shampoo (0325)		
Dressing ☐ Upper Body (0330) ☐ Lower Body (0335)		
Grooming ☐ Oral Care (0340) ☐ Shave (0345)		
Hair and Skin care ☐ Brush (0350) ☐ Comb (0355) ☐ Nail Care (0360) ☐ Foot Care (0365) ☐ Skin care (0367)		
☐ Toileting (do not include transfer and ambulation) (0370)		
☐ Bed Mobility/Transfers (0375)		
☐ Manual Wheelchair mobility (0377)		
Medication Assistance ☐ Remind (0385) ☐ Assist (0380)		
☐ Other:		
G10. PERSONAL ASSISTANCE LEVEL II DELEGATED NURSING TASKS (Based on iADL/ADL Attachment)		
☐ Task:		
☐ Task:		
G10. MEALS/FEEDING		
☐ Record Feeding Intake (0450)		
☐ Tube Feeding (0455)		Feeding Orders:
☐ G-Tube care (0460)		
☐ Monitor skin condition for adequate hydration (0465)		
☐ Other:		

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G10. MOBILITY (Based on iADLs/ADL Attachment)		
☐ Turning and Repositioning (0900)		
☐ Transfer(s) (0905)		
☐ Up in chair (0910)		
☐ Manual Wheelchair (0915)		
☐ Front Wheeled Walker (FWW) (0920)		
☐ Transfer - Patient Lift (0925)		
☐ Walk (0930)		
☐ Exercise (0935)		
☐ Safety Belt (0940)		
☐ Check Side Rails (0945)		
☐ Habilitation (0955)		
☐ Other:		

SECTION I. MY SUPPORT PLAN				
Check appropriate service and complete information. Complete the Personal Assistance/Nursing Task selection as indicated*				
SHCN or EHCN Services	☐ N/A			
SERVICES	**START DATE**	**PROVIDERS**	**FREQUENCY/AMOUNT**	**DURATION**
☐ Health Coordination	_____/ _____/ _____			
☐ Other, specify:	_____/ _____/ _____			
I1. Home and Community Based Services (HCBS) Complete for At-Risk, LTSS	☐ N/A			
SERVICES	**START DATE**	**PROVIDERS**	**FREQUENCY/AMOUNT**	**DURATION**
☐ Health Coordination	_____/ _____/ _____	RN: SW:		
☐ Adult Day Care (ADC)	_____/ _____/ _____			
☐ Adult Day Health (ADH)	_____/ _____/ _____			
☐ Assisted Living Facility (ALF)	_____/ _____/ _____			
☐ Community Care Management Agency (CCMA)	_____/ _____/ _____	RN: SW:		
Counseling and Training ☐ Nutrition ☐ Coping/Support ☐ Crisis Intervention ☐ Family Training ☐ Caregiver Training ☐ Other:	_____/ _____/ _____			

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☐ Environmental Accessibility Adaptations (EAA) ☐ Assessment ☐ OT ☐ PT ☐ N/A	_____/ _____/ _____			
☐ Home Delivered Meals	_____/ _____/ _____			
☐ Home Maintenance	_____/ _____/ _____			
☐ Moving Assistance	_____/ _____/ _____			
☐ Non-Medical Transportation	_____/ _____/ _____			
☐ Personal Assistance Level I (PA I Chore)* ☐ PA I Agency ☐ PA I CDPA	_____/ _____/ _____			
☐ Personal Assistance Level II (PA II Personal Care)* ☐ PA I Agency ☐ PA I CDPA	_____/ _____/ _____			
☐ Personal Assistance Level II Delegated (PA II Delegated) ☐ PA II Agency ☐ PA II CDPA	_____/ _____/ _____			
☐ Skilled (or private duty) Nursing	_____/ _____/ _____			
☐ Personal Emergency Response Systems (PERS) ☐ Basic Reassurance ☐ Enhanced Reassurance/Calls	_____/ _____/ _____			
☐ Residential Care ☐ Expanded Adult Residential Care Home (E-ARCH) ☐ Community Care Foster Family Home (CCFFH)	_____/ _____/ _____			
☐ Respite ☐ In-home ☐ Community based ☐ Institutional	_____/ _____/ _____	☐ Hourly ☐ Overnight		
☐ Specialized Medical Equipment/Supplies (SMES)	_____/ _____/ _____			
☐ Other, specify	_____/ _____/ _____			

DHS 1147/1147e
Approved LOC: Functional Points: Expiration Date:

I2. INSTITUTIONAL SERVICES ☐ N/A

TYPE OF FACILITY ☐ ICF/ID ☐ Nursing Facility ☐ Hospital ☐ Prison/Jail ☐ Hawaii State Hospital (2 boxes for future use)		**START DATE** _____/ _____/ _____
Facility Name:	Name of Contact:	Phone:

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☐ Discharge Planning *(Must complete if pending discharge)*
Pre-Discharge Assessment Date: _____/ _____/ _____
Anticipated Discharge Date: _____/ _____/ _____
Discharge Location:
Anticipated Discharge Planning Meeting Date: _____/ _____/ _____
Discharge Date: _____/ _____/ _____

☐ Other:

I3. ADDITIONAL SUPPORT SERVICES – a. PROVIDED THROUGH DHS/MQD/MCOs

SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY/AMOUNT**	**DURATION**
☐ Community Care Services (CCS)				
☐ Dental	_____/ _____/ _____			
☐ Home Health Agency ☐ HH Aide* ☐ LPN* ☐ RN* ☐ OT ☐ PT ☐ Speech	_____/ _____/ _____			
☐ Transportation, Medical	_____/ _____/ _____			
☐ CWS ☐ APS ☐ Foster Care ☐ LIHEAP ☐ SNAP ☐ VOC Rehab ☐ Financial Assistance ☐ Other ☐ Employment	_____/ _____/ _____			
☐ Behavioral Health Services ☐ SUD ☐ MH	_____/ _____/ _____			
☐ HIV/AIDS Services	_____/ _____/ _____			
☐ Meals on Wheels	_____/ _____/ _____			
☐ Housing Assistance ☐ CIS	_____/ _____/ _____			
☐ Disabled Parking Permit	_____/ _____/ _____			
☐ Homeless Shelter ☐ Transitional Housing	_____/ _____/ _____			
☐ Legal Assistance ☐ Guardianship ☐ POA for Healthcare ☐ Advance Directives	_____/ _____/ _____			
☐ Volunteer ☐ Companion	_____/ _____/ _____			
☐ Other, specify:	_____/ _____/ _____			

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I3. ADDITIONAL SUPPORT SERVICES – b. PROVIDED THROUGH OTHER STATE AGENCIES				
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY/AMOUNT**	**DURATION**
☐ CWS ☐ APS ☐ Foster Care ☐ LIHEAP ☐ SNAP ☐ VOC Rehab ☐ Financial Assistance ☐ Other ☐ Employment ☐ Probation/Parole				
☐ HIV/AIDS Services				
☐ Legal Assistance ☐ Guardianship ☐ POA for Healthcare ☐ Advance Directives				
☐ Disabled Parking Permit				
☐ Homeless Shelter ☐ Transitional Housing [If not provided by health plan]				
☐ Volunteer ☐ Companion				
☐ Congregate Meals				
☐ Other, specify:				

I3. ADDITIONAL SUPPORT SERVICES – c. PROVIDED BY OTHER STATE AGENCIES				
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY/AMOUNT**	**DURATION**
Department of Education (DOE) School Based Services ☐ Home Schooling ☐ Skilled Nursing ☐ Behavioral Health ☐ Special Education ☐ Speech ☐ OT ☐ PT	_____/ _____/ _____			
Department of Education (DOE) ☐ Early Intervention (0-3) ☐ OT ☐ PT ☐ Speech ☐ Healthy Start ☐ PHN ☐ Audiology ☐ CAMHD ☐ AMHD (Legally Encumbered) ☐ ADAD	_____/ _____/ _____			
☐ Other State Agencies, specify:	_____/ _____/ _____			
☐ Other, specify:	_____/ _____/ _____			

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I3. ADDITIONAL SUPPORT SERVICES – d. PROVIDED THROUGH NON-STATE AGENCIES				
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY/AMOUNT**	**DURATION**
☐ Palliative Care	_____/ _____/ _____			
☐ Hospice Care	_____/ _____/ _____			
☐ Other, specify:	_____/ _____/ _____			

I3.d. REFERRALS			
Referral Service/Specialty	**Provider Name and Contact Information**	**Frequency/Amount and Duration**	**Comments**

SECTION K. SUPPORT PROVIDER		
K1. PRIMARY CARE PROVIDER (PCP)		
Name:	Phone:	Fax:
☐ Review HAP annually and as needed	☐ Coordinate overall medical care of member	
☐ Perform Health and Physical Exam as needed	☐ Provide requested medical information, complete and return forms	
☐ Complete DHS 1147/1147e annually and as needed	☐ Other:	
K2. LEAD (L) AND CONSULTING (C) HEALTH COORDINATORS		
Lead Health Coordinator Name and Title:	Phone:	Fax:
Consulting Health Coordinator Name and Title:	Phone:	Fax:

L	C	
☐	☐	Implement the HAP and coordinate services of the member with physician(s) and other providers
☐	☐	Review and update HAP every _____ day(s), if not occurred earlier due to the occurrence of a significant event
☐	☐	Review and update current medications during each home visit and as needed
☐	☐	Monitor the member and the primary caregiver status through ☐ Home Visits every _____ day(s) and as needed ☐ Phone Contacts every _____ and as needed
☐	☐	Monitor the member within 48 hours after or next business day: hospitalization, acute medical or emotional crisis, adverse event report
☐	☐	Review and update Individualized Emergency Back Up Plan annually and as needed
☐	☐	Review and update Disaster Preparedness form annually and as needed
☐	☐	Reviewed Infection Control Guidelines with member and caregiver
☐	☐	Monitor operating status of smoke alarm at every home visit

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☐	☐	Identify fire hazard(s) and establish a Fire Safety Plan
☐	☐	Provide referrals and supportive resources to the member and caregivers as needed
☐	☐	Teach/provide health information based on members
☐	☐	Provide healthy reproductive planning based on One Key Question Algorithm, if applicable
☐	☐	Assist with ordering equipment and supplies
☐	☐	Complete DHS 1147/1147e annually and as needed
☐	☐	Complete adverse events report form per health plan's policies and procedures
☐	☐	Other:
K3. PRIMARY CAREGIVER (PC) AND MEMBER (M)		
PC	**M**	
☐	☐	Responsible for the members care and safety when paid personnel are not present
☐	☐	Maintain operating smoke alarm at all times
☐	☐	Maintain operating telephone
☐	☐	Maintain a clear pathway from member's bed to the closest exit
☐	☐	Report all hospitalizations, health problems, injuries, falls, skin breakdown or other health or social problems to Lead HC within 24 hrs
☐	☐	Report worker "no show" or problems with assigned worker to the service provider then to the Lead HC
☐	☐	Report 2 hours in advance to service provider when canceling services
☐	☐	Use 24-hour emergency number 911 for all emergencies
☐	☐	Assure that all backup caregivers have been trained & are signed off on HAP by health professional i.e., PT, OT, RN, etc.
☐	☐	Report episodes of adverse events such as falls, skin breakdown, abuse, and others to case manager or health coordinator
☐	☐	Other:

K4. ALL CAREGIVERS

☐ Know all medications, its purpose, effects and side effects.
☐ Report any medical and/or social changes to the Lead HC and PCP.
☐ Maintain a clean environment and prevent the spread of disease with frequent hand washing. Use Infection Control barriers as needed.
☐ See home binder for detailed information and instructions on the member's case.
☐ Communication: Communicate with the member regularly with dignity and respect, listen to what's important to the member, face the member when speaking, talk clearly and pronounce words.
☐ Verbally intact with the member during meaningful activities.
☐ Give verbal cues to the member prior to touching member due to _____ impairment.
☐ Check equipment and supplies regularly. Notify Vendor and Lead HC if equipment needs repair and if supplies are low quantity on hand.
☐ Provide a safe environment and review the Individualized Emergency Backup Plan annually and as needed.

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☐ Report episodes of adverse events such as falls, skin breakdown, abuse, and others to case manager to health coordinator.
☐ Other:

SECTION L. ADDITIONAL COMMENTS	
AREAS OF CONCERN IDENTIFIED IN THE HFA	**PRIORITY**